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ACGIM

Advanced Medical Homes and Financing GIM Practice

William P. Moran, MD, MS

Dr. Moran is Chief of General Internal Medicine and Geriatrics, Medical University of South Carolina. He is the immediate past president of ACGIM and a former Clinical Director for North Carolina Community Care Networks (NC Medicaid).

The term “Medical Home” was coined in pediatrics in the late 1960s to designate a practice as primary care provider for a child. In 2004, Barbara Starfield described the functions of Medical Homes, which include facilitating access to care, providing longitudinal comprehensive care, and coordinating care-related services.

Despite the rise and fall of managed care and capitation, the Medical Home has remained a key organizing concept for many state Medicaid programs. It has been touted as one of several strategies to effectively improve quality of care, reduce disparities, and constrain Medicaid costs.

A 2005 study by Antonelli and Antonelli reported that 11% of pediatric patients and 25% of pediatric encounters required coordination of care services. Payment for Medical Home-related services is explicit and independent of fees charged for an office visit. For example, North Carolina Medicaid pays Medical Homes a monthly management fee for each enrollee in the practice, and this payment is in addition to visit-associated fee-for-service payments. Medicaid justifies these payments by showing cost sav-

ings in avoided emergency room visits, hospitalizations, and reductions in service duplication.

The Medical Home model has clear application in the care of complex patients seen in General Internal Medicine practice. Despite the antiquated fee-for-service payment mechanisms for acute and preventive care, general internists strive to coordinate care and services, provide patient education, and oversee “disease management” services within their practices. These functions are critical to providing excellent quality of care.

However, because they are not reimbursed, these services stress physicians and practices and contribute to dissatisfaction with GIM outpatient practice. Medical Home functions need to be acknowledged, costs measured, and practices reimbursed in addition to traditional Evaluation and Management (E/M) payments.

In January 2006, the American College of Physicians (ACP) issued a policy monograph calling for primary or principal care to be organized within Advanced Medical Homes. The ACP suggests we define Advanced Medical Home services,

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Living, Growing and Dying: Remembrances of David Calkins

Malathi Srinivasan, MD; Michael Barry, MD

As organizations grow, their members grow with them—advancing in career and seniority. And, unfortunately, advancing in age. Now that SGIM is nearing its 30-year mark, some of our beloved members who helped found the organization have succumbed to the diseases that often accompany aging. While younger SGIM members may not have known them closely, their work has indelibly shaped the organization.

Today, we would like to remember with great fondness our friend, Dr. David Calkins. David died on April 7, 2006, of complications of a glioblastoma, which he had had for several years.

He had been a guiding force at SGIM, serving as the first SGIM *Forum* Editor, then a Council member, and Chair of the Health Policy Committee. In 2004, he was given the SGIM Elnora Rhodes Service Award—one of the

highest honors of the Society. Throughout David's career, he merged clinical care, health policy, patient advocacy, and education seamlessly.

His academic and government service record was (as you might expect) impressive.

Princeton—1970. Harvard Medical School with an MPP from the Kennedy School of Government—1975. University of Washington and Beth Israel—internship and residency—1975–1978.

Josiah Macy Fellow in Health Policy (Kennedy School)—1983. Senior Policy Analyst and Assistant Director, Domestic Policy Staff, The White House—1978–1979. Special Assistant and Deputy Executive Secretary for the Department of Health and Human Services—1979–1981.

David was on faculty at the Beth Israel Hospital and later GIM Division Chief at the Deaconess Hospital from 1991–1996. He left Boston and went to the University of Kansas, where he served as Associate Dean for Primary Care, then Senior Associate Dean for Medical Education. In 1999, he returned to Harvard Medical School as Associate Dean for Clinical Programs. He became a Merck Fellow at the Institute for Healthcare Improvement (IHI) and worked on the “100,000” lives campaign to improve patient care and decrease avoidable deaths. He was especially proud of the paper describing the campaign in *JAMA* 2006;295:324, published just weeks before his death.

These accomplishments are not why we are recognizing David today. In addition to his passion for health policy and systems improvement, David was a remarkable, warm person.

David was many things to many people. To his friends, he was a devoted family man, genial golfer and fishin' buddy, and rabid Red Sox fan. To his patients, he was a tireless primary care physician and advocate. He went out of his way to help patients and their families—even coordinating care for SGIM family members in distress in other countries! To students and

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The Challenge of Leadership

Robert Centor, MD

One month prior to becoming SGIM president, Bob Centor reflects on what he's learned from Barbara Turner (current President) and Mike Barry (immediate Past President) and the prospect of leading the organization for the next year.

We need a leader to tell us: Who, precisely, do we serve? What is our core strength? Of the many things we can measure in our business, which one measure of success should we focus on? And, what specific actions can we take right now to improve our business?

