Despite the excellent articles in the SGIM Forum in the past few issues, there are still probably many questions about the Patient-Centered Medical Home (PCMH). This article will address some of the most common questions.

What is the PCMH?
The medical home was first described in 1967 by the American Academy of Pediatrics as a way to address the needs of children with special healthcare needs. In the past 18 months, the Patient-Centered Medical Home has garnered considerable attention for its call to change the way primary care is delivered and financed. The PCMH advances the idea that every person deserves excellent healthcare based on a trusting relationship with a personal physician who provides first contact and continuous and comprehensive care. The PCMH also involves a team of professionals working together in the same practice (or virtually through established relationships and agreements) to address the unique needs of each patient and his/her family. In March 2007, these principles were articulated in a document by the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), and American Osteopathic Association (AOA), referred to as the “Joint Principles” (http://www.acponline.org/advocacy/where_we_stand/medical_home/approve_jp.pdf). These principles have now been endorsed by 17 medical professional societies (http://www.acponline.org/pressroom/pcmh.pdf). To help measure the characteristics described in the Joint Principles, the ACP, AAFP, AAP, and AOA worked with the National Committee for Quality Assurance (NCQA) to modify its Physician Practice Connections module (http://www.ncqa.org/tabid/631/Default.aspx), which was released in January 2008.

Dr. Barr is Vice President, Practice Advocacy & Improvement, American College of Physicians.
Ambulatory Morning Report

Robert Centor, MD

Many internists find outpatient education more challenging than inpatient education. We developed a greater focus on outpatient education 30 years ago, but we still struggle with how one can mirror the educational rigor that inpatient education classically represented. Many training programs feature morning report as the cornerstone of inpatient education. Some programs also feature outpatient morning report. This issue features outpatient morning report descriptions from four residencies.

University of Michigan
Davoren Chick, MD, FACP (davoren@med.umich.edu)

At the University of Michigan, Ambulatory Morning Report (AMR) is essential to our general internal medicine curriculum. This small group conference is designed to review core general medical content, introduce core primary care content from non-medical specialties, and improve understanding of ambulatory healthcare systems.

AMR occurs each weekday morning from 7:30 to 8:30. Attendance is mandatory for all residents during their ambulatory block rotation, approximately 15 residents at a time. The ambulatory Chief Resident (CR) directs each AMR session. The CR invites a faculty member to facilitate each session. Faculty members are often general internists, but subspecialty faculty are also invited to share their expertise.

The ambulatory CR, under the supervision of an Associate Program Director, organizes the curriculum. Core medical topics are scheduled in advance in order to ensure breadth of content. An ambulatory block resident is scheduled to present an ambulatory case relating to the chosen topic. To kick off each AMR, the CR presents one or two “board review” questions, eliciting group discussion. The scheduled resident then provides the case presentation; the presenting resident, CR, and faculty member all contribute to interactive teaching related to the case.

Core non-medical specialty content is incorporated regularly: women’s health (twice per month), otolaryngology (twice per month), and ophthalmology (once per month, with further content in a mandatory web-based module). Guest non-medical specialty faculty members attend these sessions. Other educators contributing to the success of our AMR include a medical librarian who facilitates monthly sessions on literature search skills and a case management social worker who provides monthly sessions on practical navigation of services for high-risk patients.

While we feel the University of Michigan AMR provides an effective forum for education regarding ambulatory general medicine skills, even this approach is insufficient to cover the breadth of ambulatory general medicine. Therefore, our ambulatory block residents also participate in a separate weekly “teaching afternoon” for small group training in evidence-based medicine, geriatric care, and a variety of other topics. Also, AMR and “teaching afternoon” curricula are supplemented by a longitudinal curriculum implemented through continuity clinic. In total, these efforts provide a variety of educational opportunities.
Mental Health and the Patient-Centered Medical Home
Lisa Rubenstein, MD

“The development of collaborative care models occurred in parallel to the development of the chronic illness care model referenced in PCMH policy statements and can serve as an illustration of its potential effectiveness.”

Kimberly Myers (name changed), the sister of an acquaintance of mine, was a high-energy, optimistic 38-year-old nursing student when I first met her. She was married to a construction worker and had two teenage daughters and a charming two-year-old toddler. She lived in a rental house on a tree-lined street and enjoyed making it sparkle. Her daughters were achieving straight A’s in school and her eldest, a near genius, had been offered a scholarship to New York University. Things were going very well.

Kim’s evident delight in creating a home may have been fueled in part by her past history of financial struggles and borderline living conditions. A successful start at a university had been quickly followed by marriage to a sports star and the birth of her first two daughters. When the marriage went sour, she dropped out of school, took the daughters, and moved to Los Angeles on her own, where she began to sink into poverty and substance abuse. After being hit by a car on a Westwood crosswalk, however, she ended up in a drug and alcohol rehabilitation program and regained sobriety. She slowly pulled herself back up toward the middle class.

About a year after we met, Kim complained to her sister of anxiety, irritability, and sleeplessness. She couldn’t put her finger on a cause. Her internist gave her a benzodiazepine. She continued to spin far away, with bouts of irritability and anger and increasing use of benzodiazepines, gradually followed by amphetamines (not from her doctor) to stay awake. She became paranoid, secretive, and panicky and told her sister she felt hopeless. Several visits to her internist over a period of six months of deterioration produced no change in treatment. By the end of the following 18 months, her marriage had ended, her house was gone, her eldest daughter had gone to work, rather than college, her youngest was in foster care, and she was under threat of jail.

Would the care, and the probability of a good result, have been different under proposed patient-centered medical home (PCMH) care models for which SGIM, along with its close partners, are advocating (see http://www.acponline.org/advocacy/where_we_stand/medical_home/what.html)? I am not sure. None of the published summary statements on the PCMH mention mental health specifically. The examples given following the American College of Physicians statement on the PCMH, for example, emphasize diabetes, heart disease and immunizations. Of course, no policy statement can or should recognize all of the relevant specifics. I see overcoming the historical and cultural divide between mental and physical health, however, as being as fundamental to PCMH success as some specifically mentioned aspects, such as fostering electronic medical records and a quality improvement-oriented culture.

