

BEST PRACTICES

FIGHTING ANOTHER EPIDEMIC: STRATEGIES TO TREAT SUBSTANCE USE DISORDERS

Reem Hanna, MD; Catherine Callister, MD

Dr. Hanna (reem.hanna@cuanschutz.edu) is an assistant professor in the Division of Hospital Medicine at the University of Colorado School of Medicine and director of the Hospital Medicine Global Health Scholar Program at the University of Colorado Hospital. Dr. Callister (Catherine.callister@cuanschutz.edu) is an assistant professor in the Division of Hospital Medicine at the University of Colorado School of Medicine.

Introduction

An increase in opioid overdose and alcohol use is a consequence of the COVID-19 pandemic.^{1,2} Greater isolation, increased unemployment, and decreased access to treatment resources and support groups are likely contributing to these findings. In the face of this pandemic, there are proven tools to help clinicians treat patients with substance use disorders, however many patients hospitalized for overdose are not provided naloxone, offered medication-assisted treatment, or connected with addiction treatment.¹ In our role as hospitalists who work on our hospital's addiction medicine consultation service, we review the following five steps that physicians can take to address opioid, alcohol, and other use disorders in hospitalized patients.

1. Ensure all at-risk-patients have a naloxone prescription. Naloxone is an opioid agonist that rapidly reverses the effect of opioid overdose. The CDC recommends naloxone prescription for patients with a history of opioid overdose, any substance use disorder, opioid dosages ≥ 50 morphine milligram equivalents (MME)/day or concurrent benzodiazepine use.³ The usual dose is 0.4 mg when administered intravenously, intramuscularly, or subcutaneously. We recommend prescribing the naloxone intranasal spray as it is dispensed at a premeasured 4 mg dose of the 4 mg/0.1 mL concentration. Standing-orders for naloxone allow pharmacists to dispense naloxone

without a prescription to ensure all patients have access. Education of patients, caregivers, and household members is essential for its success.

2. Review harm reduction practices with patients.

Hospitalization is a good opportunity to introduce or review harm reduction practices with patients, including naloxone provision, HIV and hepatitis C screening, pre-exposure prophylaxis (PrEP) discussion and prescription, a review of safe injection practices, and resources for syringe exchange programs.

Test for HIV and Hepatitis C

People who inject drugs should be tested frequently for HIV and Hepatitis C; however, often opportunities for screening are missed.

Prescribe PrEP for People Who Inject Drugs

PrEP significantly reduces the risk of HIV infection in people who inject drugs, and the CDC recommends prescribing PrEP to this population. The hospital stay can be used as a time to educate patients about PrEP, prescribe it, and connect patients with close outpatient follow up.

Review Safe Injection Practices

These include: One shot = one new needle and syringe, avoid sharing needles or other injection equipment, clean

continued on page 9

CONTENTS

1. Best Practices	1
2. From the Editor	2
3. President's Column.....	3
4. From the Society.....	4
5. Sign of the Times	5
6. Annual Meeting Update.....	6
7. From the Regions.....	8
8. Improving Care	10
9. Researcher's Corner	14

SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

President

Jean S. Kutner, MD, MSPH | Denver, CO
jean.kutner@cuanschutz.edu

President-Elect

Monica L. Lypson, MD, MHPE | Washington, DC
mlypson@mfa.gwu.edu

Past-President

Karen B. DeSalvo, MD, MPH, MSc | San Francisco, CA
karendesalvo@google.com

Treasurer

Hollis Day, MD, MS | Boston, MA
hollis.day@bmc.org

Secretary

Mitchell D. Feldman, MD, MPhil | San Francisco, CA
mfeldman@medicine.ucsf.edu

Secretary-Elect

Gail Daumit, MD, MHS | Chevy Chase, MD
gdaumit@jhmi.edu

COUNCIL MEMBERS

Maria G. Frank, MD | Denver, CO
maria.frank@dhha.org

Reena Karani, MD, MHPE | New York, NY
reena.karani@mssm.edu

Rita S. Lee, MD | Denver, CO
rita.lee@ucdenver.edu

Margaret Lo, MD | Gainesville, FL
margaret.lo@medicine.ufl.edu

Michael P. Pignone, MD | Austin, TX
pignone@austin.utexas.edu

Eleanor (Bimla) Schwarz, MD, MS | Sacramento, CA
ebschwarz@ucdavis.edu

EX-OFFICIO COUNCIL MEMBERS

Chair of the Board of Regional Leaders

Julie Oyler, MD | Chicago, IL
joyler@medicine.bsd.uchicago.edu

Co-Editors, *Journal of General Internal Medicine*

Steven M. Asch, MD, MPH | Palo Alto, CA
sasch@stanford.edu

Carol Bates, MD | Boston, MA
carol_bates@hms.harvard.edu

Jeffrey L. Jackson, MD, MPH | Milwaukee, WI
jjackson@mcw.edu

Editor, *SGIM Forum*

Tiffany I. Leung, MD, MPH, FACP, FAMIA | Maastricht, NL
Editor.SocietyGIMForum@gmail.com

ACLGIM President

Dan P. Hunt, MD | Atlanta, GA
Dan.hunt@emory.edu

Associate Member Representatives

Carlos Irwin A. Oronce, MD, MPH | Los Angeles, CA
COronce@mednet.ucla.edu

Janet Chu, MD, MPH | San Francisco, CA
Janet.chu@ucsf.edu

Deputy Chief Executive Officer

Kay Ovington, CAE | Alexandria, VA
ovingtonk@sgim.org

Chief Executive Officer

Eric B. Bass, MD, MPH, FACP | Alexandria, VA
basse@sgim.org

Director of Communications and Publications

Francine Jetton, MA | Alexandria, VA
jettonf@sgim.org

FROM THE EDITOR

MANGOMOMENTS, DOUBLE TAPS, AND OTHER NEW YEAR'S RESOLUTIONS

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
 Editor in Chief, *SGIM Forum*

Welcome to 2021! Although we are not celebrating a miraculous, groundbreaking transition into the New Year, this transition from 2020 nevertheless offers us the promise of a renewed beginning. This year, we can look towards the bright spots of a COVID-19 vaccine, a refreshed presidential administration, and our continued dedication to SGIM's vision of "a just system of care in which all people can achieve optimal health."

New Year's resolutions, a four millennia old tradition, may be viewed as "unrealistic pledges" of behavior change,¹ perhaps because of the transition's similarly unrealistic sense of renewal. However, the last year was unlike no other in recent memory. Renewal and even resolutions may be just the prescriptions we need right now. The events of 2020 highlighted for us as individuals and communities numerous options for change, especially towards SGIM's vision as of 2018. I offer a few considerations as we set out to craft and commit to our own resolutions, especially those within our loci of control to help one another but especially ourselves.

Concerns about burnout, (loss of) professional satisfaction, and joy of physicians at their daily work have been steadily growing. The exhaustion, chronic distress, and uncertainties of responding to a pandemic have likely led to an acute-on-chronic problem: poorer well-being and mental health of front-line workers and health-care professionals, including physicians, clinicians, and trainees for these disciplines. There is no question that system change at all levels is needed to address the many thorny and deeply rooted contributing factors to poorer physician well-being, including those brought on by the still ongoing pandemic. As one of my collaborators wisely said, "If construction workers have universal safety precautions against mortal physical injuries, then physicians need universal safety precautions against mortal mental health injuries."²

In organized medicine, our societies and associations can resolve, on behalf of members, to publish and amplify essential policy or position statements to address vital issues of our time. In parallel to advocating for destigmatizing physician help seeking for poor mental health,

continued on page 7

CONTINUING TO IMPROVE AS A LEADER— LEVERAGING REPETITION

Jean S. Kutner, MD, MSPH, President, SGIM

As I write this column, between COVID-related command center calls and meetings, my sense of Groundhog Day is more about the COVID surge, as we again focus our energy and attention to a COVID surge exceeding the number of cases and hospitalizations we saw last spring. Once again, we ramp up our COVID surge teams, cancel elective surgeries and procedures, flip to virtual visits, provide PPE refreshers, support patients and families in a time of visitor restrictions, and implore the public to wear masks, socially distance, and wash their hands.