—Marcus Buckingham



As I read Marcus Buckingham's recent book, *The One Thing You Need to Know: About Great Managing, Great Leading, and Sustained Individual Success*, I thought about leadership.

My interpretation of Buckingham's main point about leadership is that I and the Council must consider exactly why SGIM exists. **What is universal about SGIM membership?**

SGIM contains many constituencies. As I consider those constituencies and discuss SGIM with members, I have discovered an interesting phenomenon. Members from each major constituency have expressed their concerns about SGIM's ability to satisfy their particular needs.

Within the last month, I have had clinician educators tell me that they felt underappreciated in SGIM. Researchers say that the research content of the meeting is lacking. Clinicians wonder whether SGIM speaks for them. Academic hospitalists feel slighted.

While we have many other constituencies (many represented by interest groups), I will restrict my comments to the groupings I have

already mentioned. Almost everyone in SGIM belongs to at least one of these constituencies.

So our leadership challenge becomes clear. What do all these groups share and have in common?

Developing a Shared Mission

If we can articulate our shared mission, then leading SGIM gains much clarity. Defining this shared mission will motivate our planning and our interactions with other medical organizations.

At the risk of being presumptuous, I do have some ideas on what is universal about SGIM.

Our members all desire to improve academic general internal medicine and care of the adult patient. Some of us improve academic GIM by providing compassionate, evidence-based patient care. Most of us teach students and residents, using all the tools in our educator's toolbox. Many of us advance the scientific knowledge of patient care. We are passionate about systems improvement.

My role as president requires a clear enunciation of these commonalities and constant consideration of these com-

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ASK THE EXPERT

Changing Organizational Culture

Thomas Inui, ScM, MD, and David Mossbarger, MBA, MA, Indiana University School of Medicine

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”
—Margaret Mead

Culture, at the deepest level of understanding, is a fabric of shared meanings within which we conduct our lives. Expressed in language, traditions, moral judgments, work patterns, social interactions, and even bricks and mortar, culture affects us in such pervasive and systemic ways that we have difficulty recognizing it. Instead of seeing culture as a co-constructed fabric, we mistake culture for “the way things are.”

In academic medicine, culture is no less powerful than elsewhere. Elements of our culture in academic medicine could arguably be said to include logical positivism, scientific modernism, intellectual Darwinism, and scientific discovery as the criteria of excellence, among other deeply rooted beliefs.

Culture changes slowly, but it is always changing, responding to such forces as shifting technology (the industrial revolution), political change (the rise of nation-states, the fall of colonialism), climatologic and demographic shifts, social movements, warfare, and plagues.

Culture also changes upon occasion because a small group of people take actions with the potential to shift shared meanings, even at a deep level.

Early in 2003, a few individuals at Indiana University School of Medicine (IUSM) set out to shift the culture of our very large and bureaucratic institution. We hoped that such change might strengthen our academic community’s commitment to expressing the kind of professional competencies and values that we wish our students to acquire while becoming physicians in our midst.

Our first step was to openly declare this audacious goal and to convene a small group of kindred spirits to decide what might be done to this end. This group, self-named the “Discovery Team” (DT), decided to conduct a process of harvesting the narratives of work at IUSM that described us at our very best—part of an organizational development method denoted as “appreciative inquiry.”

As leaders in this initiative, we did our best to “open a safe space” for the DT, one in which everyone could express him or herself fully, share

sensitive information confidentially, show ignorance, ask for help, speak the truth, be heard, and work with others for community. The regular meeting of the DT required respectful facilitation and attention to evolving group interests but no permission or charge “from the top” for group initiatives to take flight.

At its origin and over time, the DT attracted diverse individuals, each with a stake in shifting our organizational culture toward a more tangible expression of positive professional values.

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ABSTRACTIONS

A Brief Discourse on Patient Safety

Jeff Jackson, MD, in an interview with Robert Wachter, MD, and Kaveh Shojania, MD

Tell me about how SGIM members can get involved with patient safety...

Kaveh: General internists have a unique view of the complexity and richness of the patient safety field and are in the best position to understand, research, teach, and advocate about patient safety.

Bob: I agree. Generalists are genetically predisposed to be unusually effective in this area. By our nature we tend to be collaborative, comfortable with interdisciplinary work, and open to new kinds of knowledge from all sorts of different avenues. To be effective in this field, you have to learn about clinical psychology, engineering and systems thinking, human factors, and information technology—these are disciplines that are natural for generalists and a little bit harder for people who have narrowed themselves to a single specialty.

Kaveh: In general medicine, we see the broken aspects of the system, both in the hospital and outpatient setting, and so we have more of a realistic view of the obstacles that stand in the way. But we also have the passion and desire to fix them. Other types of physicians—and most non-clinicians—are sometimes a bit Pollyanna-ish. They often don’t realize how complicated it can be to fix broken systems.

