

Society of General Internal Medicine

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

SGIM

FORUM

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SPECIAL THEME ISSUE: FOCUSING ON QUALITY

Reaching for Excellence in Patient Care, Education, and Research

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SGIM Forum Editors

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"Quality is never an accident; it is always the result of intelligent effort."

—John Ruskin (1819-1900)

This year's annual meeting theme is "The Puzzle of Quality" in patient care, education, and research. In plenary sessions, symposia, and workshops, SGIM members will be asking a series of critical questions. What is quality? How can it be defined and measured? And how, as a result of intelligent effort, can it be improved?

In this special theme issue, SGIM *Forum* explores quality from several perspectives. In his final *President's Column*, Bob Centor reminds us of the incredibly durable conceptual foundation laid by Avedis Donabedian in 1966. Donabedian's model of structure, process, and outcome continues to guide quality measurement and improvement some 40 years later.

In *VA Research Briefs*, Rodney Hayward tackles a paradox in quality improvement: even "effective" interventions may not be worth delivering to low-risk patients. His recommendation that we insist on multivariable risk-stratified analysis in clinical trials would be the beginning of the end of one-size-fits-all performance measures. This would be welcome news to many SGIM members. As described by SGIM staffer Francine Jetton in *From the Society*, SGIM has taken a lead role in defining the role of generalists in the care of the complex patient. Unless quality care for complex patients is recognized and rewarded, general internal medicine as a specialty is doomed.

Elsewhere in this month's *Forum*, Mark Liebow shows us how "quality" became a health policy issue. His historical perspective reminds us that health

care quality has gained traction only in the past 20 to 25 years. Former SGIM President and Deputy Assistant Secretary of Health Nicole Lurie has made a career performing translating quality-of-care research into policy. Her unique perspectives can be found in an interview with *Forum* associate editor Carol Horowitz.

In other articles, Rajlaksmi Krishnamurthy describes the New England VA's new pay-for-performance initiatives that incentivize physicians to improve their own quality of care; Marshall Chin explores areas for improvement in health disparities research; Linda Pinsky shares a tale of participatory decision-making in practice; and Joe Conigliaro describes research funding opportunities in patient safety.

Health care quality cognoscenti tend to distinguish between technical and interpersonal quality. An important aspect of interpersonal quality is patient-centered care. While Toyota, Starbucks, and (until recently) Jet Blue Airlines have discovered ways to delight and amaze their customers, health care has had trouble becoming truly patient-centered. Al W. Gatmaitan, CEO of the Clarian West Medical Center in Indiana, describes how one health system focused on relationship-centered care, became a "healing sanctuary," and worked on bridging quality gaps.

Quality matters not only in patient care but in education as well. *In Training* associate editor Karran Philips talks with Wendy Bennett and Judy Zerzan about the importance of having a quality mentoring relationship.

We hope that you enjoy the quality of this meeting in Toronto, and we welcome your thoughts and reflections.

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VA RESEARCH BRIEFS

Performance Measurement Must Begin & End with Understanding How Treatment Benefit Varies Between Patients

Rodney A. Hayward, MD

Dr. Hayward is a quality researcher at the VA Ann Arbor HSR&D Center of Excellence and Professor at the University of Michigan Department of Internal Medicine. Ideas or comments can be emailed to rhayward@umich.edu.

Over the past 30 years, medicine has made dramatic advancements in the management of many important conditions, including active treatment (e.g. CHF, depression, psychosis, arthritis) and preventive interventions (e.g. stroke, viral illnesses, some cancers).

Some of our new interventions are cheap, unobtrusive, and have few adverse effects. Yet many interventions are expensive, intrusive, or carry substantive risks to the patient.

There lies the rub. Most of our treatments do not achieve the trifecta of being very cheap, unobtrusive, and free of adverse effects. The expected net benefit of intervening varies dramatically across patient populations.

Performance measurement and quality improvement have generally been focused on under-treatment. In trying to highlight a legitimate problem, we have generally ignored variability in treatment benefits. In particular, although many academics have been preaching about the importance of considering absolute patient benefits when considering medical interventions, I have seen little progress in this regard.

In fact, many leaders in performance measurement (PM) are surprised when you raise the issue. I find that even those who feel that they have sufficient information to strongly support a specific performance measure still cannot answer the following questions:

“Approximately how much benefit do you think the average patient will get from adherence to this PM?”

“What do you think will be the average costs and risks incurred from the interventions needed to comply with the PM?”

Some leaders are even so bold as to suggest that such questions are unimportant in a discussion of quality measures.

There are many issues that could be discussed in relation to this disconnect. After all, it's fairly noteworthy that those who are often quite critical of current medical practice are not even willing to consider the patient-level risks, costs, and benefits of their proposed PMs.

However, I'd like to focus on a fundamental contributor to this problem—that even when we have “grade A evidence” from clinical trials, these clinical trials usually do not make a reasonable attempt at examining treatment heterogeneity. In recent years, considerable work has demonstrated how the “average” result from clinical trials can be quite misleading. In particular, clinical trials rarely examine how the relative and absolute benefits of treatments vary across lower- and higher-risk study subjects.

This needs to change.

Errors of means and medians. First, it is important to realize that the baseline risk within study populations is often extremely heterogeneous. In such instances, the average benefit across all subjects in the trial can be quite misleading.

We can easily come up with instances in which the average benefit across all subjects in the trial has no resemblance to the expected benefit for the average patient in the trial.

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SGIM Forum welcomes submissions from its readers and others. Please send your ideas and pieces to one of the editors-in-chief, who will direct you to the appropriate Associate Editor for consideration.

The SGIM World-Wide Website is located at <http://www.sgim.org>

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PRESIDENT'S COLUMN

Quality: What is it, and can we measure it?

Robert Centor, MD

The theme of this year's national meeting is "The Puzzle of Quality—Clinical, Educational, and Research Solutions." My presidential address will focus on a philosophical discussion of quality. I have spent much time this year contemplating quality. Many colleagues at my institution and throughout the country have informed my thought process. Two papers, one from 1966 and the other from 1970, have influenced me greatly. As an introduction to my comments at the national meeting, this column will share some important quotes from those two papers.

The first paper, probably better known, is by Avedis Donabedian. (Donabedian A. Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly* 1966;44:166-206). Most experts consider this paper the seminal work in our conceptualization of quality. As I read this paper for the first time, I highlighted the following quotes. Remember that he wrote this paper in 1966!

