SGIM Taking the Lead on Promoting Education on Health Disparities

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Disparities in health and health care are, unfortunately, widespread and persistent in the United States. SGIM, its members, and particularly the SGIM Disparities Task Force (DTF) have exercised leadership in drawing awareness to this problem and devising interventions to reduce them. This leadership has been in advocacy, research, and education. Recently, the DTF, with funding from The California Endowment, completed a several-year effort to enhance and make education on this topic more accessible. This effort has culminated in online continuing education health disparities education modules that are now available on the SGIM website for use by educators interested in thinking about how to best provide disparities curriculum at their institutions (www.sgim.org/go/disparities).

This effort, led by Cristina Gonzalez and Dionne Blackman, builds on the Health Disparities Education Symposium that was held at the American Association of Medical Colleges’ Annual Meeting in November 2009. The purpose of this symposium was to inspire a critical conversation on how to improve and promote effective health disparities education across the medical education continuum—from medical school to continuing medical education. This symposium provided an opportunity for the DTF to share its expertise with medical school deans and curriculum leaders involved in medical education. The entire meeting was videotaped, and the presentations and discussions from these meetings have served as the basis for five online learning modules. These online modules bring the issues regarding disparities education to a broader audience of educators.

Module 1 opens with a keynote address by John Rich, MD, addressing the future of disparities education in medicine and public health. A MacArthur Fellow and member of the Institute of Medicine, Dr. Rich is a professor and chair of Health Management and Policy at the Drexel University School of Public Health.

Module 2 reviews educational strategies for addressing health disparities through provider-patient communication. Module 3 provides model strategies for teaching about disparities in the clinical setting. Module 4 describes curricular models for disparities education and its role in improving diversity. Module 5 focuses on challenges and strategies for developing and implementing a health disparities curriculum. The modules continued on page 10
When the word physician comes to mind, one conjures up the image of an individual trained in and licensed to practice the art of healing. Indeed, a physician must have a wealth of medical knowledge, an astute power of observation, and a keen sense of diagnosis. He/she must be able to promptly recognize the presenting malady, devise a management algorithm, and create an appropriate care plan.

In the present day model of health care, a good doctor is often one who can efficiently diagnose and effectively treat a patient in a 20-minute consultation. However, we must ask ourselves: Is this enough? Does our current practice truly reflect the warmth and humanity that the physicians of old brought to their patients? In practicing the science of medicine, have we lost the art of medicine?

Over 80 years ago, renowned physician Francis W. Peabody aptly wrote, “One of the essential qualities of the clinician is an interest in humanity, for the secret of the care of the patient is in caring for the patient.” To me, these words made sense but had no meaning until three life changing experiences completely altered my perception. It dawned on me that now, more than ever, these words hold true and must not go unheeded.

It is said that to truly understand the plight of those we treat, we must become them. Many of us have thankfully not experienced an acute medical problem or been admitted to a hospital for any reason. Thus, we may sympathize with our patients but not truly empathize with them. My moment of understanding came while residing in Dublin, Ireland, when I herniated a lumbar disc working out in the gym.

Initially, I had excruciating back pain and diminished sensation/motor function in the right lower extremity. This was unnerving, as I had never experienced anything like this before. In the emergency department, several physicians saw me, and I was subsequently bundled off to get an MRI. Following this, I saw a neurosurgeon who examined me in roughly 30 minutes. As I was a medical colleague, he extended his usual 20-minute consultation slot. I was informed that there was some unusual contrast uptake on my scan that could be due to an epidural hematoma or a tumor. Then, I was presented with the option of either undergoing an exploratory laparoscopic discectomy or waiting three months to have follow-up imaging. At that stage, the hematoma should be quell, but there just wasn’t time. A repeat scan in three months and a follow-up appointment in possibly four months seemed an eternity to wait. I at least had the luxury of having some medical wherewithal—that is, I could find out on my own what continued on page 10
ACOs: New Frontier for GIM or Déjà Vu All Over Again?
Gary Rosenthal, MD

...ACOs have a much stronger focus on improving quality and more equal sharing of economic incentives and risk between generalists and specialists.

I vividly remember a discussion at a department meeting 15 years ago about a then-recent study by Jack Billi and colleagues1 that sent shivers down the spines of many academic medical centers (AMCs). At the time, the rising tide of managed care had pushed AMCs to build capacity in primary care to ensure adequate referral volumes for their specialty services. Billi’s article estimated the primary care population needed to support the numbers of clinical faculty at one AMC (University of Michigan) under more widespread adoption of managed care. For the departments of medicine, neurology, and radiology, Billi estimated the number to be roughly 4 million, suggesting that it was unrealistic to expect that his medical center could develop a network large enough to support the current number of clinical faculty for most specialty services. Billi concluded, “A more reasonable option may be for AMCs to reconsider the distribution of their clinical faculty members. The traditional emphasis on tertiary care by specialists may need to change to reflect the growing demand of the marketplace for more providers of primary and secondary care.”

At the department meeting I attended, some questioned the basic premise that managed care would shrink demand for specialists. However, most felt that the changes envisioned by Billi were inevitable and that it would be prudent for departments of medicine to consider retraining subspecialists, such as invasive cardiologists, as primary care providers. While retelling this discussion might prompt some to ask, “What were they smoking?”, it was the belief of most policy makers (and high-priced consultants) that further growth in managed care would decrease demand for specialty services. At the time, GIM was at a zenith with an increasing number of trainees interested in careers as ambulatory general internists.

Shift forward 15 years and most AMCs are actively developing plans to develop accountable care organizations (ACOs). While ACOs do not currently exist and remain ill defined, the creation of ACOs figures prominently in the Patient Protection and Affordable Care Act (PPACA) and is one of the only provisions of the legislation that enjoys bipartisan support. ACOs are probably best viewed as affiliations of health care providers that are jointly accountable for improving quality and controlling costs and that accept internal payment arrangements.2,3 ACOs may assume a number of different structures, including integrated delivery systems, primary care or multispecialty medical groups, hospital-based systems, or independent practices associations of physicians.3 The specific structures that evolve in individual markets are likely to be predicated on factors unique to the market, such as the relative strengths and sizes of hospitals and physician practice groups, market concentration, and the penetration of managed care.