I see two possible career options for individuals interested in patient safety: researching the problem or trying to fix the problem.

Bob: The divergence between the career paths of researching problems versus fixing them is beginning to break down. Funders are less interested in pure academics and more interested in translating research into making a difference. At the same time, institu-

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Assessing Pain: Provider Behavior Before and After a System Intervention

Adam Gordon, MD, MPH

This Month in JGIM, Dr. Gordon interviews Richard A. Mularski, MD, MSHS, of UCLA/RAND. Dr. Mularski works in the Pulmonary and Critical Care Sections of the VA Greater Los Angeles Healthcare System, the Department of Medicine, the RAND Health Sciences Program, and the Department of Health Services at the UCLA School of Public Health. They discuss his article, “Measuring Pain as the Fifth Vital Sign Does Not Improve Quality of Pain Management.”

Acute and chronic pain syndromes are the most frequent symptoms reported by patients to their providers. While policy makers recognize the importance of pain assessment and intervention, pain management is complex and challenging, even for the most seasoned internist.

This Month in JGIM, Dr. Richard Mularski and colleagues report upon their study, “Measuring Pain as the Fifth Vital Sign Does Not Improve Quality of Pain Management.”

In his study, Dr. Mularski reviewed VA medical records to evaluate the impact of the VA’s “Pain as the Fifth Vital Sign” initiative on pain assessment and the quality of pain management.

They compared providers’ pain management before and after implementing the initiative. They found that the quality of pain was unchanged between visits before and after the pain initiative. In particular, nearly a quarter of patients who reported substantial pain did not receive recommended care, with attention to pain documentation missing in the medical record.

Dr. Mularski said that the study highlighted both deficits in the provision of quality pain management and difficulties associated with affecting change in practice patterns. He notes: “Ensuring high quality pain care amongst competing concerns and limited resources is difficult. Measuring pain is a necessary first step, but far from sufficient. Our evaluation suggests more comprehensive and multifaceted systemic approaches will be necessary to change provider behavior and improve pain management.”

Suprising Findings

Despite VA and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandates that providers assess and treat patients’ pain, the

...we found that that some practitioners were not aware of the fifth vital sign field....

study found assessment of pain was lax even after the initiative was in place. Dr. Mularski observes: “Given 55 million encounters a year across the VA and assuming just a few seconds for a nurse to ask and record the pain as the fifth vital sign, the VA has roughly spent over 850,000 hours in RN time since the mandate. Our study suggests much more will be needed to change the complex process of pain assessment and management.”

Implications

As with many clinical investigations, Dr. Mularski notes that his study raises more questions than answers: “One of the major unanswered questions is: ‘What are the barriers in allowing the fifth vital sign strategy to make a difference?’”

He continues, “Exploring the quality performance at multiple institutions may identify variation in practice. Qualitive study could further identify best practices and barriers. For instance, through informal discussions with providers, we found that that some practitioners were not aware of the fifth vital sign field or did not have ready

access to the computerized record of the pain level at the time of patient visit.”

Dr. Mularski said that identifying practitioners who performed well at identifying and treating pain could

enable effective implementation strategies to improve pain management care. He and his study team are already working with the VA Office of Quality and Performance to better

characterize national quality performance in pain management.

Future Work

Dr. Mularski sees important questions that remain and hopes to continue his investigative inquiries: “I am developing rigorous quality measures, not only for pain management but for other important aspects of palliative and end-of-life care, and ensuring linkage to changes in outcomes, such as the improvement in patient suffering. Concurrent with efforts in developing and testing rigorous evaluation tools is the need for innovation in quality improvement techniques.”

Fortunately, the VA is receptive to his work. “The VA is working with many investigators and quality leaders through the National VA Pain Management Coordinating Committee and has already employed a more comprehensive pain management guideline that includes algorithmic tools to aid the practitioner in recognizing and treating pain,” Mularski said. *SGIM*

46 Million Americans Are Uninsured: Why Haven't We Fixed the Problem?

Mark Liebow, MD, MPH

Most health policymakers are aware that 46 million Americans or about 15.4% of the population don't have health insurance. Arguably, this is the most important problem in American health care today—perhaps even more important for overall patient care than Medicare drug coverage or NIH funding.

However, this fact has a critical caveat. Since virtually everyone over age 65 has Medicare, **the proportion of those under 65 without health insurance is more than 17%.**

Yet, in Congress, bills that would improve access to care and provide health coverage to millions of uninsured people are introduced every two years and go nowhere. These bills don't even get committee hearings in the Republican-controlled Congress.

Why has this pattern persisted?