Which of a multitude of possible dimensions and criteria are selected to define quality will, of course, have profound influence on the approaches and methods one employs in the assessment of medical care.

Few discussions of quality focus on the multidimensionality of this construct. As I consider quality, I reject performance measurement as the sole determinant of quality. I fear that too many payers and politicians think that the performance scorecards are a Holy Grail.

"If we construct 10 quality indicators, how do we weight them? What is most important—trying to lower the cholesterol or diagnosing the subtle coronary artery disease?"

Judgments of quality are incomplete when only a few dimensions are used and decisions about each dimension are made on the basis of partial evidence.

Here he re-emphasizes the same concept but adds an important dimension. If I care for 20 patients, of whom only four have diabetes mellitus, yet the only measure of my performance is on diabetes quality indicators, the measure is greatly flawed. We must not focus all of our efforts on the easy measurements, as they will give a skewed view of quality.

A major problem, yet unsolved, in the construction of numerical scores is the manner in which the different components are to be weighted in the process of arriving at the total.

Forty years later we still struggle with this problem. If we construct 10 quality indicators, how do we weight them? What is most important—trying to lower the cholesterol or diagnosing the subtle coronary artery disease? Is checking diabetic control more important or examining the feet? How important is the flu vaccine, and is it more important than colon cancer screening?

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FROM THE SOCIETY

Measuring Quality of Care in Complex Patients

Francine Jetton

The content of this article has been taken from conferences, symposium, and a final paper organized and written by members of the Society of General Internal Medicine.

Performance measurement has been widely advocated as a means to improve health care delivery and, ultimately, clinical outcomes. However, complex patients present substantial challenges to performance measurement because the evidence supporting the value of quality measures in these patients is often weak. Moreover, their provider may strive to meet a quality measure instead of delivering more necessary care or may shun patients who make it harder to meet a quality standard.

To help define and address these issues, SGIM convened a conference in March 2006 to discuss the challenge of measuring performance in the complex patient. This multidisciplinary conference of experts was convened to: 1) define key components of patient complexity when assessing quality of care; 2) describe the underlying principles of quality measures; 3) suggest changes in implementation and analysis of quality measures to address clinical complexity; and 4) identify other types of less commonly used measures of quality care in complex patients.

The one-day meeting, sponsored by The Commonwealth Fund and the ABIM Foundation, was held in Philadelphia. Conference participants were selected to offer a breadth of

relevant expertise, represent key stakeholders in the quality measurement field, and offer nationally diverse representation.

The conference had three main outcomes. First, participants identified multiple dimensions of patient complexity but deemed the most important to be patient comorbidity (based on number, type, severity, and concordant or discordant status). Second, the group identified strategies to adapt existing measures for use in complex patients, including creating exceptions to existing standards, changing performance targets to a different standard based on cost-effectiveness analysis, and using weighted measures based on the expected clinical benefit or the degree of difficulty involved in reaching the performance target. Third, participants identified novel generic, interpersonal, and structural measures with potential value for assessment of quality of care in complex patients.

A final paper, which summarizes key themes that emerged during this expert panel conference as well as areas of substantial controversy, is available on the SGIM website at <http://www.sgim.org/PDF/SGIMReports/MeasuringQualityCareFinalReportOct42006.pdf>.

On September 29, 2006, in Chicago,

SGIM members and researchers took the next step in efforts to refocus the quality movement. Held in conjunction with the SGIM Midwest Regional Meeting, researchers at the Quality II Symposium presented 12 abstracts that addressed complexity in quality measures. These abstracts and the discussion that followed have continued to inform and inspire research in this area leading up to this year's Annual Meeting.

At the 2007 Annual Meeting, the Agency for Healthcare Research and Quality (AHRQ) will sponsor a symposium, titled *Measuring Quality in Complex Patients*, through their Small Grant Program for Conference Support. This special symposium will provide a forum for several of the year's most highly rated abstracts, each of which will bring a different methodological perspective to the measurement of quality in complex patients. Dr. Sheldon Greenfield will lead a discussion about the next generation of performance measures. Ideally, these abstracts will appear as peer-reviewed research papers for an upcoming issue of the *Journal of General Internal Medicine*.

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ASK THE EXPERT

Using Quality Improvement to Enhance Public Health

Nicole Lurie, MD, MSPH, with Carol Horowitz, MD, MPH

Nicole Lurie is Senior Natural Scientist, Professor of Policy Analysis, and Director of the RAND Center for Population Health and Health Disparities. She was formerly Principal Deputy Assistant Secretary of Health in the US Department of Health and Human Services, Medical Advisor to the Minnesota Commissioner of Health, and Past President of SGIM

You have come into the field of quality from a different starting point than many. What's your angle?

Quality improvement offers an interesting lens through which to view a range of important issues. For example, health care disparities can be addressed, in part, by using basic principles from the quality of care field, but there are several challenges in doing so. There is some evidence that disparities in processes of care are improving, but disparities in outcomes, as we now measure them, are not. There are at least two potential reasons. First, it is clear from the quality literature that what you measure and report on quality of care has a lot to do with the approaches you take and results you get. Second, there's only so far improving quality of care in the formal health care delivery system can take you. We need to look outside of this system to measure and improve processes that are in place in communities and to think differently about partnering with communities in our work. Some basic questions always come up. For example, do people get their prescriptions filled and take them? If not, why not? Are people eating healthy meals? If not, why not? Is there a supermarket in the community that provides access to affordable fruits and vegetables? What is going on in people's lives outside their doctors' offices? These kinds of questions imply that we need to think of quality broadly. And it means that we need to measure outcomes (and additional processes) more clearly so that we can develop approaches to improving them. Measuring processes of care alone can lead us to overlook important factors that impact outcomes. Since approaches to measuring and improving quality are still evolving, there is a lot of room for creative work here.

You are very actively engaged in work with the public health community. What's its role in improving quality?

I have been doing a lot of work on public health infrastructure, analyzing public health preparedness as a vehicle to look at how public health systems function. In that work, it has been striking to me that there is a culture of measurement but not necessarily a culture of acting on the measurement. We have found in so much of our work that, like in medicine, people in public health learn from their experiences. These experiences change them, but they often don't change the systems they work in. Many individuals cannot or do not know how to make system changes that address problems they identify. We were driven to work on quality improvement in public health because, at least in the preparedness area, very well-intentioned and hard-working people would participate in exercises only to rediscover the same problems that they had noted in prior exercises and felt frustration that nothing had changed.