Mental illnesses, including depression (the most common mental illness), are far more common in primary care than, for example, diabetes and produce greater disability in the population. Depressed patients are hopeless and helpless by virtue of their illnesses and difficult to treat successfully for any condition while their depression remains untreated. Depression is also now widely recognized as a cause of later physical illnesses, including cardiovascular disease and stroke. Yet quality of care for depression in primary care is substantially worse than for other chronic diseases for a variety of important reasons. Furthermore, depression treatment will always be provided primarily by primary care clinicians, if at all, because 10% or so of the primary care population experiences the condition—far too many to be referred to a mental health specialty. Doing so would be analogous to sending all patients with chest pain to be cared for by cardiologists.
To blind or not to blind: that is the question.

Whether ‘tis nobler in the review to blind

The slings and arrows of outrageous criticism...

With apologies to the Bard, I’m presenting my more prosaic views (based on experiences as an author, reviewer, and JGIM Deputy Editor) on whether journal authors’ identities should be revealed (unmasked) to reviewers and whether authors should be blinded to reviewers’ identities. The current JGIM editorial team initially masked authors’ names, institutions, and acknowledgements when sending manuscripts out for review but eventually abandoned that practice. However, JGIM never reveals reviewers’ identities either to authors or other reviewers. In contrast, a number of on-line journals do expect reviewers to reveal their identities, and some print journals will accept signed reviews. The point of masking and blinding, of course, is to improve the quality of the peer-review process. In this perspective piece, I will address the feasibility and effectiveness of these strategies.

Completely masking authors’ identities can be challenging. An astute reviewer will be able to identify authors based on the research area or the description of the study setting and subjects. In some manuscripts, authors explicitly cite themselves in the reference list. The rationale for masking is that a reviewer could have an ax to grind with the authors and would submit a biased review. However, there are some safeguards in place. Authors usually have the opportunity to specifically exclude certain reviewers when submitting manuscripts. A harshly negative review that fails to provide substantive criticism should be a red flag for an editor. When I think that some of a reviewer’s comments are inappropriate, I will explicitly instruct authors to ignore them—and give the reviewer a poor rating. When a manuscript is sent back for revision, authors can address criticisms that they perceive to be unfair. Consequently, from a practical standpoint, I do not think it feasible or necessary to mask the identities of authors.

I do strongly believe that authors should not know the reviewers’ identities—and this can be easily accomplished (though the occasional reviewer has to be restrained from forwarding track-change edits to the author or citing his/her own work). My impression of journals that systematically unblind reviewers is that the reviews lack rigor. The concern is that reviewers will pull punches—especially knowing that what goes around comes around. An offended author may later be judging the reviewer’s manuscript or grant submission. Qualified reviewers could end up recusing themselves to avoid this potential problem.

My experience with these journals has also been that they obtain only one or two reviews. JGIM strives to obtain three reviews; having this much input is valuable for editors who rely on the content and/or methodological expertise of reviewers in making acceptance decisions. The JGIM editorial office typically asks us to provide 12 to 15 names of potential reviewers; in the past year my lists have tended to range closer to 20 names. Given the busy schedules of our reviewer colleagues—and the profession’s expectation for their altruistic service to the medical literature—I do not think that journals can afford to impose any additional barriers to reviewing. I believe that revealing reviewers’ identities can lead to poorer quality reviews—and ultimately lower the quality of the published literature.

However, as a curious and conscientious academic internist, I decided, after drafting the previous paragraphs, to search the medical literature to seek support for my empirical observations. Not surprisingly, a study of British Medical Journal submissions found that 42% of the reviewers correctly identified at least some of the study authors.1 Additionally, a randomized trial found that masking the identities of authors did not improve the quality of reviews, at least as judged by editors and authors.2 A systematic review of peer review found inconsistent results for the effect of revealing reviewers’ identities on review quality; however, the better quality studies consistently showed no benefit.3 Interestingly, the systematic review concluded that “editorial peer review, although widely used, is largely untested and its effects are uncertain.” So my observations are at least not overtly contradicted by the medical literature. I think that the JGIM policy of unmasking authors’ identities and blinding reviewers’ identities makes sense. At the very least, this strategy is not likely to decrease the quality of reviews and may help increase the pool of reviewers.

References
Whether or not you are a Michael Moore fan, it is hard not to be puzzled by our curious system of health care delivery. The challenges facing underserved communities extend from coast to coast, afflicting rural as well as urban areas. Yet some of the most stark and compelling concerns are from inner city neighborhoods, where the average life expectancy may be no better than in the world’s least developed countries.

Nestled within these neighborhoods—in Philadelphia, Baltimore, and New York to name a few—lie academic medical centers. Although many of these centers are remarkably expansive, they also face significant economic challenges due to their disproportionately large contribution to unsubsidized care for the underserved. Academic medical centers represent 2% of the nation’s hospitals but provide 22% of all uncompensated care. A majority of this care is provided to patients who live in the immediately surrounding communities.

In the last few years, the University of Chicago Medical Center has unrolled an Urban Health Initiative, which represents “a long-range plan to build and maintain a network of partnerships and mutually beneficial relationships throughout the community to provide superior care for patients, advance community-based clinical research, and broaden medical education.” The Initiative has many goals, including to: 1) develop the medical center’s comparative advantage in complex clinical care and research, 2) help community health care partners develop a solid network of community-based primary and secondary care providers, 3) enter partnerships with surrounding community providers to create new venues for medical education, and 4) reduce the volume of non-emergent care provided by the Emergency Department. These goals have also provided important opportunities to consider the nature and extent of the commitment of the medical center to the community, as well as how this can best be realized.