To this day, the myth persists that the uninsured get care anyway from Emergency Departments and free clinics. Another popular myth suggests that most people who don't have insurance choose not to get insurance so they can spend their money on luxuries.

SGIM members, who as a group provide a disproportionate amount of the care received by the uninsured, know the truth. They understand the literature, which shows that uninsured people don't receive medical care as often as their insured counterparts for most illnesses. SGIM members have read the studies that illustrate how uninsured people are more likely to die or to suffer from illness than those with insurance even when controlling for other differences.

Access to care is a complex issue. Anyone who has listened to abstracts at SGIM meetings knows that having insurance may not be enough to get patients the care they need. Even in Canada, where everyone has insurance,

there are disparities in access to care. Those kinds of variations are not likely to be fixed by policy changes at the Federal or state level. What can be fixed by legislation is *health insurance coverage*.

In the early 1970s, President Nixon had a serious proposal for universal coverage in this country. It seemed like the next logical step to follow a period of economic expansion and the initiation of Medicare and Medicaid. Unfortunately, that proposal, like Nixon, was a casualty of Watergate.

The number of uninsured rose substantially through the rest of the 1970s and much of the 1980s, reduced only by expansions of Medicaid. The percentage of uninsured people fell slightly in the late 1990s, especially

among children, but has risen again in this decade. It is projected to rise even higher.

No other industrialized country has as high a percentage of uninsured citizens as the U.S. does.

The United States surpasses all industrialized countries in the proportion of its citizenry who are uninsured.

SGIM has long taken the position that the United States should have universal coverage with a single payer. Our position was reaffirmed by a poll of the membership in 2004.

Although a major political shift will be required to make universal coverage a top-tier political issue, SGIM will continue working for universal coverage and access to care. **SGIM**

FUNDING CORNER

Variety and Innovation in Aging Research?

Joseph Conigliaro, MD

This month's issue of Forum highlights two potential funding sources for career development among SGIM faculty interested in aging research.

Opportunities for funding in aging research are available for junior- to senior-level investigators from multiple organizations. Over the past several years, SGIM members have successfully obtained funding from the NIH's National Institute on Aging and other federal groups. Here, we wanted to highlight another source of funding—specialty foundations.

Foundations and specialty interest groups can provide bridge and pilot funding for investigators. While some of these funding opportunities provide support for projects that are somewhat limited in scope, cumulatively, they can make a significant contribution to one's

overall research portfolio. Here, we explore two such opportunities at RAND and the Hartford Foundation.

RAND Study of Aging Fellowship

The RAND Study of Aging Fellowship is designed for junior and senior faculty in aging research who are interested in broadening their methodologic skills and advancing their research career. The goal of the award is to combine formal coursework and training through RAND with the opportunity to collaborate with its interdisciplinary faculty. The program accepts one fellow per year for one year, but the fellowship can be

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Meet the Bloggers: Blogging in the Medical Community

Linda Pinsky, MD, and Malathi Srinivasan, MD

In this month's *Human Medicine*, we look to traditional and new media sources to discuss current issues in medicine. "Blogging" about medical issues represents a new method of convening national discourse about important issues and a new way to influence public opinion.

"Conscience, man's moral
medicine chest"
—Mark Twain

Currently, the US medical community is ablaze with discussion of David Leonhardt's *New York Times* article "Why Doctors So Often Get It Wrong." The article examines doctors' persistently high rate of mistakes—estimated to be up to 20% of fatal diagnosis. The specific "hot spot" in the *Times* article centers on the author's attribution of misdiagnosis to inappropriate financial incentives.

In response to this article, two parallel sets of discussions have ensued: the first is the traditional response from media news outlets and medical organizations, and the second is a more facile, passionate, potentially less accurate conversation by people on the Internet.

Meet the bloggers.

The Blog

Blogs are open web-based discussion pages that are usually run as personal journals. According to the Pew Internet and American Life Project, funded by the Pew Charitable Trusts, by 2004, eight million Americans had created blogs, and about 30% of Internet users read blogs. By the end of 2004, 32 million Americans were blog readers.

These numbers have only increased in the past two years. While blog creators were more likely to be younger men with broadband at home, blog readers are a more diverse group—with women, older individuals and minorities climbing in readership. Blog readers are your patients.

Medical Blogs

Medical blogging is a growing phenomenon. An Internet search of the terms "medical blogging" resulted in over 3 million hits. Included are sites run by promotional companies, patients who want to share their experiences, support groups, medical marketers, advocates, politicians, and physicians.

As physicians have joined the blogging world, the line between personal and professional has blurred. Medical blogging raises the question: Should physicians be impartial providers of health care, or should they let their private opinions on medical topics be known to the world?