So what should we do?

Our team at RAND has been working with a small group of health departments to see if the kinds of quality improvement collaboratives that are common in the health care system can be modified for public health. We are hoping that teaching health department staff to use basic QI methods will result in improvements in how public health agencies work. Our current effort has focused on improving preparedness for pandemic influenza.

How did you get started?

As a high school student, I worked with an infectious disease doctor who saw lead poisoning as a major problem in the com-

munity. I volunteered to collect paint chips and blood samples in the community. I saw, firsthand, the relationship between a kid seizing from lead poisoning, a clinic failing to detect the case of lead poisoning until the kid seized, and the reality that you can't fix the problem as a health system without fixing the problem in the community. Little did I know then what a profound influence this experience would have on my career.

What's made the most impact in the work you've done?

Helping the people who have come after me to make a difference.

You have had a successful and varied career, and your work has made a difference at the policy level. How does one chart a career that has impact?

Ask questions that really need to be answered. The answer, no matter what you find, shouldn't lead to "so what?". It should lead to "so what do we do about it?". I've also learned to involve the kinds of diverse partners that are needed to make change happen.

Can people do that and still be successful academically?

Unfortunately, many in academics focus their work on questions that can be answered (often with an existing data set), rather than what needs to be answered. This can be problematic. I would advise people not to get hung up on *tenure*, but to get hung up on *making a difference*. If you do research that makes a difference, and you write about it, chances are that you'll be successful. But let's face it, a more important marker of success has to do with whether you're

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POLICY CORNER

How Did Health Care Quality Become a Public Policy Issue?

Mark Liebow, MD, MPH

Twenty-five years ago there were few efforts to measure, much less improve, the quality of individual physician-patient encounters. The Federal Government had not traditionally regulated the practice of medicine. States dealt mostly with individual physicians accused of substandard practice. Much has changed since then.

Physicians now must report their performance on selected measures to Medicare in order to get a small increase in payments. There is pressure to pay physicians different fees depending on how well they meet certain outcome or process standards. What led to the change?

Some of the change came from within the profession. Many organizations developed practice guidelines, standards, or parameters that permitted measurement of whether physicians were practicing at a level defined by their peers.

The work of John Wennberg and his colleagues demonstrated that there was substantial variation in practice patterns by physicians in different geographic areas without obvious differences in outcomes. Hospitals and medical groups became involved in quality improvement activities.

How we pay for health care also had a role in making “quality” a policy issue. The way managed care developed in the 1990s sometimes gave physicians clear, usually financial, incentives to refuse to provide medically necessary services. Legislators and regulators wanted to ensure that health plan members were getting the services they needed. Of note, this was portrayed as protecting quality rather than access to care.

Most importantly, rising costs of care led those paying for care, whether in government or in the private sector, to cast about for ways to keep costs down. Many became enamored of the notion, drawn from industrial quality improvement

experience, that improving quality would reduce the rate at which costs increase.

Perhaps most important, the topic was taken up by organizations, notably the Institute of Medicine (IOM), that are viewed by policymakers as competent and non-partisan.

The publication in 1999 of “To Err Is Human” by the IOM paved the way for “quality” legislation and Executive branch action. The publication of “Crossing the Quality Chasm” and later books by the IOM, all of which contained specific policy recommendations, provided further signals that quality was policy relevant.

Forces outside medicine had an indirect role in making quality an issue. Traditionally, patients were not thought to be capable of evaluating clinical quality and relied on professional reputation instead.

The conservative movement of the last two decades has pushed the concept of treating health care more like a market-based activity. This movement has led to developments such as consumer-driven health plans. In such plans, patients are supposed to make value decisions about who provides the health care services they think they need or are told they need. This means that patients need to know the price and quality of those services in order to make an informed decision.

Patients in such plans have been frustrated because of difficulty determining price or quality. Their complaints have stimulated legislators to think about how we can assess quality in health care services and make that information easily available to patients.

Finally, legislators are not like internists. We are stereotyped as thinking too long and acting too late. Legislators want to take action or at least be perceived as supporting moves to improve a situation.

Unfortunately, sometimes legislators choose the easiest target to go after rather than the most important. In an era where it is frequently said that the health care system is broken and needs fundamental change, many legislators want to do something to help fix the problem. They have also heard the adage that there are three key aspects to health care—cost, access, and quality—but see that reducing costs or increasing access to care are daunting tasks. Instead they focus on improving quality, as it seems somewhat easier to do and is less likely to require government resources.

Health care quality has become an issue in the last quarter century because:

- We can measure it more easily.
- Medical organizations have tried to improve their own quality of care.
- Political reactions have developed to private cost-containment efforts.
- Society has acknowledged it as an important problem that may be improved by government action.

Governmental efforts to measure or improve quality will likely continue to get serious consideration in Washington and in state capitals.

We believe that SGIM, because of its members’ expertise on health care quality, can have an important role in the quality debate. SGIM can help determine what to do with quality improvement efforts and will continue its advocacy efforts in this area through the Health Policy Committee (HPC). The HPC is looking for comments or ideas on policy issues relevant to quality. Please send your thoughts and ideas to John Goodson at jgoodson1@partners.org. SGIM

To provide comments or feedback about Policy Corner, please contact Mark Liebow at mliebow@mayo.edu.

Disparities and Quality of Care

Marshall H. Chin, MD, MPH

S GIM clinicians, educators, and researchers are perhaps uniquely qualified to develop new interventions to reduce racial and ethnic disparities in the quality of care. Equity is one of the six fundamental pillars of quality defined by the Institute of Medicine along with effectiveness, efficiency, timeliness, patient-centeredness, and safety. However, equity has traditionally taken a back seat to effectiveness in discussions of quality. Within the disparities field, most work documents differences in care and explores mechanisms rather than testing interventions. Thus, there is an urgent need to meld the disparities and quality of care fields. Disparities should be an integral part of mainstream quality improvement implementation, research, and educational efforts, not a marginalized activity.