Despite their nebulous character, ACOs have once again created a seat at the table for GIM. At a meeting of chiefs and leaders of GIM in Scottsdale last December, many in attendance recounted their discussions with their institution leaders regarding strategies for creating ACOs and rebuilding primary care networks within their AMCs. Interestingly, these discussions typically bypassed the chairs of medicine (and often medical school deans) and put chiefs in direct contact with health system CEOs, COOs, and CMOs. Indeed, the central goals of ACOs—improving coordination of care across providers, improving chronic disease management, developing more effective information systems to monitor and report quality metrics, and
I recently posted a query on the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) listserv requesting information about hospitalist fellowships. We had recently developed a hospitalist research training fellowship at the University of Michigan, and I wanted to know who else was preparing hospitalists for careers in academia. I found no shortage of options for aspiring academic hospitalists.

A review of hospital medicine fellowships by Ranji and colleagues reported that in 2006 there were 16 active hospitalist fellowships in the United States, ten of which were intended for graduates of internal medicine residencies. Several of these fellowships focused not on research training but rather emphasized quality improvement methodology, skill building for educators, or additional clinical work. The authors reported that hospital medicine fellowships were a “work in progress,” and they anticipated their number and influence would increase over the coming years. The recent listserv postings strongly suggest they were correct. While certainly not a comprehensive assessment, postings from Johns Hopkins, Alabama, Chicago, Michigan, Northwestern, UCSF, and the Medical University of South Carolina highlight just a few of the many institutions now targeting hospitalists for their fellowship programs. Some institutions have created separate fellowships specific to hospitalists, while others have taken existing generalist fellowships and have sought to include hospitalists within their ranks. It appears that formal training in research is increasingly the main focus, but many programs also provide an opportunity for advanced training in education or quality improvement methodologies.

The need for fellowship-trained academic hospitalists has never been greater. The number of hospitalists in the United States has increased dramatically over the past decade, and data from the 2008 American Hospital Association Survey suggest that more than 90% of “major teaching hospitals” have hospitalist programs, with an average of 16 hospitalists per program. Despite this impressive growth, many academic hospitalists are struggling. A consensus conference in 2007, jointly sponsored by the Society of Hospital Medicine, the Society of General Internal Medicine, and ACLGIM, sought to identify the problems facing academic hospitalists and propose solutions. Chief among the issues identified was the fact that the word “academic” was an afterthought in many academic hospitalist programs. Hospitalist jobs were primarily aligned with the hospital, whose focus was on clinical care, productivity, efficiency, and quality improvement. The departments in which hospitalists resided, however, emphasized education, research, grants, and dissemination of scholarly work. This misalignment results in hospitalists not feeling valued by their home departments, with subsequent promotion difficulties, job dissatisfaction, and high faculty turnover. Suggestions on how to solve those problems were many, but key solutions proposed by conference attendees were enhanced training and mentoring along with enhanced research career pathways. Fellowship training, while not the universal solution, does go a long way toward addressing many of the problems and helps start academic hospitalists off on a pathway that is likely to lead to success in academic medicine. More of our internal medicine residency graduates who are interested in careers in academic hospital medicine should consider fellowship training.

What can we do as leaders in general medicine? Of most importance in my opinion is timely mentoring. Academic general internal medicine divisions faced this issue in the 1980s. The advantage these divisions had were two major programs that “jump started” academic careers—the RWJ Clinical Scholars and the Kaiser GIM Fellowships. This cadre of fellowship-trained generalist researchers and education scholars gave their divisions a scholarly bent. The big advantage in the 1980s came from these trained academicians and the programs they started. Still, many academic GIM divisions have struggled with the same issues facing hospital medicine.

Hospital medicine lacks this initial bolus of fellowship-trained researchers and educators. Too often, academic hospitalists start in primarily clinical jobs for a few years before they understand that they need additional skills if they want to do rigorous quality improvement work, lead educational programs, or conduct research. At that point it is hard to make a decision to go “back” and do a fellowship. Had they understood during residency the path for success in academic medicine and how a fellowship might better prepare them, I suspect many would have strongly considered fellowship training. That being said, not everyone will—nor should they—choose fellowships. Many academic hospitalists have found great success getting targeted training (short of a fellowship) in quality improvement, education, leadership, and health care administration. But I would argue that even a few fellowship-trained hospitalists can raise the whole ship. A cadre of scholarly academic hospitalists can do for academic hospitalist groups what scholarly academic general internists have done for their GIM division.
The ACA is a Powerful Endorsement of Primary Care

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It is now apparent how the Affordable Care Act (ACA) 2010 will favorably influence primary care practice. Although Congress enacted the law, the Centers for Medicare and Medicaid Services (CMS) are charged with publishing the regulations. These are called the “rules” and were released in the November 2010 Federal Register, becoming operable on January 1, 2011. There are many that specifically apply to primary care practice.

The Annual Wellness Visit

With the ACA, Congress established two new service codes legislatively, the initial and subsequent Annual Wellness Visits (AWV) (Table 1). CMS has very specifically defined the content needed for these visits in the 2011 “rules.” These codes allow primary care physicians an opportunity to bill for services that have heretofore not been covered under the E/M (evaluation and management) guidelines. Furthermore, CMS has stated that the AWV codes can be combined with E/M codes if the visit includes both the AWV content and problem evaluation and management. For example, a patient might be seen for the comanagement of diabetes, hypertension, and hypercholesterolemia. If all the requirements for a new or subsequent AWV are met and documented as well as the E/M visit requirements, both codes can be submitted (the E/M with a -25 modifier), and both will be fully paid. If the AWV code is G0438 (the first AWV) and the E/M code is 99214, the total work relative value units (RVUs) = 2.43 + 1.50 = 3.93. Practice expense and liability RVUs would also be combined.