In response to the Urban Health Initiative, medical center and community stakeholders have grappled with a variety of tough questions, many with no unique answer. How should academic medical centers determine how much charity care to provide? How else should they participate in underserved communities? How does greater community focus strengthen the missions of an academic medical center? When, and how, does such a mission compete with or enhance the other missions of the center?

One particularly complex issue has been the degree to which the medical center should adjust the ratio of primary to tertiary care, and care paid for by private vs. public payers, as part of its efforts. These ratios have profound implications for the center’s fiscal wellness, since each offers different levels of reimbursement. Yet efforts to balance patient care mix, along these or other dimensions, are naturally sensitive. On the one hand, community partners such as local hospitals and federally qualified health centers may be well equipped to provide greater primary care due to their more efficient cost structure, and the health care needs of the defined service area around an academic medical center are often an order of magnitude greater than that the center can address. On the other hand, efforts to change case mix, at their extreme, may be perceived as self-interested, financially motivated, and quite polarizing.

During our conduct of recent key informant interviews, stakeholders’ beliefs reflected the boundless sub-jectivity of the questions posed. For example, when asked about the degree to which financial considerations should dictate the balance of specialty to primary care, one clinician commented “the institution, although not-for-profit, is still running a corporate enterprise and cannot be obligated to absorb losses just to be a good neighbor.” By contrast, another cautioned against “using finances [as] an easy crutch to justify . . . very profitable, very specialized care.”

Overall, most stakeholders seem to believe that academic medical centers do have an obligation to underserved communities in their proximity, and most commonly this has been framed in the context of a social contract. Nevertheless, this obligation is often discussed while acknowledging the importance of balancing it with other missions in the setting of fixed resources. One administrator discussing the Urban Health Initiative spoke at length about the importance of sequentially developing principles, and a business plan to support them, that allowed for sustainable growth and development of community partnerships. A clinical provider emphasized the importance of developing measures of outcomes that matter, such as rates of treatment for common chronic diseases, as part of any serious undertaking to impact the health of the community.

Given the health care needs of communities surrounding academic medical centers, there is a genuine opportunity for these centers to make a substantive impact on the health, and health care, of large populations of vulnerable, underserved patients. Although there are natural differences in stakeholders’ views, there are also some points that all can agree on—including that the issues are complex, the relationships are important, and there is more work to be done.
A 69-year-old man is admitted for jaundice. He saw his primary care physician complaining of weakness, malaise, and poor appetite—all increasing over the course of one week. The patient had not noticed his jaundice. The patient was in his usual state of health until one week ago.

In addition to the constitutional symptoms noted, he reports subjective fevers and chills and mild shortness of breath but denies cough, sore throat, abdominal pain, nausea, vomiting, change in bowel habits, rash, joint complaints, myalgias, and pruritis. He notes that his urine has been dark.

My first thoughts, in this jaundiced gentleman with constitutional symptoms but no abdominal pain, concern his liver, biliary tree, pancreas, possible exposures, and a possible hemolytic process. The latter seems particularly likely with his shortness of breath. I would seek additional information about both his presentation and history.

Regarding his presentation (i.e., How sick is he?), I would assess current vitals, including O₂ saturation, severity of the fevers, ability to tolerate oral intake, clinical gestalt, etc. Regarding his history, I would inquire about his past medical history, medications (both prescribed and over-the-counter), social history (including occupation and alcohol intake, smoking, and illicit drug exposure) and finally a travel/exposure history. I would be curious as to the results of his physical exam with specific attention to his lungs, heart, abdomen (i.e., Does he have an enlarged liver or spleen?), and any lymphadenopathy. Finally, I would ask for a basic lab: CBC, CMP, UA, blood cultures, LDH, chest X-ray, and, I suspect, an ultrasound of his abdomen.

The patient works as a salesman and travels within one Southeastern state. He drinks wine occasionally and denies tobacco use. He denies intravenous drug use, sexual promiscuity, travel (outside of his state), and tattoos. He lives with his wife in an urban setting. He does eat out regularly and recently ate seafood in a restaurant. He denies known sick contacts.

His past medical history is notable for diabetes, hypertension, and coronary artery disease—all considered stable. He has never had a history of liver disease. His medications include insulin, glucophage, glipizide, pioglitazone, metoprolol, lisinopril, hydrochlorothiazide, aspirin, vitamin E, and ezetimibe. There have been no recent adjustments or additions to medications; he denies use of herbal preparations or other over-the-counter medications.

On examination, the patient is jaundiced and in no distress. His blood pressure is 129/72, heart rate is 80, respiratory rate is 14, and temperature is 97 degrees. Sclera and mucosal membranes are icteric; conjunctivae are pink; and mucosal membranes are moist without lesions. There is no jugular venous distension. Chest examination is clear to auscultation; cardiac examination reveals no murmurs, rubs, or gallops. The patient’s abdomen is soft, without tenderness, and non-distended, with normal bowel sounds. The estimated liver span, midclavicular, is 16 cm. The spleen is not palpable. No bulging flanks, fluid wave, or shifting dullness is noted. Extremity exam reveals petechiae over the shins. Skin exam is otherwise normal. He has no evidence of muscle wasting, gynecomastia, or caput medusa. The patient is alert and oriented, reflexes are normal, and there is no asterixis.

Our jaundiced gentleman is fairly typical of many ambulatory internal medicine patients. He has at least three chronic diseases and is on multiple medications. Notably, with both diabetes and coronary heart disease on his problem list, he is not on a statin. I would infer intolerance (myalgias or potentially liver dysfunction?) and thus the unproven ezetimibe. He is also on Vitamin E; I would clarify the indication, present the persuasive evidence against supplementation, and encourage him to stop it.