Let us return to the *Times* article briefly. Reaction to the Leonhardt article was swift by bloggers. Physician blogging sites included *dbsmedicalrants*, *doctorrr*, and *secondopinion.com*.

Some argued that Leonhardt oversimplified many major issues about medical errors, including the clinical time pressures imposed by P4P measures, problems with risk adjustment software, etc.

In the past, individuals or small groups could not respond to major health issues effectively—in a way that could impact health policy, medical standards, or the health care community. The Leonhardt article makes an interesting case study for the power of blogging to broadcast nuanced discussions to an interested readership.

Traditional media are limited in their scope and reach to broad audiences. If an individual does not subscribe to a journal, a newspaper, or watch the evening news, access to relevant information is challenging.

Reaching health policy makers (such as the much-read Ariana Huffington blog) was nearly impossible for the individual.

Complementary changes in technology and society are increasing the impact of blogging. For instance, the Public Library of Science and the Soros Foundation's Open Society Initiative are changing the way health professionals share scientific information. Pod-casting and regional mobile networks (via PDAs and cell phones) are changing how consumers stay in touch and obtain information. TiVo allows users to watch TV shows on their own schedule, free of commercial influence.

Yet, as described by Forbes (www.forbes.com/best/2004/1213/bow001.html), blog readers still need to look for content riddled with "spam, promotions disguised as content, and an ever-present problem with anything published in cyberspace, credibility."

The health care information world is becoming more open and more accessible. In this new milieu, physicians with experience with emerging technologies will be poised to take new leadership roles and shape important informal discussions. These informal discussions may form the core of a new informed health care electorate, who can help us develop better solutions for our pressing health care problems—and to quickly respond to (and correct) simplistic misperceptions created by well-intentioned writers such as Leonhardt. **SGIM**

ACGIM

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Medical Home functions need to be acknowledged, costs measured, and practices reimbursed in addition to traditional Evaluation and Management (E/M) payments.

establish criteria for certification of Advanced Medical Homes, and develop a training and research focus on the characteristics of Advanced Medical Homes that leads to higher quality of care and lower costs. SGIM has already begun to address many of these questions, most recently in the “Future of General Internal Medicine Report” and “Reforming Residency Report.”

Unfortunately, changes recommended in these reports lead to higher costs, and financing these changes has always been the challenge.

The Advanced Medical Home model suggests an accepted financing mechanism to pay for practice-level services not adequately

covered by E/M payments.

In this model, Medicaid programs pay a monthly management fee for each patient enrolled in an Advanced Medical Home. Although it may be a long uphill struggle, Medicare could do the same. A separate reimbursement mechanism acknowledges the cost of Advanced Medical Home functions, provides practices with additional

revenue to provide those services, and is readily budgeted.

On the other hand, embedding Advanced Medical Home fees within existing E/M services could unnecessarily drive up outpatient volume and seems politically less tenable. A simple per-member per-month management fee prevents gaming, but more complicated strategies such as risk-adjustment mechanisms could be used as well to prevent adverse selection. Obviously, payment type and magnitude as well as service requirements would need to be thoroughly scrutinized.

Nonetheless, the Advanced Medical Home holds promise to provide a financing mechanism for general internists to care for complex patients in the way our patients need and deserve. **SGIM**

FROM THE SOCIETY

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residents, he was a masterful clinical teacher who insisted on doing a “double share” of ward attending each year. To his colleagues, he was passionately devoted to patient safety and wise in the machinations of health policy at all levels. David readily shared his experiences with us. He took time to explain the “why” behind the “what” to junior SGIMers and friends who had questions about his work or ideas.

As his health problems accumulated, he simply embraced all these roles more enthusiastically. He just would not let his illness keep him down. Michael Barry recalls visiting David in the hospital the morning after his first craniotomy: “It was during a visit by Dr. Chris Cassel as a visiting professor. Swathed in head bandages, David’s first request was that I apologize to Chris for him for missing her grand rounds that morning! I do believe that if it had been the next day, he would have insisted on attending!”

In an organization as rich as SGIM, certain individuals leave their mark. Even if you did not know David Calkins, you do know many individuals influenced by him. It is a wonderful legacy he has left behind, and we are the richer for having known him. As you look around SGIM today, please try to recognize and appreciate the wonder-

ful diversity of people who call this organization “home.”

We extend deepest condolences to David’s wife and son. Contributions may be made in his honor to the Institute for Healthcare Improvement at 20 University Road, Seventh Floor, Cambridge, MA 02138. **SGIM**

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PRESIDENT'S COLUMN

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monalities as we prioritize our agenda. I believe that, as a profession, GIM will be successful now and in the future. Our members are passionate, energetic, and light a path to do the “right thing” in medicine.