For years, Medicare patients have been eligible for a “Welcome to Medicare” visit (Initial Preventive Physical Examination or IPPE), but this code has rarely been employed because physicians cannot easily determine when patients transition to Medicare and because the documentation needed to support these visits has not been standardized. For E/M visits, there are chart documentation conventions that have been widely disseminated. Such standards do not exist for the IPPE, so physicians opt out because they have been understandably confused. Note that the AWVs codes can only be used after the first year of Medicare eligibility. There are several implications for office operations. Registration processes will have to inform providers about insurance status and the dates of Medicare enrollment. Schedules will have to inform physicians when patients are eligible for an IPPE, an initial AWV, or any subsequent AWV (one year after the last AWV) and allow physicians to specify to the scheduler at check out if the next visit will include the AWV so added time can be booked.

Importantly, there is no requirement for physical examination or medical decision making in the AWVs. This is an opportunity for primary care physicians to educate, plan, and counsel.

The Primary Care Bonus

The ACA specifies that primary care providers (physicians, PAs, and NPs) will be paid a 10% bonus based on Medicare billings from 2011 through 2015. This PC bonus will be automatically paid to all primary care physicians (and DOs, PAs, and NPs—the latter if they bill with their own NPI) with over two years of existing Medicare B billings. There will be a 10% bonus if the total outpatient billings from new and established outpatient visits, new and established nursing home visits, and new and established home care visits are more than 60% of all Part B billings, excluding new and follow-up inpatient and ER visits. Payments will be generated automatically by the regional CMS contractor and sent to individual physicians or to their billing entity on their behalf. Medicare carriers are required to post the names of eligible physicians online so SGIM members should be able to determine how much money has been paid to their institution or practices on their behalf. New physicians will be eligible to participate if they have any Part B billings from the previous calendar year (CY) (i.e. even if the physician has only a claim or two from late December). Payments will be made quarterly. For new physicians, the first payment will come at the third quarter of the CY but will cover the whole CY back to January 1.

RBRVS Reform

ACA specifies that the Secretary of Health and Human Services review “misvalued” codes but allows the Secretary to use existing sources, such as the American Medical Association’s Relative Value Update Committee (RUC). Whether CMS focuses on this final but essential component of payment reform will depend on the willingness of CMS leaders to initiate and fund the health services research needed to provide a more reliable alternate source for assigning values to CPT service codes.

Patient Costs

The ACA eliminates patient costs (copayment and deductibles) for all wellness and prevention visits, US Preventive Services Task Force level A and B screening tests, and AICP-approved vaccinations. Amazingly, this applies to all insurance products. When codes are combined at a visit, such as the example provided above, the patient will only be liable for the copayment on the E/M service, not the AWV.

For non-Medicare patients, the private insurance companies have not shown any interest in following the Medicare example and paying for continued on page 9
NEW PERSPECTIVES
The Patient-centered Medical Home: What’s All the Hype?
Jonathan Birnberg, MD

Dr. Birnberg is a fellow in general internal medicine at the University of Chicago.

You may have noticed a lot of press for the medical home in the past couple years. You may be wondering what all the hype is about and where the idea came from. You also may be wondering how this could affect your life as a primary care provider. Since it is a care model that is gaining momentum in the policy world, and it could in fact affect the practice of primary care, it is important for all internists to learn about it.

History
The medical home concept began in the pediatrics literature as an attempt to provide coordinated care to children with special health care needs. More recently, the medical home has been receiving increasing attention as a model of practice change that can improve the quality, access, and efficiency of our health care system. In fact, the medical home has found remarkable traction with the major stakeholders in the health care system including physician organizations, health care companies, and large employers. This has prompted a large investment in demonstration projects throughout the country sponsored by Medicare, Medicaid, and private insurers. The idea has even gained a foothold in the health care reform legislation, with funding for the medical home through the Center for Medicare and Medicaid Innovation and the creation of teams to assist small community practices with medical home implementation.

What is the medical home?
The medical home is a model for practice transformation that provides comprehensive primary care and coordinated chronic care in a patient-centered environment that facilitates partnerships with individual patients and personal physicians. The model generally focuses on an outpatient clinic or group of clinics but does make recommendations for interacting with specialists and hospitals.

Many policy groups have released conceptual models for the medical home, but the National Committee for Quality Assurance has taken a large role in defining the operational requirements of the model. In fact, the 2008 accreditation tool has been the gold standard “certification” used in many medical pilots, especially in the private sector. The NCQA just recently released the 2011 standards, but it is unclear if these will become the new standards.

Proponents of the model believe it formalizes many of the essential components of primary care and provides reimbursement for previously unrecognized patient care activities. However, critics believe it is simply a rebranding of the managed care “gatekeeper” model. To be sure, much of the medical home may sound familiar for those who lived through the managed care era and funding strategies that involved capitation. However, proponents would say that the medical home model incorporates aspects of the managed care model but merges them with a patient-centered approach that will hopefully avoid the backlash to managed care.

How will it affect primary care providers?
Given widespread concern over the primary care shortage and its affect on costs, proponents of the medical home are certainly aware that rebuilding the primary care system requires recruitment of primary care physicians. While there are many reasons for the current workforce shortage, most would agree that two issues that must be addressed are salary and job satisfaction.

As for salary, many of the current medical home pilots involve increased reimbursement contracts for practices. There are different models for increased payments, but many involve monthly payments to practices to perform medical home activities for a group of patients. That money is intended to reimburse the staffing and operational requirements of medical home activities, but it is unclear if it will lead to higher physician salaries. Funding based on savings from reduced patient expenditures is another possibility, but it remains to be seen how much money would be available and if physicians would benefit.

Regarding job satisfaction, the medical model could reduce physician burden by transferring some responsibilities to other staff members at the practice. For instance, administrative tasks could be shifted to ancillary staff, and in between visit care could shift to other clinical staff. In addition, providers might benefit from a more efficient and satisfying work environment. In contrast, the model could increase physician workload and significantly change staff roles. Therefore, strained providers may feel the medical home model is simply adding to their list of unachievable goals. At least one medical home pilot study provided evidence for increased physician satisfaction, but additional evidence from further studies is necessary.

The medical home model also has the potential to improve primary care physicians’ stature. To be sure, health care in the United States is specialty oriented, so a dramatic shift to preventive care and public health may sound fanciful. However, the medical home does establish internists as leaders of a health care team. In addition, the medical home and other innovative models, such as accountable care organizations, could put internists at the center of delivery system redesign.