As yet, we have not discovered a compelling indication for hospitalization. His physical is remarkable for his jaundice, a generous liver (but no other stigmata of chronic liver disease), and petechiae over his shins but no edema. The petechiae, of course, make me curious about his platelet count/function, but petechiae or what is assumed to be petechiae can be seen in dependent areas in patients with venous insufficiency. Aside from his medications, which clearly will need to be revisited once his lab is available, we learn he claims to consume alcohol only occasionally, is from a Southeastern state, and has a penchant for seafood (which could be relevant for a possible infectious exposure). At this point, I am curious whether his lab will be most consistent with liver cellular damage, cholestatic jaundice, or a hemolytic process. Each certainly deserves consideration. I would reserve judgment on continuing his current medications—particularly his diabetes meds—until after his initial lab is available.

Laboratory studies reveal sodium, 131mmol/L; potassium, 3.8mmol/L; bicarbonate, 23mmol/L; BUN, 48mg/dL; creatinine, 1.14mg/dL; and glucose, 120 mg/dL. WBC is 8,800; Hgb is 15.0; and platelet count is 98. The liver panel is ALT, 5241 units/L; AST, 4149 units/L; albumin, 2.9 g/dL; alkaline phosphatase, 209 units/L; total bilirubin, 12.3 mg/dL; INR, 2.1; PT, 21 sec.; and ammonia, 117 umol/L.
A Doppler of the liver and liver ultrasound were performed. Laboratory evaluations were also sent. The ultrasound revealed a liver 17 cm in span, mild non-specific parenchymal disease, cholelithiasis, no masses, and patent blood flow in all vessels.

Our patient appears to have the picture of someone who has suffered an acute insult to his liver. The severity of the liver transaminase elevation limits our differential, which now includes viral hepatitis, medications (both prescriptions and OTC), toxins, Reye’s syndrome, acute liver rejection, acute biliary obstruction, and an acute ischemic injury.

Working through this differential, acute ischemic injury seems unlikely with no history of hypotension. We now know the patient has cholelithiasis. As he did not present with pain and there was no duct dilatation, acute obstruction also doesn’t seem likely. Some aspects of his presentation greatly reduce the likelihood of several items on our differential: Reye’s syndrome (wrong age and no aspirin exposure), acute rejection (no history of transplantation), and toxin exposure (no mention of chemical exposure or specific ingestion e.g. mushrooms). Almost any medication can cause significant liver disease and even fulminant hepatic failure. Among his medications, pioglitazone, lisinopril, metformin, and possibly hydrochlorothiazide and metoprolol might be considered. Occult acetaminophen or other OTC products deserve mention in this discussion, too. Finally, viral hepatitis classically causes exactly this picture.

Acute Hepatitis A infection seems the most likely culprit. The patient might also have a previously unrecognized hepatitis B or C infection, which would predispose him to a more severe course.

Evaluation included the following:

- Acetaminophen level
- Ceruloplasmin
- Anti-smooth muscle antibody
- ANA
- Hepatitis A IgM
- Hepatitis A total
- Hepatitis B core IgM
- Hepatitis B core total
- Hepatitis B surface antigen
- Hepatitis B e antigen
- Hepatitis B e Antibody
- Hepatitis C Ab
- Hepatitis C RNA
- HIV
- Factor V
- Factor VII

Of the evaluation listed above, Hepatitis A total Ab was positive, Hepatitis B core antibody - IgM was positive, Hepatitis B surface antigen was positive, and Hepatitis B e antibody was positive. The patient was diagnosed with acute hepatitis B, developed fulminant hepatic failure, and passed away within three days of admission.

I am curious if a potential source of the Hepatitis B in this traveling salesman was ever identified. Fulminant hepatic failure from acute Hepatitis B is uncommon, and I would wonder again about significant/concomitant acetaminophen use and his total intake of alcohol.
Clinician educators are important. More than any other internal medicine organization, SGIM values clinician educators. We all know the star clinical educators from our training. We can identify the stars at our institutions. We value their contributions, and students and residents seek their advice and teaching.

But few clinician educators, no matter how skilled, become known outside their own institution. Being a great clinician educator is a local phenomenon. Rarely do these heroes have an opportunity for national recognition.

Below you can read the stories of several star clinician educators. These clinician educators have participated in our morning report series. Periodically we will publish brief summaries about these important faculty members.

Chad S. Miller attends on the wards at the Medical Center of Louisiana-New Orleans. He is an Assistant Professor of Medicine at Tulane University, participates in morning report on a daily basis, and loves the intellectual rigor of the experience.

“For me, morning report is some of the best practice for treating real patients.”

Joseph Rencic completed his residency at Penn and then worked two years as a hospitalist in a suburb of Philadelphia. He currently is a general internist, associate program director, and clerkship site director at Tufts Medical Center.

The way that most of us retain and recall medical knowledge is through the cases that we have seen or discussed. Cases provide the scaffolding upon which we can hang this knowledge for later recollection.

David V. O’Dell first began attending on Internal Medicine wards in 1989. He began his career in Family Medicine but later switched residency programs and completed his training at the University of Nebraska. He has directed the Primary Care Residency Program there since 1989 and has been the Junior Medicine Clerkship Director since 1992. He continues to love ward attending and relishes the opportunity to work with both residents and students.

“Ward attending continues to stimulate me and stretches me. I always look forward to new cases, particularly ones that allow us to help the learner come to a new understanding of the pathophysiology of a disease process.”

Daniel Federman, Professor of Medicine at Yale, attends on the inpatient medicine service and is actively involved in administration, clinical care, teaching, and research. One of his favorite activities is attending morning report twice weekly.

“When I look back on my own training, I believe my favorite part was morning report. It still is. When done well, residents and attendings can think about a case in an intellectually rigorous and supportive fashion, generate extensive differential diagnoses, and try to incorporate evidence-based medicine. I notice that

Alan J. Hunter, MD, founded the Oregon Health & Science University, Department of Medicine Hospitalist Program in 1998, following three years of re-design of the inpatient medicine teaching environment. He is currently building an uncovered (no residents) hospitalist program within his division. Since 1995, he has been active in medical education with medical students as well as residents in his role as an associate residency program director.

Dr. Hunter continues to derive the greatest passion and energy from his daily interaction with medical inpatients, residents, and medical students. He feels strongly that clinical cases and discussions provide the best substrate for engaging learners.