The University of Chicago, along with SGIM members on our National Advisory Committee (including John Ayanian, Lisa Cooper, Ralph Gonzales, Said Ibrahim, and Carol Mangione), leads a Robert Wood Johnson Foundation program, titled *Finding Answers: Disparities Research for Change* (www.solvingdisparities.org). *Finding Answers* aims to identify, fund, and evaluate interventions to reduce racial and ethnic disparities in care, systematically review the disparities intervention literature, and disseminate findings. We have focused our efforts on utilizing the tools of quality improvement to attack disparities.

We have conceptualized five levels of quality improvement interventions in great need of research:

1. **Policy.** For example, little attention has been devoted to how pay-for-performance and public reporting of performance measures impact minority populations. How can such programs be designed to improve the care of minority patients?
2. **Organization.** Few empirical studies have examined how the tools of qual-

“The challenge of integrating expertise in quality improvement and disparities is one that fits core values of SGIM...”

ity improvement, such as techniques of total quality management, chronic care management, audit and feedback, and information technology, can improve quality of care for organizations serving minority populations. Moreover, how can interventions be implemented in a financially sustainable manner?

3. **Provider.** SGIM clinician-educators have been national leaders in developing cultural competency curricula that introduce the social context of medicine. An emerging field is systems quality improvement training. Two of the ACGME’s core competencies are practice-based learning and improvement and systems-based practice. The best ways to teach trainees and providers the tools of quality improvement to reduce disparities are unknown.
4. **Patient.** Buzz words like patient activation, consumer engagement, and patient empowerment have become more frequent. How to successfully operationalize these concepts remains a vexing question.
5. **Community.** The NIH Roadmap has created new priorities to engage and serve the community. We need to find the best ways to link the community to the health care system and tap into the strengths and expertise of the community.

The challenge of integrating expertise in quality improvement and disparities is one that fits core values of SGIM—providing excellent patient-centered, scientifically sound care and promoting the

health of vulnerable, diverse populations. SGIM researchers must discover promising ways to use quality improvement tools to reduce disparities. Educators

must develop innovative curricula that provide trainees with the conceptual and practical skills to analyze their practices and implement systems improvements to lessen racial and ethnic differences in care. Administrators must create a viable business case for implementing quality improvement interventions that reduce disparities. These are exactly the types of difficult interdisciplinary problems SGIM excels at solving.

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FUNDING CORNER

Research Funding in Patient Safety

Joseph Conigliaro, MD

After the Institute of Medicine (IOM) publication of “To Err is Human,” and the follow-up, “Crossing the Quality Chasm,” patient safety has quickly become an important area of research.

Several factors have contributed to this national movement and increased emphasis on patient safety and quality issues. The IOM report “To Err is Human: Building a Safer Health System,” published in 1999, increased public awareness of patient safety issues. The report attributed between 44,000 and 98,000 hospital deaths per year in the United States to medical errors. The publication and its findings have created an urgency among federal regulatory agencies, payers, and patient advocacy groups to mandate strict reporting guidelines on hospitals and health care systems.

Over the last 10 to 15 years, health care systems have identified the impact and studied the underlying mechanisms of medication errors and non-standardized care within a variety of populations. Leaders in education and research are needed to effectively implement interventions to translate these findings into evidence-based clinical practice specifically designed to reduce or eliminate errors or standardize processes such that quality is optimized. Several opportunities exist for training and research.

The Agency for Healthcare Research and Quality (AHRQ) and the Department of Veterans Affairs are among the leading agencies supporting patient safety training and research. This month’s *Funding Corner* highlights several programs from these agencies for SGIM members who are interested in focusing on patient safety in their academic generalist careers or whose existing work is closely related to the spirit of patient safety (i.e., disparities research).

AHRQ, in its mission statement, aims “to decrease errors, risks, and/or hazards in health care and their harmful impact on patients.” This emphasis on reducing errors makes AHRQ one of the most important funders of patient safety

research today. AHRQ’s ongoing Program Announcement titled “AHRQ Health Services Research”

(<http://grants.nih.gov/grants/guide/pa-files/PA-07-296.html>) conveys AHRQ funding priorities for ongoing extramural grants for research, demonstration, dissemination, and evaluation projects. AHRQ is looking to support research that understands and enhances decision-making at all levels of the health care system. AHRQ is interested in a broad array of research topics, including studies to develop valid and reliable measures of the process and outcomes of care, causation and prevention of health care errors, strategies for incorporating quality measures into quality improvement programs, and dissemination and implementation of validated quality improvement programs. Recent RFAs have evaluated the role of health information technology in ambulatory care quality and patient safety measurement, proactive risk assessment, and patient-centered care.

The Department of Veterans Affairs has also championed the need for inquiry into the area of patient safety through its National Center for Patient Safety and the Office of Research and Development’s Health Services Research and Development Service (HSR&D). The NCPS (<http://www.patientsafety.gov>) recently funded six VA fellowship sites to develop leaders and capacity in patient safety. Although not specifically designed for

researchers, these fellowships seek to develop the VA’s ability to implement, evaluate, and teach patient safety concepts and programs. Recently, the NCPS has solicited for Patient Safety Centers of Inquiry. These are designated programs that design, evaluate, disseminate, and implement theme-based programs based on a recognized topic in patient safety in VA facilities.

VA HSR&D (<http://www.hsr.d.research.va.gov>) has funded several patient safety related investigator-initiated and service-directed projects. Topics include an assessment of safety culture and outcomes in VA Hospitals, impact of resident work hours on errors and quality in VA Hospitals, the evaluation of errors in documentation unique to an electronic medical record, and the benefits of “repeat back” protocols within a computer-based informed consent program.

Patient safety research encompasses many areas of interest to SGIM members, including racial disparities, palliative care, hospitalist care, and medication safety. The National Patient Safety Foundation (www.npsf.org), offers a comprehensive report on funding sources in patient safety in the United States. Although slightly out of date (2001), it offers researchers potential avenues to pursue for pilot and other funding. **SGIM**

To provide comments or feedback about Funding Corner, please contact Joseph Conigliaro at jconi2@email.uky.edu.