Given the potential effects of the medical home on primary care, physicians must continue to stay informed about new developments. In addition, primary care physicians should get involved in research and advocacy work to take the lead in influencing the medical home field. There continued on page 9
Ascites
Meridale Baggett, MD

Chalk Talk is edited by Douglas Wright, MD, PhD, who is faculty, along with Dr. Baggett, in the Inpatient Clinician Educator Service of the Department of Medicine at Massachusetts General Hospital in Boston, MA.

Objective: To provide a framework for approaching the differential diagnosis of ascites

Case: A 63-year-old woman with coronary artery disease, emphysema, and post-menopausal vaginal bleeding presents with new abdominal and lower extremity swelling. Exam reveals pitting edema to the knees bilaterally and bulging flanks with shifting dullness. Ascites is confirmed with abdominal ultrasound. How will you help your team think through the differential diagnosis of this patient’s ascites?

Teaching Logic: New onset ascites has a broad differential diagnosis. Grouping potential etiologies based on “portal hypertension absent” versus “portal hypertension present” helps to organize learners’ thought processes and suggests a rational approach to diagnosis using the serum-ascites albumin gradient. When considering ascites associated with portal hypertension, the exercise of following blood from the capillaries of the intestine through the liver and back to the heart helps us remember the various etiologies of this process.

Ascites Formation
The exact location(s) of ascites formation is a topic of some debate but probably includes two sites: liver sinusoids and intestinal capillaries.1 Capillaries in the liver are called sinusoids and normally have a fenestrated, discontinuous endothelium without a basement membrane. This allows the passage of fluid, small molecules, and many large molecules across the walls of the sinusoids into the extrasinusoidal space of Disse. When hydrostatic pressure increases in the sinusoids, more fluid moves into the space of Disse. Although under normal conditions extra fluid in the space of Disse is returned to the circulation via lymphatics, ascites forms when the lymphatics are overwhelmed, resulting in fluid accumulation in the peritoneum.

The other site of ascites formation is thought to be splanchic or intestinal capillaries. In portal hypertension, there is increased hydrostatic pressure within the intestinal capillaries, as well as vasodilatation of the intestinal arterioles. This vasodilatation increases the volume of blood flow, which leads to further increases in hydrostatic pressure. Intestinal arteriolar vasodilatation is also associated with increased capillary permeability. The increased hydrostatic pressure and increased capillary permeability favor increased lymph production—which leads to further increases in hydrostatic pressure and lymph formation, ascites forms.

Portal Hypertension Absent versus Portal Hypertension Present
It is helpful to approach the differential diagnosis of ascites with the first major branch point being whether or not portal hypertension is present. In one large study in the United States, only 4% of patients with ascites did not have portal hypertension. In 85% of patients, the cause was portal hypertension due to cirrhosis. The remaining 11% was divided between portal hypertension associated with cardiac disease (3%) and portal hypertension due to mixed disease (8%).2

Serum-Ascites Albumin Gradient (SAAG)
The portal pressure gradient represents the difference between the pressures in the portal vein and the intra-abdominal inferior vena cava. The portal pressure gradient is normally less than 5 mm Hg. Portal hypertension becomes clinically significant at gradients greater than 10 to12 mm Hg, when esophageal varices and ascites may form. Portal hypertension can be measured invasively with the hepatic venous pressure gradient (wedged hepatic vein pressure minus free hepatic vein pressure). Fortunately, there is a simpler test that correlates well with portal hypertension, the serum-ascites albumin gradient (SAAG), which requires only simultaneous measurement of serum albumin and ascitic fluid albumin.3 The difference between these two is the gradient. A SAAG greater than 1.1 g/dL has a 93% positive predictive value for portal hypertension.4 The SAAG is not affected by diuresis, therapeutic paracentesis, or concomitant infection.

Portal Hypertension Absent: SAAG less than 1.1 g/dL
Disruption of lymphatic drainage or increased permeability of the vasculature of the peritoneum will result in ascites formation in the absence of portal hypertension and without a substantial gradient between the serum and ascites albumin. Examples include infections such as tuberculosis or peritonitis from a perforated viscus. Peritoneal carcinomatosis is one way that malignancy can lead to ascites. Patients with severe hypoalbuminemic states such as that seen in nephrotic syndrome may also have low SAAG ascites and absence of portal hypertension.

Portal Hypertension Present: SAAG greater than 1.1 g/dL
After paracentesis and simultaneous measurement of serum and ascites albumin, you calculate the SAAG to be greater than 1.1 g/dL and are confident that the patient’s ascites is a result of portal hypertension. How do you know what is causing the portal hypertension?

Portal hypertension can be caused by either increased resistance to blood flow or increased volume of blood flow through the portal circulation. It is helpful to think through the potential etiologies by imagining the flow of blood starting from the intestinal capillaries and moving through the...
portal system. The blood starts in the intestinal arterioles, capillaries, and venules (pre-sinusoidal) and moves along the portal venous system to the sinusoids of the liver (sinusoidal) before collecting in the hepatic vein, emptying into the inferior vena cava, and going back to the right side of the heart (post-sinusoidal). Drawing a simple schematic will help the learners remember this anatomy and organize their differential diagnosis.

**Pre-sinusoidal.** Pre-sinusoidal causes of portal hypertension typically cause splenomegaly and varices but rarely cause significant ascites in the absence of another diagnosis (e.g. concomitant cirrhosis). This makes sense if you think about the differences between the sinusoids in the liver and the intestinal capillary system. Increased pressure that is post-sinusoidal or sinusoidal results in increased flow across the fenestrated discontinuous walls of the sinusoids. But increased pressure that is pre-sinusoidal is transmitted back to the intestinal capillaries, which have smaller fenestrations and a basement membrane that can maintain a strong osmotic gradient to counterbalance the increased hydrostatic pressure. Portal and splenic vein thrombosis can result in portal hypertension, as can schistosomiasis. In schistosomiasis, adult worms live in the superior mesenteric vein and lay eggs that travel toward the liver and become trapped in portal venules. This leads to inflammation and fibrosis, resulting in increased resistance to blood flow and portal hypertension. Alternatively, increased volume of blood flow through the portal vasculature, such as that seen with splenomegaly, can also cause portal hypertension.