FROM THE EDITOR

In Appreciation of Clinician Educators
Robert Centor, MD
technological advances now allow some reports to incorporate laptops with LCD projectors, allowing the projection of digital images (radiology, clinical photos, EKG’s, pathology, etc.). Some even have access to the Internet. While ‘seasoned’ clinicians often believe that ‘things were better in the old days,’ I like the use of newer technology.”

**University of Colorado**

**Aran C. Nichol, MD, and Thomas Meyer, MD**
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Internal Medicine (IM) residents at the University of Colorado participate in a unique outpatient rotation at the Denver Veterans Affairs Medical Center called the “Office-Based Medical Team” (OBMT). The OBMT concentrates on the management of chronic and sub-acute medical problems. During the day, residents see three types of patients: ambulatory general IM patients, outpatients in various subspecialty clinics, and inpatient IM consults.

Since the rotation began in 1996, residents have taken part in a distinct morning report that focuses on answering clinical questions in outpatient medicine and critically reviewing the medical literature. Report occurs daily during an hour of protected time and is attended by 10 to 15 residents, two to four faculty members and the Ambulatory Chief Medical Resident (CMR). At the beginning of each month, residents receive two introductory lectures on evidence-based medicine (EBM) by a senior faculty member and participate in two librarian-led sessions on advanced literature search techniques and point of care resources.

Report begins with a clinical image and a board review question related to outpatient medicine. A brief problem-based didactic on biostatistics is then given by the CMR or a faculty member. Each resident presents two articles during the month, both of which are tied to a patient-centered question. The presenter gives a brief introduction to the case, the question that arose, and the search technique employed. He/She reviews any pertinent background information and then proceeds with the critical appraisal using the McMaster’s criteria. At the end of the presentation, the resident answers questions and discusses how the article changed his/her practice and what specific decision was made regarding the patient in question.

By the end of the month, each resident is expected to have a working knowledge of the principles of EBM and basic biostatistics, to be able to present a critical appraisal in a complete and concise manner, and to have gained expertise in the management of complex outpatient illnesses. The development of these skills and exposure to the ambulatory medical literature are essential aspects of residency training that are not easily integrated into the traditional inpatient morning report format. We are pleased that our residents have consistently described the OBMT rotation as a valuable educational experience.

**Stuart J. Bagatell, MD, and Nick Van Sickels, MD**
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During the four-week ambulatory medicine rotation, our residents engage in a three-hour conference on a weekly basis. This conference is attended by at least one faculty member in the General Internal Medicine Department, the Ambulatory Chief Resident, and the Associate Program Director. We have developed the three-year curriculum with a goal of having all residents exposed to the core ambulatory medicine topics.

Each three-hour conference focuses on a particular disease process or chief complaint (e.g. hypertension or cough). The first hour is a didactic lecture given by a faculty member.
Beginning in late 2007, a working group of leaders in geriatrics and/or education began a project to specify competencies in geriatrics for all Internal Medicine and Family Medicine residents. Competencies were envisioned as few in number, feasible to implement, and measurable. Through a development process that involves input from content experts, program directors and non-geriatrician educators, and multiple stakeholder organizations, the goal is to achieve consensus on a minimum set of competencies in the care of older adults essential for all primary care and subspecialty physicians in the early decades of the 21st century.

The project is timely, with high potential for substantial impact. A number of organizations have emphasized in particular the need for enhanced competence in caring for older patients. Several professional and certifying organizations are currently revising recommendations defining the scope and focus of residency training in Internal Medicine. In 2007, a AAMC consensus process defined geriatrics competencies for medical students (available at www.pogoe.org and www.aamc.org), and recent initiatives have been launched to enhance training in the care of older patients in medical subspecialties (Association of Subspecialty Professors) and geriatrics fellowships (American Geriatrics Society). An updated, limited set of competencies for Internal Medicine and Family Medicine residents would play a critical role in helping residency programs maintain consistency with, and inform, geriatrics curricula developed for physician learners before, during, and after residency.

Along with activities by leading organizations in developing curricula in the care of older adults, new methods are being developed to teach and measure geriatrics competencies among residents, consistent with growing emphasis by the ACGME on performance-based measures of residency training.

Our work through September 2008 has consisted of securing funding and/or in-kind support for the project from several sources (American Medical Association, American Board of Family Medicine, Society of General Internal Medicine, and the American Geriatrics Society) and outlining an initial set of approximately 50 topics and candidate competencies. Candidate topics or specific competencies were developed from previously proposed curricula, consensus among the working group, and systematic input from more than 100 geriatricians and geriatrics educators at a recent meeting in St. Louis, Missouri.

We are now inviting non-geriatrician educators and program directors from SGIM (and other organizations, including the Association of Program Directors in Internal Medicine, the Society of Teachers of Family Medicine, the Association of Family Medicine Residency Directors, and the American Geriatrics Society) to contribute to this work as expert reviewers. Reviewers will participate in a wiki-based collaboration to review, refine, and/or replace candidate competencies to develop a limited set of essential, behaviorally oriented competencies. The resulting competencies will be further refined and reviewed by key stakeholder organizations and content experts prior to final dissemination.

We estimate approximately two to four hours of time will be required during the period from early November to mid-December 2008.

SGIM members interested in further information or participating may contact Brent Williams (bwilliam@umich.edu) by November 21, 2008.

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References
Who supports the PCMH model?
The initial advocacy for the PCMH was led by the ACP, AAFP, AAP, and the AOA. Now, more than 160 organizations representing more than 50 million people and just about every perspective on the US health care system have joined the Patient-Centered Primary Care Collaborative (PCPCC) to support the concept of patient-centered primary care and the need to test delivery and payment reform (www.pcpcc.net).