Focus and effectiveness

This summer's SGIM Council Retreat will focus primarily on developing our shared mission. We must think strategically as we marshal our resources. We will then effectively communicate the

needs of our patients and SGIM members at critical policy debates.

While we are relatively small in numbers, we are large in ideas. The rest of the Internal Medicine community expects us to provide the ideas to improve patient care in the future.

SGIM now works with all the major Internal Medicine organizations. Thanks to the leadership of Mike Barry and Barbara Turner, we have a seat at the “table.” We will use this seat to advance our mission aggressively.

My job as president is to enable our members to make a difference and to advance our shared mission. The difficult part of the job is the prioritization of the many issues important to GIM. The easy part of the job comes from the great resource that our members provide.

I look forward to working with you over the next year. My greatest task will be an enjoyable one—enabling our members to make a difference. **SGIM**

ASK THE EXPERT

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They included staff, faculty, students, patients, and administrators striving for various goals—better learning, better communication, better patient care, more collaboration in research, more common understanding of administrative processes, effective problem-solving approaches to resource constraints, less risk of cheating (among students) or scientific fraud (among faculty), and a deeper capacity to respond to unavoidable human tragedy in or outside our community.

In this “open space,” we issued no mandates and exercised no authority.

IUSM citizens have, instead, chosen to pursue their diverse goals in whatever ways seem best to them, giving priority to those actions that sponsor a deeper community of values. Acting as change agents, they have begun to make tangible impacts on our institution in ways we have described elsewhere (*JGIM* 2004; 19:501–504).

Individuals take these actions because they yearn for an alternative culture of academe. Moreover, having tasted an alternative micro-culture in small groups like our standing committees (admissions, academic standards,

student progress, executive deans, and curriculum evaluation, to cite a few) where they have chosen to take initiatives to change interaction and shared beliefs, they are moved to wider action. We know of no significant pushbacks to these initiatives, which are largely received as better ways of working.

Culture change in organizations takes off because hearts catch fire, not because a better strategic plan mandates reorganization. **SGIM**

FUNDING CORNER

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renewed for a second year. Stipends are based on the individual applicant's post-doctoral experience and can range from \$47,000 to \$61,000 per year.

A unique aspect of the program is that more established fellows can use the year to focus on their research and write full time to secure funding. Fellows develop an individualized program based on their needs, interests, and stage in their research career. Formal coursework is available through RAND on a variety of topics, and fellows interact with RAND staff in seminars at RAND, the University of California at Los Angeles, and the

University of Southern California. For more information: <http://www.rand.org/labor/fellows/>

Hartford Geriatrics Health Outcomes Research Scholars Awards Program

The John A. Hartford Foundation and the American Geriatrics Society Foundation for Health in Aging are co-sponsoring the Hartford Geriatrics Health Outcomes Research Scholars Awards Program to support clinician-researchers interested in aging. This program is focused on the transition from junior to independent research faculty. The program specifically is

interested in funding outcomes research, defined as the study of functional status, impairments, perceptions, social opportunities, and health services utilization influenced by disease, injury, treatment, or health policy. The program is sponsored; emphasis is placed on having a sponsor with content expertise and a strong background in training and outcomes research. Up to four candidates receive the award. The amount of each grant is \$130,000 (\$65,000 per year for two years). For more information: <http://www.healthinaging.org/hartford/> **SGIM**

ABSTRACTIONS
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In the old days the administrative people just helped you get through your JCAHO survey. Now they're doing more and often have ongoing projects.

tions are becoming less interested in pure operational work, recognizing that if it is not supported by data collection and evidence-based practice, it will fizzle very quickly. I think academic general internists are positioned to be those translational bridges between research and implementation.

But there are thousands of systems to fix...

Bob: If you start with the premise that you can't fix anything locally until the whole system is fixed, that's a formula for paralysis. Yes, people have to be working on solving our national problems with insurance, access, and disparities. Yet there are real live problems in every individual doctor's

practice and every academic clinic, and they can be improved tomorrow.

Kaveh: "Think globally, act locally." Even though it's a cliché to say, it is very relevant in this field.

How does one go about making a difference?

Kaveh: There are so

many things wrong and so many potential problems that you should pick one that you're passionate about and that your institution will be interested in—so you'll have success.

Bob: The single physician acting as a Lone Ranger, with no organizational support or resources, will be terribly disadvantaged. What physicians sometimes don't recognize is that across the street are people who work for the organization whose job is to improve quality.

The first step to effective systems change is to figure out who those quality improvement people are, meet with them, and see if they have any existing projects that they are struggling to fix—because they are institutional

priorities. Maybe it's a quality measure that's been reported publicly, or the subject of a pay performance initiative, or an area in which you've already had major errors.