**Sinusoidal.** Increased pressure in the sinusoids is most commonly caused by fibrosis and distortion of hepatic architecture associated with cirrhosis, including sinusoid defenestration and appearance of basement membranes. Acute hepatitis and extensive malignancy can also lead to sinusoidal portal hypertension. Uncommon causes include vitamin A toxicity in which excess vitamin A stored in fat cells in the liver bulge into the sinusoids, decreasing their volume and leading to portal hypertension. Arsenic and vinyl chloride poisoning have also been implicated in non-cirrhotic portal hypertension.

**Post-sinusoidal.** Processes that interrupt the normal flow of blood out of the liver can result in portal hypertension and ascites. Sinusoidal obstructive syndrome (SOS) is a rare disease in which injury to endothelial cells leads to fibrosis and occlusion of the terminal hepatic venules. SOS most often follows hematopoietic cell transplantation but may be seen following chemotherapy or high dose radiation to the liver in non-transplant settings. Moving out of the liver, any cause of hepatic vein or inferior vena cava obstruction can cause ascites; examples include intravascular thrombosis, such as in Budd-Chiari syndrome, and tumors compressing or invading the vasculature. Traveling towards the heart, right-sided congestive heart failure, severe tricuspid regurgitation, constrictive pericarditis, and restrictive cardiomyopathy can all cause portal hypertension and ascites.

A helpful test to differentiate cardiac ascites from ascites due to cirrhosis in patients with portal hypertension (both with SAAG greater than 1.1 g/dL) is the ascitic fluid total protein. In a normal liver, because of the large fenestrations, proteins move more easily across the sinusoid walls, and ascitic fluid often has high levels of protein. This is the case with post-sinusoidal causes of portal hypertension such as cardiac ascites, where the ascitic fluid total protein is typically greater than 2.5 g/dL. However, in cirrhosis, the sinusoids of the liver become “capillarized” with collagen deposition.

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**CHALK TALK**
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**PORTAL HYPERTENSION**

**POST-SINUSOIDAL**

**SINUSOIDAL**

**PRE-SINUSOIDAL**

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continued on page 9
In cirrhosis, continued from page 6

portal hypertension, using the SAAG.

to group potential etiologies

diagnosis beyond cirrhosis. Ask learn-

ers to reason through the differential

portal hypertension due to cirrhosis.

Ascites is most commonly caused by

Summary

severe right ventricular dysfunction

liver. An echocardiogram revealed

sinusoidal etiology with a normal

3.2 g/dL, raising suspicion for a post-

The ascitic fluid total protein was

greater than 1.1 g/dL, confirming

The SAAG in your patient was

Case Resolution

The SAAG in your patient was

greater than 1.1 g/dL, confirming

ascites due to portal hypertension. The

ascitic fluid total protein was

3.2 g/dL, raising suspicion for a post-

sinusoidal etiology with a normal

liver. An echocardiogram revealed

severe right ventricular dysfunction

and pulmonary hypertension.

If portal hypertension is confirmed, a

simple sketch can help learners use

basic anatomy to recall the causes of

portal hypertension.

References

1. Cardenas A, Bataller R, Arroyo V. 
2. Runyon et al. The Serum-Ascites 
Albumin Gradient is superior to the 
exudate-transudate concept in the 
3. Hoefs JC. Serum protein concentration and portal pressure determine the ascitic fluid protein concentration in patients with 
4. Pare P, Talbot J, Hoefs JC. Serum-ascites albumin concentration gradient: A 
physiologic approach to the 
differential diagnosis of ascites. 
5. Phillips M, Steiner J. Electron microscopy of liver cells in 
cirrhotic nodules. Am J Path 
1965; 46:985-1005.

NEW PERSPECTIVES

is finally momentum to reinvigorate 
the primary care system, so we 
must ensure we shape those efforts.

References

1. National Committee for Quality 
Assurance. Physician Practice 
Connections-Patient-Centered 
Medical Home Standard and 
Guidelines. Washington, D.C.: 
NCQA, 2008.
2. National Committee for Quality 
Assurance. Physician Practice 
Connections-Patient-Centered 
Medical Home Standard and 
Guidelines. Washington, D.C.: 
NCQA, 2011.
3. Bodenheimer T, Grumbach K, 
Berenson RA. A lifetime for 
360:2693-6.

4. Reid RJ, Coleman K, Johnson EA, 
Fishman PA, Hsu C, Soman MP, 
Trescott CE, Erikson M, Larson 
EB. The Group Health medical 
home at year two: cost savings, 
higher patient satisfaction, and 
less burnout for providers. Health 

SIGN OF THE TIMES

AWWs. However, many private insur-
ance products allow the use of the 
prevention codes (Table 2). There will 
be no patient cost for these visits. Like 
the IPFE, there in no national consen-
sus about the chart documentation 
requirements for these prevention visits, 
so you will need to check with your 
local carriers. Medicare allows physi-
cians to use the prevention codes for 
Medicare patients. However, there is 
no Medicare payment provided for 
these codes, so practices may be fully 
liable. Patients can justifiably claim that 
these visits should be fully covered, 
and physicians and practices may not 
get any reimbursement. For Medicare, 
it is best to use the AWWs.

What does this mean for us?

SGIM members have much to sup-
port in the ACA. Congress has clearly 
and powerfully endorsed primary 
care. For our patients, cost barriers 
for screening, vaccination, and wellness and prevention services have 
been completely removed. For pri-
mary care providers, specific service 
codes were created for us to use as 
we work with patients to improve 
their health through wellness and 
prevention education and coaching. 
We have been given a five-year 
bonus to supplement our income. 
Congress recognized that the en-
trenched inequities of the resource-
based relative value scale (RBRVS) 
discriminated against primary care. 
These legislated changes give pri-
mary care some breathing room.

Medical schools, such as Harvard 
and others, have found a new enthu-
siasm for primary care career train-
ing. There are profound practice 
innovations around the country that 
give all of us hope for a better work 
life. The final and most important es-
sential part of primary care’s rebirth 
is payment reform, the third leg of the 
stool. The ACA has given us 
new tools to assure appropriate pay-
ment for our work to improve the 
lives of our patients (the AWWs), a 
10% bonus (for five years), and hope 
that the RBRVS system will finally 
be reformed.