Why is change needed?
The current health care system does not adequately serve the needs of our patients, parents, children, grandparents—or the more than 46 million uninsured Americans. Just about every country that performs better than the United States on quality measures has a strong and well-supported primary care base (http://www.annals.org/cgi/reprint/000605-200801010-00196v1.pdf). Primary care will not survive without significant changes in the way we teach, deliver, value, and reimburse for health care. While the PCMH is not the complete answer to each of these issues, a growing number of people and organizations believe that it can, and perhaps should, be part of broader health care reform.

What payment model is being proposed?
ACP supports a hybrid model of payment that preserves fee-for-service, adds a performance-based component, and includes a prospective payment. That payment is based on the range of services provided by a practice as measured by the NCQA tool referenced above (service adjustment) and the population being served by the practice (case-mix adjustment). This prospective fee would cover care coordination and non-face-to-face care (email, scheduled telephone visits) and other services that provide value but for which practices are not typically reimbursed. The goal is for these prospective payments to offset the costs of incorporating the PCMH elements into practice and to recognize the value these services bring to patient care. The payment model must also recognize the value—yet to be proven—of the PCMH in reducing unwarranted variation and avoidable health costs. Other payment models are also being tested.

Isn’t this a gatekeeper model?
The PCMH is not a gatekeeper model. There are no authorizations, pre-authorizations, denials, or other remnants of the managed care practices of the 1990s. However, as practices are rewarded for service (as measured by patient experience), quality, and efficiency, physicians will likely seek better ways to identify those colleagues, hospitals, and other ancillary health care providers in their communities who are more timely, responsive, and collaborative in helping manage their patients.

Where and when are demonstration projects occurring?
Multiple private and public-private tests of the model are under development and several have moved into the recruitment and implementation phase. For more information on these demonstration projects, see http://www.pcpcc.net/content/pcmh-pilot-summary. A purchaser’s guide to the PCMH was recently published by the PCPCC to promote the awareness of the concept and to facilitate demonstration project development (www.pcpcc.net).

The Center for Medicare & Medicaid Services (CMS) will conduct a PCMH demonstration beginning in 2009/2010, and Congress recently passed H.R. 6331, the Medicare Improvement for Patients and Providers Act of 2008, which added $100 million to support the Medicare Medical Home Demonstration Project.

Summary
The patient-centered medical home has become a topic of considerable interest. Interest is turning into implementation and testing. The new emphasis on primary care (for example, see the June 2008 MedPAC report “Reforming the Delivery System” at http://www.medpac.gov/documents/ Jun08DataBook_Entire_report.pdf) may create some controversy because of the perception that changes in reimbursement could result in gains for some at the expense of others. For now, the current PCMH demonstration projects do not create shifts in payment since they are funded by the private and public payers based on expectations of improved quality and reduced health care expenditures. Evaluations of these demonstration projects will include measures of cost, quality and a return on the investments made by all stakeholders. Expanded demonstration projects will hopefully address issues such as transitions in care between the PCMH and hospitals, subspecialists, and long-term care facilities where there are significant opportunities to improve communication, information-sharing, and quality of care. Should the PCMH model demonstrate positive, sustained changes in health care quality and slow the increase in health care expenditures, these savings could be used to help support the new model of care. Additional studies such as the Commonwealth Fund/ACP sponsored “Costing of the Medical Home” project (http://www.acponline.org/pressroom/grant_pcmh.htm) will also inform future payment models.

The PCMH will not solve all of the issues that complicate our health care system. However, it may provide a pathway to reinvigorate the patient-physician relationship and improve the outlook for primary care as part of a larger initiative to reform our health-care system.

The PCMH is not a gatekeeper model. There are no authorizations, pre-authorizations, denials, or other remnants of the managed care practices of the 1990s.
gists for the rest of their lives—an obvious impossibility. Furthermore, most depression in primary care presents in early phases of illness, when treatment is simplest and most preventative of later collapse.

Kim’s is one of the many kinds of stories that are behind the known benefits (shown in more than 35 randomized trials in the latest meta-analysis) of new approaches to supporting primary care clinicians in managing depression. These approaches, called collaborative care for depression, depend on collaboration between primary care clinicians, mental health specialists, and patients. The development of collaborative care models occurred in parallel to the development of the chronic illness care model referenced in PCMH policy statements and can serve as an illustration of its potential effectiveness. Collaborative care uses a variety of alternative methods to provide primary care clinicians with support for assessing depression symptoms and co-morbidities, enhancing patient self-management, and implementing guideline-concordant treatments including mental health consultation and psychotherapy. This kind of care for depression reduces job loss, improves social functioning, and improves depression outcomes for as long as ten years afterward. Minorities and elderly people, compared to other populations, benefit as much or more. For many depressed people, active, decisive intervention early in the course of their depressive illnesses seems to be able to prevent the kind of downward spiral experienced by my friend’s sister—one that is incredibly difficult to reverse once fully completed.

In addition to improving overall clinical effectiveness, PCMH initiatives that incorporate a mental health focus can enhance the overall benefits of primary care training. In my primary care residency, for example, we spent a month each year being specifically trained in behavioral medicine. As far as I know, few primary care programs now provide such in-depth training. Yet there is no aspect of my residency curriculum that, looking back, had greater positive effects on my career. While early on, when I spent more than half my time on clinical care, the major impact of this training was in being able to see and work with the mental health and behavioral aspects of my patients; during later years this training also served me well for leadership. It fostered my ability to work effectively with the variety of personalities and psychological issues that arise in any group of people, whether on the wards or clinics or on research projects. Behavioral medicine training opened my eyes wider, and approaching medicine without an integrated mental health/primary care perspective would seem to me now like practicing blind.