ASK THE EXPERT

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happy. Having passion for what you do, and being excited about the work, makes it a lot easier to be happy—and probably also to be successful in the academic sphere. So, back to quality—I’ve regularly done small quality measurement exercises related to my own career. Most times that I felt dissatisfied, the root cause was usually that I was bogged down in doing work that I didn’t think

was interesting or important. Fortunately, I was able to use ‘measurement’ to lead to change. While I’m working on a wide array of projects, and often working pretty hard, I’m also really excited about all of them. **SGIM**

To provide comments or feedback about Ask the Expert, please contact Carol Horowitz at carol.horowitz@msnyuhealth.org

IN TRAINING

Find a Mentor! Experience and Advice for SGIM Mentoring Programs

Wendy Bennett MD, MPH, and Judy Zerzan MD, MPH, with Karran Phillips, MD, MSc

This month, Karran Phillips speaks with Wendy Bennett, a mentee, and Judy Zerzan, a mentor, about mentoring opportunities at the SGIM Annual Meeting. Comments provided by Wendy Bennett are identified with WB and comments by Judy Zerzan with JZ.

Mentoring programs at regional and national SGIM meetings pair medical students, residents, and fellows with faculty members who share common interests and goals. This article examines one mentee's experience in a regional mentoring program and provides helpful hints to improve the experience.

Signing Up to Be a Mentee

Wendy Bennett (WB): The SGIM Mid Atlantic Region's website advertised a mentoring program, so I signed up when I registered for the meeting. As a third-year resident interested in academic medicine and planning to start a GIM fellowship, I was looking for a mentor to advise me given my interest in women's health.

Judy Zerzan (JZ): Mentees have an active role in a mentoring relationship. Signing up for a program like this is important to advance your career and seek advice. Desirable mentee qualities are self-assessment, receptiveness, initiative, responsibility, creativity, honesty, and respect for time.

Preparation Before the Meeting

WB: One week before the meeting, I received an e-mail identifying my assigned mentor, a clinician-researcher with a focus on women's health. What a great match! She e-mailed asking me about our meeting focus—a tough question because I was feeling very unfocused. I was interested in her research and career trajectory and wanted input on how to shape my fellowship and career in women's health. I was hoping this wasn't too tall an order.

JZ: Before looking for a mentor, think

about your values and needs: What energizes you? What values and attributes do you respect? Do you have preferences about gender or race congruence or personality style? Do you need structured guidance or prefer more gentle supervision? What knowledge and skill gaps do you have? Are they personal (work-life balance, confidence building), professional (networking, establishing career goals, fellowship or job choice), practical (communication, time management, clinical skills), or research oriented (collaboration, methodology, writing). Do you want help pursuing specific opportunities, such as presenting at a conference?

Think about and write down goals for three months, one year, and five years. Be as specific as you can because setting goals will help you present yourself and your needs to potential mentors. The clearer you are at self-assessment the more efficiently and effectively you can seek mentoring.

Meeting My Mentor

WB: My mentor and I met during the designated lunch time, and she gave me an overview of her career trajectory and current position. I was interested in how she found her research mentors, developed her own projects, and balanced her busy career with her personal life.

JZ: When first meeting a mentor, have a plan in place so you are productive in the time allowed. One way to start the conversation is by having both individuals share their background and then have the mentee express his/her values and needs. Ask the mentor's permission to ask for more help later. Taking good notes will help you remember the conversation later.

After the Meeting

WB: My meeting with my mentor was very successful—I walked away feeling confident and motivated. We planned to keep in touch, but given our very hectic work schedules, this has been the hardest part.

JZ: The mentee should make the effort to stay in touch if he/she wants the relationship to continue. One way to start this is to follow-up with a thank you email summarizing the discussion and how you plan to proceed. Finding a suitable mentor requires effort and persistence; brief interactions like this experience can grow into learning partnerships and long-term alliances.

WB: Good mentoring is a two-way relationship requiring time and attention to develop. By knowing yourself, taking initiative, and showing appreciation, you will become a successful mentee. Even if you have a successful mentoring relationship within your own institution, developing mentoring relationships at other institutions can be beneficial because they provide a fresh perspective on professional goals/challenges and build collaborations for future work.

Editor's Note: We hope people will look to SGIM as a valuable resource for mentoring relationships both through the one-on-one programs at the regional/national meetings and through the year-long program. (<http://www.sgim.org/am07/Mentoring.pdf>)

SGIM

To provide comments or feedback about In Training, please contact Karran Phillips at karran.phillips@jhmi.edu.

INNOVATIONS IN CLINICAL PRACTICE

Relationship Centered Care: A Gateway to Quality

Al W. Gatmaitan, FACHE

Al Gatmaitan is President and CEO of Clarian West Medical Center in Avon, Indiana. He had the unique opportunity to build a patient-centered hospital from the ground up. Forum invited him to provide his perspective on the process.

If one had the opportunity to develop a new hospital, new workforce, and new medical staff from the ground up, would a generous budget and a wealth of expertise from a parent system be all that was needed? If the vision to provide unsurpassed hospital care were to be realized, would an enthusiastic staff, devoted physicians, and remarkable building be enough to succeed?

These questions were the focus of senior leadership throughout the development of Clarian West Medical Center, a new general community hospital opened in December 2004 in a growing suburb west of Indianapolis. As a result of deep reflection, a single set of core Operating Principles were articulated for the very complicated three-year “activation” phase leading to opening day and also for the ongoing operation of the hospital. The principles included being a Healing Sanctuary and focusing on Patient Safety, Knowledge-Driven Care, Service Excellence, and Measured Performance.

The integration of each of these Operating Principles is important to the quality of care we deliver. Being a Healing Sanctuary involves creating a healing physical, psychological, and social environment; using enabling technology; and implementing relationship-centered care have had important impacts on quality.

Ample start-up funds and sophisticated expertise from the parent system can be credited with the realization of Clarian West as one of the most complete applications of healing environment architectural design, replete with a sophisticated array of enabling technologies. Learning about the principles and practices of relationship-centered care

and management has been an exciting learning endeavor for our organization.

Enhanced by formal coaching and facilitation from Tony Suchman, MD, and Penny Williamson, ScD, two outstanding relationship-centered guides/consultants (and SGIM members), the leadership at Clarian West has been intent on building an organization that appreciates each employee/caregiver, where physicians articulate the principles of the organization in conversation with colleagues, administrators, staff, and in direct interaction with patients and families. These relationships and conversations result in a certain set of mental models, reactions, and perceptions that directly influence decisions and behaviors in the provision of care.

Greater awareness of the numerous complex relationships that develop within a hospital setting still was not enough. We also knew that the “typical” hospital performance, while at times extraordinarily good, often yielded wide variation in care outcomes, patient perceptions, and caregiver fulfillment.