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FROM THE SOCIETY

continued from page 1

are free and open to the public for viewing. Nine hours of CME credit is available at $100 for members and $130 for non-members.

To date, health disparities education has had limited acceptance and implementation in medical schools and residency training programs. This reluctance is due, in part, to uncertainty about what should be taught in such a curriculum and how it should be taught. SGIM and the DTF continue to take the lead in advancing education on this topic. To this end, the DTF has developed an engaging interactive educational program in online format to address some of these concerns and to promote more effective teaching on health disparities and evaluation of this type of teaching.

ESSAY

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the probability was of this possible tumor being malignant. But what would another patient without any medical background or resources do? Who would they turn to? How would they make the passage of time any easier?

My mind brought me back to the patients with new onset diabetes that I had seen in the endocrine clinic. The 20-minute slot had been barely enough time to complete an exam, give them a quick overview of their diabetes, and book a follow-up appointment. I could imagine the innumerable number of questions that went unanswered. These patients too were left anxiously awaiting their next appointment. It was then that I truly began to gain a sense of empathy and understanding for my patients.

A second case that reminded me of the words of Francis W. Peabody was that of an elderly illiterate lady with vascular dementia and depression who presented to a geriatric evaluation clinic with memory loss. She was depressed, tearful, and initially very reluctant to engage. As fate would have it, due to a couple of no shows, I found myself with 40 precious minutes to spend with her. In an attempt to understand the person behind the consult, the traditional line of disease-specific questioning was abandoned to allow her to fully express her feelings. Then, lightening struck! The patient, not having mentioned anything to any of her previous providers, now voiced a sense of abandonment by her family, disclosed thoughts of suicide, and revealed that she had urges to cut herself.

This took me completely by surprise! The patient’s daughter was also flabbergasted and dumfounded. Not knowing what to do next, I let the patient continue. The patient then volunteered that she had recently been prescribed Cymbalta by a consulting neurologist, unknown to both her primary care physician and psychiatrist. My attending and I realized that the combination of Aricept and Cymbalta may have over activated her and caused her suicidal ideation. Late that afternoon, the patient’s psychiatrist was contacted and saw her soon thereafter. The remainder of the visit was spent counseling the patient and organizing social support. Both she and her daughter were contracted for safety. When I look back on that day, I feel that compared to any medical intervention we helped her the most by listening and understanding her complex psychosocial dynamic.

My third unforgettable experience involved a middle-aged lady with Werner’s syndrome (progeria) and severe coronary artery disease. She was referred to geriatrics for the evaluation of possible cognitive impairment. During the interview, she appeared to be quite distressed by her phenotypic appearance—in particular, her hair loss. The patient interacted in a very child-like manner and took a great deal of time to respond to questions. She resisted cognitive testing, attempting to conceal her limitations.

A careful history revealed extensive deficits, particularly in executive function and memory. These were the root cause of her dependence and “noncompliance” with therapy for her heart disease and diabetes.
Table 1. What is an Annual Wellness Visit (AWV)?

Who can deliver the AWV?
1. Any PC provider (MD, DO, NP, PA—the latter two have to bill with a separate NPI number)
2. Any health professional “under direct supervision in the suite and immediately available” to the MD, DO, NP, PA
3. Someone other than the provider billing for the service (Health professionals include health educators, nutritional professionals, and others; there are no credentialing requirements.)

When is a patient eligible?
1. Medicare patients are eligible after the completion of their first year of Medicare participation.
2. For the first year of Medicare Part B eligibility, only the initial preventive physical examination (IPPE), the Welcome to Medicare visit code, can be used. This is a glitch in the system that will create confusion for the first calendar year of a patient’s Medicare eligibility.
3. A patient’s first AWV (G0438) will be reimbursed at 2.43 RVUs (99204).
4. All subsequent AWVs (G0439) will be reimbursed at 1.50 RVUs (99214).
5. The AWV codes can be combined with another service code with a -25 modifier. (For example, a 75-year-old patient new to your practice can be billed as an initial G0438 AWV and a 99204-25 new patient visit. The work RVUs would be 2.43+2.43=4.86. The practice expense RVUs and liability RVUs are likewise combined.)
6. A patient can have only one initial AWV in their lifetime; all others will be subsequent AWVs.
7. It will be the responsibility of providers to ensure that the data from the AWVs travels with the patient to other providers.
8. Separate documentation for the AWVs is recommended when combined with an E/M code.

What are the requirements for the AWV?
1. Medical history
2. Medications, prescription and non prescription (OTC, vitamin, etc.)
3. Family history
4. List of “current providers and suppliers that are regularly involved in providing medical care to the individual” (not every single MD who has been involved, such as the colonoscopist)
5. Basic vital signs including height, weight (BMI is then calculated), BP, and “routine measures based on the individual’s medical and family history”
6. Detection of cognitive impairment based on the provider’s “best clinical judgment” (No instrument is specified, and no formal testing is required.)
7. Review of individual’s “potential” (risk factors) for depression based on provider’s “best clinical judgment,” with encouragement to use “screening instruments for persons without a current diagnosis of depression…” (No instrument is specified, and no formal testing is required.)
8. An assessment of functional ability “based on direct observation or the use of appropriate screening questions or a screening questionnaire…”
   a. Hearing
c. Fall risk
   b. ADLs
d. Home safety
9. A written schedule for the needed USPSTF recommended (Grade A or B) screening and Advisory Committee on Immunization Practices vaccination needs for the upcoming 5 to 10 years
10. A list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended (This is highly discretionary, and there are no details specified.)
11. Written advice or referral to appropriate health education or prevention services or programs (This allows primary care providers to creatively fulfill the intent of the AWVs.)
12. Any other elements determined in the future through the National Coverage Determination process (This has not been defined by CMS, but CMS will update this in the future.)