In case it’s not clear from this piece so far, I’m an advocate for calling out mental health/primary care integration as a fundamental principle within the PCMH. The VA, Kaiser Permanente, and Group Health systems, among others, have begun to take this stand as well. A new September article in *Health Affairs* by Rittenhouse and colleagues presents data showing that practices are ill-prepared to support integrated mental health in the PCMH. I realize that there are many other as yet unspecified but important aspects of the PCMH model that need substantial attention. However, like access to electronic medical records, I see the capacity to deliver integrated mental and physical health care as absolutely essential to the effectiveness of the PCMH in any of its potential formats. Let me know your opinions about the desirability of calling out mental health/primary care integration as an integral part of the PCMH at Rubenstein.Lisa@gmail.com.
HOW DO YOU DO THAT?
continued from page 9

During the third hour, we review a journal article distributed to the group the week prior. It is during the second hour that we have a resident present a case they have encountered in the clinic to the group. This presentation occurs in the “morning report” format.

A resident presents a case from his/her continuity clinic that complements the weekly discussion topic. He/she presents the entire history and physical and generates a list of clinical questions. The Ambulatory Chief or Associate Program Director acts as the moderator, standing at the white board while the resident presents the case. It is the moderator’s responsibility to involve the group in discussion and to review any teaching points, with input from the faculty in the audience. If a question is raised that no one in the audience can answer, the Ambulatory Chief reviews the literature and makes a short presentation at the next ambulatory conference.

University of Alabama at Birmingham
William A. Curry, MD; Erin D. Snyder, MD; Carlos Estrada, MD, MS (wcurry@uab.edu)

Why do it? Fifteen years ago, our division wanted to bring the same level of intellectual rigor and interest to outpatient care as traditional inpatient morning report.1,2

Who attends?
• House-staff on ambulatory rotations and consult services (10 to 18 participants);
• Ambulatory Chief Resident, who records the case presentation and key discussion points;
• General internal medicine faculty (one to two participants, though others often attend); and
• Internal medicine house-staff applicants (approximately 10 participants) during interview season.

What are the logistics? We hold three sessions weekly from 8 to 9 a.m., prior to clinics and consult rounds. Participants gather around a conference room table in our division with whiteboard, LCD projection, and Internet access. Breakfast is provided.

What is the format?
A faculty member facilitates case discussions as in traditional morning report. Presenters focus on ambulatory issues and bring a peer-reviewed article related to the case or theme of the week.

During the first half hour, the assigned resident presents a case from ambulatory clinic or consults. At the end, the resident summarizes the main teaching points. During the second half hour, a faculty member presents a case or a case-based lecture, depending on the format of the day:
• Day 1: Topic of the Week selected from the Yale Curriculum, which includes common illnesses seen in internal medicine practice. If a desired topic is not available, division faculty develop the material. We previously compiled our own lectures. Other curricula are available (e.g., Hopkins). Recently we began using resident Intraining Exam results to guide curriculum content.
• Day 2: An in-depth or more specific issue related to the Topic of the Week. For example, during the venous thromboembolism week, we may discuss peri-procedural anticoagulation management.
• Day 3: A faculty member other than the facilitator presents a case from his/her own practice illustrating the Topic of the Week.

How do we know it works?
• Residency applicant attendees have provided positive feedback.
• Resident attendance is excellent.
• Combining traditional and novel educational evaluation methods, ongoing assessment, and redesign have been essential to success.4

What are the benefits?
• Residents and faculty use the archive of cases in clinical problem-solving conferences, vignette submissions, and other scholarly activity.
• Educational assessment and curriculum design have been effective tools for faculty development in both teaching methods and educational research.
• The highly interactive AMR is an exciting learning venue for both residents and faculty.

References
3. Yale Internal Medicine Office Based Curriculum (http://residency.med.yale.edu/combine/omc.html).

Summary
Ambulatory education carries a different challenge set from inpatient education. These programs (and others like them) are exploring techniques from bringing intellectual rigor to diagnosis and management of outpatients. Many internal medicine programs have traditionally treated outpatient education without such rigor. These programs understand that the curriculum for outpatient education is important, different, and exciting.
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 Web-site at http://www.sgim.org. Send your ad, along with the name of the SGIM member sponsoring ForumAds@sgim.org, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

Bioethics Fellowships At The National Institutes Of Health

The Department of Bioethics in the Clinical Center at the National Institutes of Health, US Department of Health and Human Services invites applications for its two-year fellowship program. Fellows participate in bioethics seminars, case conferences, ethics consultation, review of research protocols and IRB deliberations, and have access to multiple educational opportunities at the NIH. Fellows conduct theoretical and empirical research in the ethics of health policy, international research ethics, and human subject research. Two year positions are available beginning in September 2009. Salary is commensurate with Federal guidelines. Applications are to include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not to exceed a total of 30 pages, and three letters of reference. APPLICATION DEADLINE: RECEIVED BY DECEMBER 31, 2008. Submit applications by mail to:

Becky Chen, Department of Bioethics-NIH, 10 Center Drive, 10/1C118, Bethesda, MD 20892-1156. Direct inquiries to: 301/496-2429; fax 301/496-0760, email bchen@cc.nih.gov. Further inquiries to: 301/496-2429; fax 301/496-0760, email bchen@cc.nih.gov.

Postdoctoral Research Fellowship Addiction & HIV in International Settings

A Two-Year Program to Train Future Physician Faculty in Addiction Medicine Research Funded by the National Institute on Drug Abuse (NIDA-R25)

Fellows will develop advanced research skills through mentoring and training with faculty in the BU Schools of Medicine and Public Health. Opportunities exist on research projects involving HIV and substance use in domestic & international settings (e.g., Russia & India). The fellowship is within the established BU General Internal Medicine Fellowship Program and includes salary and benefits, tuition for a master’s degree at the BU School of Public Health, and conference travel.

Fellowship begins July 2009.

Interested applicants send a CV and cover letter to:

Jeffrey Samet, MD, MA, MPH
Chief, Section of General Internal Medicine
Boston University School of Medicine
801 Massachusetts Ave., 2nd Floor,
Boston, MA 02118
Phone: 617-414-7288;
Fax: 617-414-4676
Email: carly.bridden@bmc.org
www.bumc.edu/CARE

Clinician-educators

The Division of General Internal Medicine, Department of Medicine at the University of Colorado Denver School of Medicine seeks full-time clinician-educators interested in a career as a clinician, practicing and teaching in the outpatient setting. Positions are at the Instructor or Assistant Professor level. Candidates must be board certified or board-eligible in internal medicine. The physician will care for their own patients and precept residents and medical students in the internal medicine faculty and resident group practice. Diverse opportunities to participate in medical education are available.