Senior leaders began the practice of holding each other, and eventually all staff and physicians, accountable for task performance—a traditional measure of care quality—and the dimensions of relationship, which also impact quality. For example, senior leaders regularly take time for reflection and relationship-building in meetings and other hospital activities. The CEO and vice presidents meet twice a month with an internal facilitator for the express purpose of challenging, questioning, and designing management practices and making decisions to assess leadership effectiveness. Ongoing training and role modeling is available to all management in the use of appreciative inquiry,

story telling, and active listening. Traditional performance improvement teams work regularly from negotiated agendas and in a forum that provides everyone with an opportunity to speak and contribute to the task.

Perhaps most telling has been the integrated and intentional work of management and medical staff leaders to deal with disruptive physicians. By previously understanding that a Healing Sanctuary meant “mutual respect,” physician and administrative leaders interceded in two cases where a surgeon’s behavior was threatening quality of care. Engaging these individuals in multiple appreciative conversations has successfully led one of the surgeons to change his behavior. He is now effectively relating quality concerns and is a respected leader and champion for improving quality. In the second case, a refusal by the surgeon to acknowledge potential risk of serious injury occurring as a result of his practice resulted in the dramatic action of his removal from the medical staff.

Important to note is that both surgeons’ behaviors were consistent with their behavior at other institutions; however, the culture of relationships at Clarian West caused leadership to deal with the behaviors early before patterns were established and the culture diminished.

While we can’t say that relationship-centered care “causes” high-quality outcomes, we have been impressed by our performance on a number of quality indicators. Medication administration has improved to a level of one significant error per 500,000 doses; third-party patient perception scores are in the top 25th percentile nationally; and CMS performance indicators have steadily improved to with-

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FROM THE REGIONS

One Health Care System's Experience with Pay for Performance

Rajlakshmi Krishnamurthy, MD

Dr. Krishnamurthy is the Acting Primary Care Service Line Director for VISN1 (New England Region) of the Veterans Health Administration. Based at the West Haven, Conn., VA Medical Center, she is an Assistant Professor at Yale University School of Medicine.

The VA Health Care Personnel Enhancement Act of 2004 was the first major overhaul of the Veterans Health Administration (VHA) physician payment system in more than a decade. This legislation, which took effect in January 2006, was designed to modify VHA physician salaries to be more in line with the private sector. It also included a mandate that VHA adopt a pay-for-performance (P4P) system based on the clinical performance of individual physicians.

The P4P Incentive Program

In July 2006, VA New England began development of a P4P incentive plan across eight primary care practices that care for more than 200,000 veterans in 45 clinical sites, in both academic and nonacademic settings. With input from physician managers of each practice, we created a plan encompassing three domains of care: 1) quality, 2) access, and 3) "building healthy communities." The third domain was designed to include clinician researchers in the plan and to encourage organizational stewardship activities, such as participation in network-wide committees, teaching, and research.

A monetary award was set at a maximum of \$3,000 quarterly per physician for both part-time and full-time doctors. The award was an additional bonus to the physician's base pay.

P4P Measures

We created a menu of seven different metrics with graded outcomes to reward clinicians for meeting clinical thresholds. Thresholds were set above the baseline performance mean, thereby rewarding physicians for exceeding current performance.

Physician practice managers were asked to select up to five metrics for

each clinician, including at least one from the quality domain and one from the access to care domain. This flexibility enabled incentivization of problem areas, while at the same time standardizing data collection across the system.

The quality metrics were organized around VHA's existing performance goals and areas where provider-specific data were available. They included both process and outcome measures. For example, we selected blood pressure control in hypertensive patients and lipid control in high-risk cardiac and diabetic patients as quality of care targets.

We also developed a composite metric covering documentation of several preventive care processes: diabetic eye and foot exams, vaccinations, cancer screening, and appropriate medication use in CHF and CAD patients. While this metric may seem unusually broad, it incorporates measures we have been tracking for many years. Historically, our physicians have performed well on these measures, and we wanted to continue prioritizing them.

In the access to care domain, we assessed no-show rates and new patient wait times and established patient wait times for each physician practice. Our goal with the access metrics was to balance the extra effort physicians might put into improving quality of care with maintenance of open access and a patient-centered focus in the physician's schedule. Higher quality of care is less beneficial if it means patients have to wait longer for an appointment or if physicians are unable to see as many patients.

Preliminary Outcomes

The P4P plan was implemented in the fall of 2006. Preliminary analyses show a roughly bell-shaped distribution of physi-

cian P4P awards with a mean of about \$1,500. Most physicians received some compensation, while only a handful received the full performance pay amount.

Sites where provider-specific data were regularly distributed and discussed had the least controversy about data validity, source data sets, and definitions. Sites that did this less effectively are now working to improve their organizational structure for performance data dissemination and rapid cycle quality improvement.

The additional performance pay has promoted physician understanding of where and how quality data are captured. Through the P4P program, our physicians have developed a greater sense of responsibility for their individual performance. The most controversial metric was the access monitor of new patient wait time. Physicians felt less able to control performance on this measure, especially in clinics that were above capacity or faced turnover in provider staff.

Did the P4P plan consistently improve quality or access in VA New England's primary care clinics? This has yet to be determined. The degree of individual customization we allowed has made it difficult to measure changes in specific outcomes across the system.

In my opinion as a manager, the P4P program has raised awareness, ownership, and organizational stewardship without any overt disincentives. P4P provides an additional mechanism to motivate physicians to think about their practice performance and improve quality and access to care.

SGIM

To provide comments or feedback about From the Regions, please contact Keith vom Eigen at vomeigen@adp.uchc.edu.

HUMAN MEDICINE

Glimpses: Quality Health Care from a Patient's Perspective

Linda Pinsky, MD

This is the second in a series of patient profiles titled “Glimpses” appearing episodically in the Human Medicine column. This story includes the tale of a patient who has helped me become a better doctor. Her story, told with her permission, comes from her chart notes [in italics] and from my recollection. As such, in my retelling, her story has also become a composite of the stories other patients have told me.

Quality health care, like pornography, is hard to define. But, in contrast, we don't always know it when we see it. The definition differs, depending on whose perspective is dominant. In particular, doctors and patients have somewhat different views.

Historically, doctors, when speaking of quality in health care, emphasize biomedical issues such as accuracy of diagnosis and appropriateness and efficacy of therapies. They may add other concerns, such as safety and cost. In considering quality health care, the Helsinki doctrine proposes that the core principles of medical care are competence, compassion, and patient autonomy. Surveys of patients show that they look for similar, albeit not identical, things.