Table 2. 2011 Work RVUs for Select Service Codes (2011 Conversion Factor = $33.98)

<table>
<thead>
<tr>
<th>Service code</th>
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<tr>
<td>99201</td>
<td>0.48</td>
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<td>0.93</td>
<td>99215</td>
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<td>99203</td>
<td>1.42</td>
<td>“Welcome to Medicare” visit</td>
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<td>99204</td>
<td>2.43</td>
<td>G0402 (IPPE)</td>
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<td>Established patients</td>
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limiting the use of unnecessary and ineffective treatments—all play to the strengths of general internists. GIM may once again be rising to the top of the mountain.

However, given that numerous details regarding ACOs need to be clarified (e.g. strategies for equitably attributing patients to specific ACOs, integrating smaller medical practices into ACOs), it is reasonable to ask some serious questions. For example, will ACOs prove to be too challenging to create and sustain? Will ACOs prove ineffective at improving quality while controlling costs? Given the short stay at the mountain top that GIM enjoyed in the mid to late 1990s, will history once again repeat itself? (Remember I’m from Cleveland and still recovering from the departure of LeBron James.)

For several reasons, I think not. First, the fall of managed care and capitation more than a decade ago can be traced to a preoccupation with decreasing costs, setting up general internists as gatekeepers, and limiting access to specialists. In contrast, ACOs have a much stronger focus on improving quality and more equal sharing of economic incentives and risk between generalists and specialists. Second, reducing the federal budget deficit has become a priority on both sides of the aisle, and controlling federal health care expenditures has never been more important. Third, the increasing adoption of electronic health records and tools for communicating with patients outside of patient visits make it feasible to introduce new efficiencies in care. Lastly, the creation of increased accountability for patient outcomes among providers is a notion that strongly resonates with consumers and policy makers.

Thus, while it would be foolish to ignore the many challenges that lie ahead on the road to creating effective ACOs, it’s a journey that needs to be taken and one for which GIM is particularly well suited to play a leading role.

I’d like to conclude this column (my last as president) with a heartfelt thank you to members for giving me the opportunity to serve as president and for everyone’s hard work in advancing SGIM’s missions and goals. My year as president further confirmed the wealth of talent that exists within the Society and the collective passion and dedication of members. The past year has also confirmed for me the special role that SGIM holds as a thought leader and a beacon in a professional world that is increasingly tainted by economic self-interest and conflicts of interest.

SGIM has had a tremendous year—a new home, a successful capital campaign, building our influence in organized medicine, and convening an agenda-setting conference on patient-centered medical home educational issues to name a few accomplishments. Nonetheless, it has also been a year that has had its challenges, most notably the difficult decision we reached last summer to keep our annual meeting in Phoenix and the difficult task taken on by Council of developing a plan for long-term fiscal stability without seeking support from the pharmaceutical industry. We’ve also been on a roller coaster ride with regard to advancing our agenda in health policy. While the year began with unbridled enthusiasm as a result of provisions in the Affordable Care Act that called for increased reimbursement for primary care and funding for primary care training, comparative effectiveness research, and innovative practice models, the year is ending with some uncertainty with regard to the ultimate fate of these provisions, as a new Congress begins its tenure.

Through it all, though, I remain bullish on SGIM and the broader field of GIM. Our collective desire to build a more effective and more equitable delivery system and to center patient care on the patient will ultimately win out. As Churchill adroitly noted, “You can always count on Americans to do the right thing—after they’ve tried everything else.”

References
Prior visits with multiple providers had been focused on her burden of cardiovascular disease. Thus, the extent of her dementia had not been revealed, and her family had not been offered the proper support and assistance for coping with her limitations. Again, I felt that only by spending time with the patient and letting her express herself were my attending and I able to make a difference in her care.

When I think back to these turning points in my life, I feel that we as a profession must rethink our present day practice. Modern medicine is at great risk of overemphasizing the technological advances that have rapidly enhanced our scientific understanding and diagnostic capabilities. Physicians today often rely heavily on investigations to expedite care plans, with patients being viewed as conglomerations of lab results and systems-based problem lists. Current health care models and financial constraints have led to the shortening of office visits.

Patients are often unable to express themselves. Elders are frequently limited in their ability to communicate and are challenged by a variety of complex psychosocial problems that require attention and deserve evaluation. By limiting the time devoted to physician-patient interactions, we run the risk of blunting the expression of humanity that the physicians of old brought to their practices. To them, the time needed to connect and communicate with patients was paramount in understanding not only disease processes but also the struggle to accept the burdens of those maladies.

Finally, the rapid expansion of sub-specialization in medicine risks further fragmentation and the discontinuity of care. Multi-provider and multi-specialty medicine can result in individuals being exposed to a world of expertise. However, this can be a double-edged sword due to poor communication—not only between doctors and patients but also among health care providers. Poor continuity and lost opportunities for communication can result in missing a crucial diagnosis or adverse drug reaction.

In summary, the true nature of medicine is often the topic of scholarly debate; it is both art and science. The science clarifies pathophysiology and may lead to disease-specific interventions and even cure. However, the art allows us to understand the patient behind the illness and holistically care for complex human needs. It is this art that the physicians of old brought to the profession, and it is this art that we must not forget. More than ever, the key to successfully treating our patients and avoiding adverse outcomes lies in the art of skilled and empathic communication, the art of understanding the individual behind the illness, and the art of practicing patient-centered care. Only then will we provide care that is satisfying to both patients and physicians.

Acknowledgements
I would like to thank the countless number of patients who have allowed me to be a part of their care, thus enabling me to continue to grow and develop as a person and as a physician. I would also like to thank Dr. Maura Brennan, Division of Geriatrics at the Baystate Medical Center/TUFTS University School of Medicine, for all her guidance in writing this paper.

References
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 sponsor, to forumads@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

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Peter K. Lindenauber, MD, MSc, Director, Center for Quality of Care Research; 280 Chestnut Street; 3rd Floor; Springfield, MA 01199. Peter.Lindenauber@bhs.org

Academic Hospitalist

Walter Reed Army Medical Center, Section of General Internal Medicine in Washington, DC, seeks BC/BE Academic Hospitalist for our inpatient teaching service. Duties include teaching, quality improvement and patient safety initiatives, and some committee work. Prior training or clinical experience at a major academic medical center is preferred. Research opportunities are available for qualified candidates. Successful candidates will receive a faculty appointment at the Uniformed Services University of the Health Sciences. Inpatient service six months annually, no overnight call required.