Salary is commensurate with skills and experience.

Applications accepted until position is filled. The University of Colorado is committed to diversity and equality in education and employment. Apply at www.jobsatcu.com, job postings 805136 or 803924.

Senior Health Researcher

This position is for a full-time health policy researcher at the Center for Studying Health System Change (HSC). The researcher would primarily conduct investigator-initiated research that has the potential for informing policymakers, but could also participate in client-directed research through collaborations with Mathematica Policy Research and other organizations. Over time, researchers are expected to contribute to proposal writing and project management.

The ideal candidate will have demonstrated research experience in the areas of quality of care, performance measurement and improvement, payment policy, health care disparities, the organization of care delivery and/or care delivery systems. Candidates should have some formal training in quantitative research methods; interest in and/or knowledge of qualitative research methods also would be valuable. Knowledge of methods in analysis of claims data is a plus. Excellent verbal and written communication skills are essential. Both physician researchers and Ph.D. researchers are welcome to apply.

We are interested in candidates at all levels of experience. Senior or mid-career candidates (those with four or more years of experience) should have established expertise and a track record of peer-reviewed publications in the priority subject areas above. Demonstrated ability and success in proposal writing is expected.

HSC is a non-partisan health policy research organization in Washington, D.C. with a current staff of 22 including eight senior researchers in the fields of economics, sociology, medicine, and political science. We focus on objective, timely, and policy-relevant research, with an emphasis on aggressive dissemination to policymakers and other stakeholders. Our diverse funding includes that from major health care foundations and agencies in the U.S. Department of Health and Human Services. Through partnerships with Mathematica Policy Research, HSC also contributes to the design of health care policies and programs.

The Center for Studying Health System Change offers a supportive and collegial working environment, a competitive salary commensurate with your qualifications and comprehensive benefits including an on-site fitness center and 3 weeks of paid time off. To apply, please submit a cover letter, curriculum vita or resume, two writing samples and contact information for three references via our employment web-site:


HSC is an Equal Opportunity / Affirmative Action Employer

Academic Hospitalist University of Kentucky College of Medicine

The University of Kentucky, Department of Internal Medicine is seeking excellent candidates in Internal Medicine for opportunities in academically oriented hospitalist practices. Physicians recruited will have full clinical faculty appointments, competitive compensation and benefits and the advantages of practice in our academic multi-disciplinary group. Candidates must be board eligible or board certified in internal medicine. Our department benefits from an integral association with a vibrant and robust healthcare enterprise, UK HealthCare, which has recently embarked on an aggressive building program that will bring state-of-the-art facilities and technology to our campus as we move toward our goal of becoming a top 20 medical center. The University of Kentucky, founded in 1865 as a land-grant institution, has grown from 190 students and 10 professors to a campus that now covers more than 716 acres and is home to over 26,000 students and nearly 11,000 employees. Recently ranked as one of the safest, most creative, and brainiest cities in the nation, Lexington, KY is an ideal location to balance the work-life balance that the University strives to provide to its employees. Salary will be commensurate with the applicants qualifications and professional experience.
Applicants should submit curriculum vitae to:

T. Shawn Caudill, M.D.,
Department of Internal Medicine,
University of Kentucky,
740 S. Limestone, Room K512,
Lexington, KY 40536-0284.

Upon offer of employment, successful applicants must pass a pre-employment drug screen and undergo a national background check as required by University of Kentucky Human Resources. The University of Kentucky is an equal opportunity employer and encourages applications from minorities and women.

University of Kentucky Med-Peds Faculty Recruitment

The University of Kentucky College of Medicine Departments of Internal Medicine and Pediatrics are jointly recruiting for a Clinical Assistant or Associate Professor to serve as a clinician-educator in our growing General Internal Medicine-Pediatrics practice. Our departments benefit from an integral association with a vibrant and robust healthcare enterprise, UK HealthCare, which has recently embarked on an aggressive building program that will bring state-of-the-art facilities and technology to our campus as we move toward our goal of becoming a top 20 medical center. Candidates for the Clinical Assistant or Associate Professor will be board certified in both disciplines and have a track record of excellence in clinical care, education and mentorship. The position primarily involves working in our combined med-peds clinic and precepting our 24 med-peds residents. Opportunities also exist for inpatient ward attending on internal medicine and/or pediatrics, administrative responsibilities, medical student educational activities and collaborative research in either department. This is an excellent opportunity for anyone looking for a primary care med-peds academic position. The University of Kentucky, founded in 1865 as a land-grant institution, has grown from 190 students and 10 professors to a campus that now covers more than 716 acres and is home to over 26,000 students and nearly 11,000 employees. Recently ranked as one of the safest, most creative, and brainiest cities in the nation, Lexington, KY is an ideal location to experience the work-life balance that the University strives to provide to its employees. Salary will be commensurate with the applicants qualifications and professional experience. Applicants should submit a cover letter, curriculum vitae and names of three references to:

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The Section of Geriatrics, Yale University School of Medicine, is seeking a well-trained clinical investigator at the Assistant Professor level. This physician must have training in geriatrics and clinical investigation as well as evidence of excellent potential for an outstanding career in Geriatric clinical investigation. Yale University is an Affirmative Action/Equal Opportunity Employer. Qualified women and members of under-represented minority groups are encouraged to apply. Please send enquiries to:

Leo M. Cooney, Jr., M.D., Chief, Section of Geriatrics, c/o Yale-New Haven Hospital, 20 York Street, New Haven, CT 06510,
or e-mail enquiries to: leo.cooney@ynhh.org.
Please respond by November 30, 2008.