Patients desire technically superior care yet recognize the limitations of their ability to evaluate the technical process of care. Accordingly, they emphasize what they can assess: good interpersonal communication skills; information exchange and education; supported (or facilitated) autonomy; and respect. While patients' core inclinations haven't changed, there has been a shift in how their medical care is implemented. One patient explains: “What I expect from medical care is different from what my father did. He went to his doctor, whom he liked and respected, with the attitude—‘I'm sick, figure out what's wrong, and make it right.’ My approach when I see my doctor, whom I also like and respect, is more of a partnership, with each of us having differentiated responsibilities.”

When I think of this newer perspective, one particular patient comes to mind—Ms. Fisher. She is an intelligent woman in her early 50s. Her husband is a

physician, as was her father. She begins her preventive health care visit with the news that she has recently received a diagnosis of breast cancer—“perhaps” she adds, with a wry chuckle. My note reads: *Problem 1. Atypical lobular carcinoma in situ (LCIS). Patient with many questions about the correct management of this condition. She is well informed, bringing a recent New England Journal article with her. She demonstrates good understanding of the study and the issues involved. She has had rewarding conversations with her oncologist and has also seen a nutritionist and a geneticist.*

We review some of the information she had received. My previous note reveals her family history of breast cancer in a paternal aunt and grandmother, as well as her sister's fairly recent diagnosis. There is neither ovarian cancer nor pre-menopausal breast cancer in her family. Despite this history, she has been instructed not to get BRCA 1 or 2 testing until her sister has done so. She says her sister is not interested in pursuing this now. I explain the rationale for testing an affected person first; this may not be a possibility for her presently because of her sister's current needs around her own disease. In terms of genetic risk, we discuss possible future testing for her sister's children. For now, she decides to confirm diagnoses on the death certificates of her other relatives.

The dilemma she now faces is the difficult decision of whether or not to follow her doctor's recommendation. The chart note continues: *Our discussion centers on a recommendation she received for annual MRI's and semi-annual biopsies. She reflects on the fact that one third of lesions seen on MRIs are false positives. She*

is sophisticated enough to know that imaging will most likely lead to excisional biopsy (and, importantly, that one set of imaging and biopsy begets another, placing her squarely on the conveyor belt of medicine). We review the studies that support the use of tamoxifen to decrease risk of future cancer along with the risks of tamoxifen. She contributes negative results from other studies. She sees herself as approaching this condition both scientifically and emotionally.

She keeps index cards on all her doctor visits. They remind me of the cards residents keep on all the patients they have admitted. Her pile is three years thick. She says she knows the sample size of many of the studies is not sufficient to lead to a definitive decision on what should be done. She says she sometimes wonders which N she is. I chart: *Her husband is very supportive. She attempts, despite some ambivalence, to prepare her 14-year-old son for her diagnosis and the possible outcomes.*

Her son is fairly independent and well individuated from his parents. He realizes when both of them pick him up at school that something is up. He responds to the news, saying “Why the *!#*^ are you telling me this?”. She doesn't react but later creates a way for him to focus on her well-being and in doing so, his own. She asks her son to ask her daily, “Mom, have you taken care of yourself today?” She has read the situation correctly—her request works out well for both of them. She begins another pile of cards on her son's responses.

During one visit, after reviewing the latest biopsy results, she reflects “You know, no one has ever asked me about
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VA RESEARCH BRIEFS

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Imagine that a quarter of patients in a trial have a baseline risk of 30%, that the remainder have a risk of 1%, and that the relative risk reduction of treatment is 50%. The average number needed to treat (NNT) to achieve the desired outcome in the trial is 24, *but* the NNT for the median patient is 200.

A small number of very high-risk subjects will disproportionately influence the average study result.

For example, if Bill Gates walked into a room of nine randomly selected people, the median income of people in the room would be affected very little, but the mean income would change dramatically.

Multivariate analysis: decreasing false negatives. A second major point to understand is that such heterogeneity in baseline risk, though quite common, will rarely be apparent unless multivariable prediction tools are used to risk stratify the population. This is because very few single risk factors even double a person's risk, but these factors might interact when taken together (for instance, predicting health status in an older patient who smokes heavily and has existing COPD or asthma). Yet using multivariable risk prediction, we may find that the risk of people in the highest-risk

quintile is 5 to 30 times higher than that of those in the lowest risk quintile.

Using simulations and real world examples, we have demonstrated that focusing on single risk factors alone generally has terrible statistical power to identify heterogeneity in treatment benefits. Conventional "one-variable-at-a-time" subgroup analyses will miss important or overestimate real differences, such as when comparing results in men vs. women without simultaneously considering differences in age, smoking, and illness severity.

We have also demonstrated that multivariable risk-stratified results will often have excellent statistical power to detect real differences.

Multivariate analysis: decreasing false positives. When multivariate analyses are conducted using an externally developed prediction tool, they represent a single *a priori* comparison. Thus, they avoid the high risk of false-positive findings to which multiple conventional subgroup analyses are so prone.

Detecting adverse events with a low baseline risk. Finally, in many cases it is only by doing full risk stratification that it is possible to identify safety problems occurring in those patients with low pre-treatment risk. For instance, it only takes a lit-

tle bit of treatment-related harm to make intervention a bad idea if the patient is at very low risk without treatment.

Recommendations. Statistical theory and empirical evidence now suggest that it is time that we insist that clinical trials routinely conduct multivariable risk-stratified analyses. These analysis should examine heterogeneity in relative and absolute benefits whenever a multivariable prediction tool is available.

Of course, testing for variability in risk is just a first step. There will be many practical, clinical, and political issues that will follow once we better understand how treatments vary across the population.

However, such complexity is inherent in medicine and in all of life. Although we must make discrete decisions (treat vs. don't treat), net benefit will always exist across a continuum. Any cut-point we choose will be somewhat arbitrary.

But making clinical decisions and health care policy without even considering this continuum of risks and benefits is not in patients' or the public's best interest. It is time that we begin to meet this issue head-on. SGIM

To provide comments or feedback about VA Research Briefs, please contact Geraldine McGlynn at Geraldine.McGlynn@va.gov.