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The Department of Health Policy and Management at the Harvard School of Public Health is seeking candidates for the position of assistant or associate professor to teach and conduct research in health policy. This is a tenure-ladder position, with the academic rank to be determined in accordance with the successful candidate's experience and productivity. We are particularly interested in candidates with scholarly interests in quality of care, although the successful candidate should possess a broad knowledge of both health care and health policy. Candidates will be expected to undertake empirical research on quality of care and related topics employing statistical and economic methods. Candidates should have demonstrated the experience and skills necessary to play a central role in research and teaching.

Candidates should hold a doctoral degree in medicine (M.D.) and additional training in research. Advanced graduate level training in health policy or another closely related social science discipline is highly desired, but not required. We expect that this individual will conduct research on quality of care and related delivery system issues. Other qualifications include advanced methodological training, evidence of ability or the potential to manage national and international projects, to collaborate with professionals in other disciplines, and to teach health policy and management courses at the graduate level.

Please send a letter of application, including a statement of current and future research interests, curriculum vitae, sample publications, and the names of four referees to the address below. The electronic submission of application documents to the email below is welcome.

Chair, Search Committee for Assistant/Associate Professor of Health Policy and Management

c/o Hayden Rockson, Search Administrator, Department of Health Policy and Management, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115. Email: hrockson@hsph.harvard.edu

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The Department of Medicine at Mayo Clinic in Rochester, MN invites applications for the Director of the Patient Safety and Quality Research Program (PSQR). The successful candidate is anticipated to lead a multidisciplinary collaborative team and enjoy a strong reputation in patient safety and quality research. Additional opportunities will be available to partner with the Mayo Healthcare Delivery Research Program and Mayo Clinic practice initiatives focused on patient safety. Generous resources will be available for both the individual’s research program and broader PSQR initiative. Candidates with an MD or MD/PhD or equivalent degree with practicing skills in internal medicine or one of its subspecialties are preferred, although applications from non-clinicians will be considered as well. Mayo Clinic is a world-class academic medical center with over 2900 staff physicians and scientists and exceptional resources for both clinical and academic activities. Its location in Rochester, MN, combines the ease of small city living with easy access to additional cultural and entertainment opportunities in nearby Minneapolis/St. Paul. Local schools are excellent. The compensation package at the Mayo Clinic is highly competitive and includes exceptional professional benefits. To learn more about Mayo Clinic and Rochester, MN, please visit www.mayoclinic.org/physician-jobs.

Interested applicants should submit a curriculum vitae, a statement of interests and goals, along with the names and contact information of three references via email to either:

Vijay Shah, M.D. Co-Chair, PSQR Search Committee, Assistant Chair of Research, Department of Medicine Email: shah.vijay@mayo.edu
Victor Montori, M.D. Co-Chair, PSQR Search Committee, Director of Healthcare Delivery Research Program Email: kerunit@mayo.edu
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Ethan Halm, MD, MPH, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75390-8889 or email: Ethan.Halm@utsouthwestern.edu

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Charleston, South Carolina. Medical University of South Carolina—Full-time faculty position at the Instructor/Assistant Professor level available April 2011 in our on-campus University Internal Medicine (UIM) academic primary care practice in Charleston, SC. Board certification in Internal Medicine is required, and fellowship training and/or MPH is preferred. Responsibilities include both resident outpatient clinic supervision as well as participation in our faculty practice. The faculty member will be expected to participate in the resident quality improvement program. This is a great opportunity to relocate to beautiful Charleston and work in a thriving academic training and practice environment. Academic rank and compensation are commensurate with experience with excellent benefits. Send CV to:

Kimberly S. Davis, MD, Director UIM—davisks@musc.edu. Tel: (843) 792-5386.

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Professor and Chief, Division of General Internal Medicine

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Cambridge Health Alliance

Associate Program Director – Primary Care Internal Medicine

Cambridge Health Alliance, a Harvard Medical School teaching affiliate, is an award winning, academic public healthcare system which receives national recognition for innovation and community excellence. Our community health system includes three campuses as well as an established network of primary and specialty practices in the Cambridge, Somerville and Boston’s metro-north area. Our practices serve an ethnically and socio-economically diverse patient population.

We are currently recruiting a dynamic primary care clinician-educator to become Associate Program Director for Primary Care Internal Medicine. This position is both administrative as well as clinical and ideal candidates will be full time and possess outstanding clinical and communication skills. Demonstrated excellence as a teacher, as well as strong interest in graduate medical education is required. Three -five years post residency experience and progressive leadership experience is preferred. The new Associate Program Director will lead residency re-design for training in a patient-centered medical home model. Academic rank will be commensurate with experience.

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Please send CV’s to: Laura Schofield, Director of Physician Recruitment, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139. via e-mail lschof@challiance.org; via fax 617-665-3553 or call 617-665-3555. www.challiance.org, EOE.

Cleveland Clinic

Research Director

The Cleveland Clinic Medicine Institute Center for Research and Innovation (MICRI) is seeking a Research Director with a PhD in epidemiology, biostatistics, nursing or a social science, and some understanding of methodology. The Research Director will ensure the scientific integrity of Medicine Institute research by overseeing development and implementation of Medicine Institute grants and research projects. The successful candidate is likely to be mid-career with at least ten scientific publications and at least one large research grant. The successful candidate will have significant experience as a principal investigator and must be willing to mentor and assist other investigators, especially generalist physicians. Excellent communication and grant-writing skills are required. The Research Director will have time to pursue her/his own research consistent with the research mission of MICRI.

The Medicine Institute Center for Research and Innovation (MICRI) was established at Cleveland Clinic in June of 2009 to support the research of Cleveland Clinic Departments of Family Medicine, General Internal Medicine, Hospitalist Medicine and Infectious Diseases. In addition to traditional clinical research, MICRI investigators study quality and safety interventions and practice transformation. They use a blend of traditional research methods and quality improvement and innovation principles to test and implement clinical innovations to improve systems of care and patient outcomes. Medicine Institute physicians provide care for over 500,000 unique patients using the EPIC electronic medical record, providing an outstanding opportunity to study clinical outcomes and comparative effectiveness.

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John Hickner, MD, MSc
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