Try to tap into existing resources. It may not be as simple as getting a hospital to pay 10% of your salary, but they may have a dataset or a quality analyst who can help you. In the research world we'd call this person a research assistant; in the hospital world they're called quality analysts.

The advantage of syncing your work with the institution's resources and priorities is not only that it helps leverage your time for the individual project but also that it markedly increases the chance that the project will morph into something that can truly be career-transforming.

Kaveh: In the old days the administrative people just helped you get through your JCAHO survey. Now they're doing more and often have ongoing projects. There can be some really nice synergies between what the hospital wants to do and what a researcher would find interesting or could piggy-back a research project on. **SGIM**

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ACADEMIC POSITION—DEPARTMENT OF MEDICINE IN SUBURBAN PHILADELPHIA. The successful candidate will devote 1/3 of his/her time to teaching residents, 1/3 for clinical practice and 1/3 to develop a community based research program. Experience in obtaining federally funded research grants is required. There is a tremendous team in place for assisting in grant writing and submittal. This is a full-time, salaried position with wonderful benefits. Crozer Chester Medical Center is a 450 bed, tertiary care community teaching hospital affiliated with Temple University School of Medicine. Contact Paul D. Woolf, M.D. Chairman, Department of Medicine; phone: 610 447-6370, fax: 610 447-6373, email: paul.woolf@crozer.org

INTERNAL MEDICINE. When medical advancements, technology and the human touch connect, an environment that heals and rejuvenates is created. This is what you will discover with Carolinas HealthCare System in Charlotte, NC. Conveniently located to both the mountains and the beaches, Charlotte offers the ideal climate for success. System-wide growth in our practices and hospitals has created Internal Medicine opportunities throughout the Charlotte community. We are looking for caring, exceedingly well-trained and highly motivated Internists that are board certified/board eligible. We offer award winning facilities, good payor mix and malpractice rates, excellent benefits, a quality of life second to none and the stability of an employed position with the incentives of a private practice. Please feel free to visit our website: www.carolinashealthcare.org/careers/physicians to learn more about the Carolinas and our exciting opportunities. For more information or to submit a CV for consideration, please contact Ryan Knox: (800) 847-5084 / (704) 355-0165 or email Ryan.Knox@carolinashealthcare.org. EOE/AA. Carolinas HealthCare System.

CENTRO DE SALUD LATINOAMERICANO. Lehigh Valley Hospital and Health Network (www.LVH.org) in Allentown, PA seeks second BC/BE General Internist to join growing practice serving the health care needs of our Latino population. Successful candidate will be innovative, bi-lingual / bi-cultural physician with sincere interest in pro-

viding care for underserved communities. Experience in health care diversity and disparities research required. Opportunity for clinical research, teaching and QI. Join GIM Faculty at the assistant/associate professor level. LVH is a major teaching affiliate of Penn State College of Medicine and is located 1 hour north of Philadelphia and 1.5 hours west of NYC. For more information, please call 610.402.7008 or email CV and cover letter to John P. Fitzgibbons, Chair, Department of Medicine to Frank.Gallagher@LVH.com. No J-1, O-1 or H1-B visas please.

ACADEMIC-EDUCATOR AND INVESTIGATOR POSITIONS available in the Division of General Internal Medicine, University of Tennessee Health Science Center, Memphis, TN. BC/BE in Internal Medicine required. Academic rank (Instructor to full Professor) based on qualifications. Excellent benefits package. Send CV/cover letter to James E. Bailey, MD, MPH, Division Chief (Phone 901/448-2475, Fax 901/448-3937, email jeb@utm.edu). The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA institution in the provision of its education and employment programs and services.

POST-DOCTORAL/JUNIOR FACULTY POSITION—HEALTH SERVICES RESEARCH. The Cancer Control Program at Lombardi Comprehensive Cancer Center of Georgetown University is seeking a promising post-doctoral candidate or accomplished junior scientist to join an established cancer health services research program. We are particularly interested in clinician-researchers and candidates with research interests in cancer outcomes, cost-effectiveness modeling, and health policy. The successful candidate will join a highly interdisciplinary Department of Oncology and Cancer Control Program with active research in health services research, including cancer policy modeling, cancer patterns of care, studies of patient preferences and decision making, and behavioral research in cancer screening, genetic testing and counseling, and community health. Lombardi is part of Georgetown University, with collaborators from the Institute for Public Policy, the School of Medicine, and the School of Nursing and Health Studies. The University is conveniently located in Washington, DC. This is a tenure track position for qualified candidates. Excellent career advancement opportunities. Minimum requirements include an MD or PhD with training in decision sciences, health policy, or a related discipline. Track record of extramural funding a plus. Georgetown University is an equal opportunity employer. Interested individuals should send a short statement of research interests and CV to: Jeanne Mandelblatt, MD, MPH Cancer Control Program, Lombardi Comprehensive Cancer Center, 3300 Whitehaven Blvd, NW, Suite 4100, Washington DC 20007. E-mail: mandelbj@georgetown.edu