PRESIDENT'S COLUMN

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Dr. Philip Tumulty was a stellar general internist at Johns Hopkins. His opening lecture to students entering the "Introduction to Clinical Medicine" course appeared in the *New England Journal of Medicine* (Tumulty PA. What is a clinician and what does he do? *N Engl J Med* 1970;283(1):20-4).

Please remember that this quote comes from 1970, so his choice of pronouns was standard then. He describes the effective clinician.

He is meticulous in accumulating the historical and physical data from the patient. His questioning of the patient is searching and incisive, like that of a wise barrister. . . . His special interest

is any human illness. His care of the patient does not end with the correct diagnosis. . . . He is inexhaustibly capable of infusing into his patient's insight, self-discipline, optimism and courage. Those he cannot make well, he comforts. . . . The things he works with are intellectual capacity, unconfined clinical experience and the perceptive use of his eyes, ears, hands and heart.

Tumulty emphasized diagnosis and bedside manner. As I consider the highest quality physicians whom I have known, I value their ability to make the right diagnosis as the most important skill. Second to that skill is the ability to

communicate with the patient. The great internists teach patients about their diagnoses and what they mean. They comfort patients. As Sir William Osler said, "The good physician treats the disease; the great physician treats the patient who has the disease."

As we consider the "Puzzle of Quality," we should keep these lessons foremost in our thoughts. Quality represents a complex construct. Trying to simplify that construct seems disingenuous at best and dishonest at worst. SGIM

To provide comments or feedback about President's Column, please contact Robert Centor at rcentor@uab.edu.

INNOVATIONS IN CLINICAL CARE

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in the 90th percentile across the board. Employee commitment, as measured by their perception of shared values and priorities with the organization, is within the 90th percentile nationally.

As impressive as these scores are, leadership realizes that errors still occur and that various other improvements can be made. We plan to use the trust and open relationships that we have created to enable Clarian West to deliver meaningful quality care routinely. For example, although our Medical Staff and Board Quality Committees were pleased with the scores on traditional performance measures, they felt “a meaningful quality experience” was as much qualitative, contextu-

al, and emergent (key elements of relationship centeredness) as it was the product of objective measurement. As a result, a facilitated retreat to better identify meaningful quality has been scheduled. In addition, management conducts intentional rounding with staff to identify when meaningful quality is occurring or where barriers exist. Caregivers are prompted to speak out in identifying potential for errors or dissatisfaction before a negative experience or outcome is realized. All staff members are routinely encouraged to speak up and answer the following two questions: When and how is the next serious error to occur? If your loved one were in our care, what would keep you up at night?

A foundation of mutual trust and commitment has been established at Clarian West by the continuous practice of relationship-centered care. That foundation has been reinforced with precise execution of patient safety processes, the application of best practice knowledge, and care delivered in a service-oriented manner with wide ranging measurement of performance. Essentially, living out the Operating Principles at Clarian West is viewed as the gateway to a sustained, extraordinary quality experience. **SGIM**

To provide comments or feedback about Innovations in Clinical Practice, please contact Paul Haidet at phaidet@bcm.tmc.edu.

HUMAN MEDICINE

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my grandmother’s death from breast cancer.” I, myself, had recorded her family history but not discussed that with her. I feel slightly defensive but try to ignore my reaction. Somewhat shamefaced, I admit, “You know, I don’t think I have either. Will you tell me?:

Ms. Fisher generously responds. “My grandmother was diagnosed with breast cancer when I was my son’s age. At the time, no one told the kids anything, but the truth slowly leaked down to our level. My father was completely traumatized when his mother’s chemotherapy failed. Heartbroken, he lamented, ‘I am a doctor. I spent my whole life being a doctor, and now I cannot even protect my own mother.’ He started drinking and essentially stopped being our father. His wife, my mother, was not a very warmhearted person; she ‘consoled’ him with insults about his persistent grief. My mother didn’t take well to this new role of being the

parent who is there for her kids, so she too quit. My brother and sister felt devastated— orphaned and embarrassed. I went to my younger sister’s teacher’s conference pretending to be her parent.”

My assessment/plan concludes: *Atypical LCIS. Discussed ongoing surveillance for breast cancer, in the context of family history and current diagnosis of LCIS. Patient is extremely reflective and articulate about the ambiguity of the prognosis of LCIS and the uncertainty of using a new imaging technology (MRI mammography) in its diagnosis. She is making intelligent and deliberate decisions according to her preferences. She will consider options and let me know her decision.*

What is high quality health care for Ms. Fisher? She wants a physician with the medical sophistication to appreciate the nuances of her “cancer” diagnosis and the analytical skills to assess an emerging technology. She recognizes

that complex problems require a team of providers. She expects her doctors to be team players, and she wants to be a starter on the team. She has always asked questions well and uses that skill to improve her own care. She makes decisions with her emotions and her intellect in concert. She expects her physician to respect that. She anticipates being included, educated, and listened to. She makes sure that her voice is heard. She wants a physician who treats her as a whole person and views her condition in the context of her whole life. She wants the type of physician I always have believed we should be.

She calls back and tells me she has decided. She will risk the conveyor belt of medicine—for now. **SGIM**

To provide comments or feedback about Human Medicine, please contact Linda Pinsky at lpinsky@u.washington.edu.

CLASSIFIED ADS

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

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ASSISTANT PROFESSOR—General Internal Medicine. The Division of General Internal Medicine in the Department of Internal Medicine is seeking one (1) applicant for a full-time position with responsibilities of providing and supervising patient care in ambulatory and hospital settings at the University of Texas South-western Medical Center. Candidate must have and M.D. degree with a current Texas Medical License. Send CV and two letters of support to

Gary Reed, M.D., Department of Internal Medicine, UT Southwestern Medical Center at Dallas; 5323 Harry Hines Blvd., Dallas, TX 75390-8889.

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Please send letter stating your area of interest and current Curriculum Vitae to: physician-recruiting@uwmf.wisc.edu or Anne Kelley, Provider Services Coordinator, University of Wisconsin Medical Foundation, 555 Zor Shrine Place, Madison, WI 53719. UW-Madison is an EEO/AA employer; women and minorities are encouraged to apply. Wisconsin caregiver and open records laws apply.

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cessful candidate will be responsible for the clinical, administrative and fiscal operations of the group while ensuring that department goals and results are aligned with the mission and strategy of the Clinic. The ideal candidate will:

- Be a Board Certified GIM.
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