SENIOR FACULTY POSITION —HEALTH SERVICES RESEARCH OR BEHAVIORAL SCIENCES. The Cancer Control Program at Lombardi Comprehensive Cancer Center of Georgetown

University is seeking an established researcher at the Associate or Full Professor level. We are particularly interested in candidates with research interests in health services research or behavioral science. The successful candidate will join a highly interdisciplinary Department of Oncology and a Cancer Control Program with active research in cancer outcomes and policy, cancer screening, genetic counseling and testing, lifespan development, cancer and aging, and community outreach. The Cancer Control Program at Lombardi is part of Georgetown University, with collaborators from the Institute for Public Policy, the School of Medicine, the School of Nursing and Health Studies, and the Kennedy School of Ethics. The University is conveniently located in Washington, DC. This position has a generous salary and recruitment package including the opportunity for additional junior faculty recruits. Minimum requirements include a successful track record of peer reviewed funding and publications. Georgetown University is an equal opportunity employer. Interested individuals should send a short statement of research interests and CV to: Jeanne Mandelblatt, MD, MPH, Cancer Control Program, Lombardi Comprehensive Cancer Center, 3300 Whitehaven Blvd, NW, Suite 4100, Washington, DC 20007. E-mail: mandelbj@georgetown.edu

CLINICIAN-EDUCATORS. Central New Jersey—The Division of General Internal Medicine at Saint Peter's University Hospital, a 400 bed general hospital with 6200 deliveries a year, is seeking BC/BE clinician-educators at the Assistant or Associate level with interests in Women's Health, Obstetric Medicine, and General Internal Medicine consultation. Responsibilities will include facilitating growth of the consultative practices, inpatient and continuity clinic supervision of residents, a private practice setting, and a reasonable call schedule. We offer the freedom to develop a unique practice within a GIM division that is the backbone of our residency program. Must also be interested in developing a strong teaching portfolio. An interest in research is strongly encouraged. Competitive salary and an incentive program based on RVU production. Contact: Michael P. Carson, MD, Chief, Division of General Internal Medicine, CARES Building 4th Floor, 254 Easton Avenue, New Brunswick, NJ 08903. Fax 732-745-2980 or e-mail at Mcarson@saintpetersuh.com

MGR/SR MGR/ASSOC. DIR/DIRECTOR, Outcomes Research & Management - OUT000102 & OUT000103. At Merck, we believe in putting patients first in all we do. This is the commitment that Merck & Co., Inc. stands on and, it is what has distinguished us as one of the world's leading research-driven pharmaceutical companies. Consistently cited as a great place to work, we discover, develop and manufacture a wide range of novel medicines and vaccines that deliver true advances in patient care. Each of our more than 60,000 employees is joined by an extraordinary sense of purpose-bringing Merck's finest achievements to

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people around the world. Location: West Point, PA. The Manager/Senior Manager/Associate Director/Director in the Outcomes Research & Management Department is expected to take a leadership role in managing a diversified portfolio of outcomes research and disease management projects in at least one therapeutic area. The person will be responsible for conducting scientific studies (designing studies, developing/implementing research protocols, conducting data analysis, writing reports/manuscripts), developing disease management tools, and communicating results to internal and external customers. This will include developing/presenting abstracts at scientific meetings and preparing manuscripts for peer reviewed scientific journals. The Director/Associate Director/Senior Manager/Manager will also have administrative responsibilities in the management of budgets, contracts and timelines. This position does not currently involve personnel management. Qualifications: Ph.D., M.D. or other advanced degree in Health

Administration, Medicine, Epidemiology, Health Services Research, Statistics, Health Economics or related fields. Candidates should have a demonstrated track record of scientific work and publication in peer reviewed journals and a minimum of 3 years relevant research experience post doctoral degree in one or more of the following areas: outcomes research, health services research, epidemiology, clinical medicine, health economics, or applied biostatistics. Strong communication skills are essential. SAS programming and data base management skills are desirable. Experience with analysis of health care and outcomes data for clinical, administrative and/or policy decisions is required. Title depends on training and previous experience. Initial title (Manager, Sr. Manager, Associate Director and Director) and progression through these titles is not a function of the position, but rather reflects the incumbent's experience, within and outside Merck, and performance, over a specified period of time. We offer a competitive salary, an

outstanding benefits package, a professional work environment and opportunities for professional growth. To apply, please visit www.merck.com/careers and search for job number OUT000102 or OUT000103. We are an Equal Opportunity Employer, M/F/D/V.

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