“Watch out for that first step. It’s a doozy!”¹



Many are familiar with *Groundhog Day*, a 1993 film directed by Harold Ramis in which Bill Murray portrays Phil Connors, a cynical TV weatherman covering the annual Groundhog Day event in Punxsutawney, Pennsylvania. He becomes trapped in a time loop forcing him to relive February 2nd repeatedly.¹ The term *Groundhog Day* has since become part of the English lexicon as a means to describe a monotonous, unpleasant, and repetitive situation or “a situation in which events that have happened before happen again, in what seems to be exactly the same way.”² It has also been invoked to describe the experience of the pandemic, most often referring to the repetitive and monotonous day-to-day life that many are experiencing

since the pandemic-related shut downs began in March.³ As I write this column in mid-November, between COVID-related command center calls and meetings, my sense of Groundhog Day is more about the COVID surge, as we again focus all of our energy and attention to a surge of COVID that is exceeding the number of cases and hospitalizations that we saw in the spring. Once again, we are ramping up our COVID surge teams, cancelling elective surgeries and procedures, flipping to virtual visits, providing PPE refreshers, supporting patients and families in a time of visitor restrictions, and imploring the public to wear masks, socially distance and wash their hands.

While there is much familiar about this “Groundhog Day” surge, there is also much different. There are many positives, such as:

continued on page 12

SGIM Forum

Editor In Chief

Tiffany I. Leung, MD, MPH, FACP, FAMIA
Editor.SocietyGIMForum@gmail.com

Managing Editor

Frank Darmstadt
frank.darmstadt@ymail.com

Past Editor In Chief

Joseph Conigliaro, MD, MPH
jconigliaro2010@gmail.com

Editorial Board

Yousaf Ali, MD, MS
Yousaf_Ali@URMC.Rochester.edu
Seki Balogun, MD, MBBS, FACP
sab2s@virginia.edu
Lauren Block, MD, MPH
lblock2@northwell.edu
Alfred P. Burger, MD
aburger.md@gmail.com
Ricardo Correa, MD, EdD, FACP
riccorrea20@hotmail.com
Michele Fang, MD
michele-fang@uiowa.edu
Maria Gaby Frank, MD, FACP
maria.frank@dhha.org

Kittu Jindal Garg, MD
jindal.kittu@gmail.com
Shanu Gupta, MD, FACP
Shanu_Gupta@rush.edu
Tracey L. Henry, MD, MPH, MS
tlhenry@emory.edu
Francine Jetton, MA
jettonf@sgim.org
Megan McNamara, MD, MS
Megan.Mcnamara@va.gov
Somnath Mookherjee, MD
smookh@u.washington.edu
Susana Morales, MD
srm2001@med.cornell.edu

Avital O'Glasser, MD, FACP, FHM
avitaloglasser@gmail.com
Tanu Pandey, MD, MPH
tanumd@gmail.com
Shobha Rao, MD
shobha_rao@rush.edu
Jorge Rodriguez, MD
jarodriguez1@partners.org
Gaetan Sgro, MD
gaetan.sgro@va.gov
Elisa Sottile, MD, FACP
Elisa.Sottile@jax.ufl.edu
David Walsh, MD
dawalsh@augusta.edu

The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.

Q & A WITH SGIM'S CEO: EXTERNAL RELATIONS MORE IMPORTANT THAN EVER

Eric B. Bass, MD, MPH

Dr. Bass (basse@sgim.org) is the CEO of SGIM.

Why are SGIM's external relations so important?

When SGIM's Council asked me to serve as Chief Executive Officer in 2017, one of its top priorities was to expand and strengthen relations with other organizations. The premise is that SGIM will have a stronger voice in influencing national policies if we all work closely with organizations having goals relevant to our mission of cultivating innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone. At a time when that mission is more important and more challenging because of the pandemic, our external relations become even more essential.

How does SGIM prioritize its external relations?

In January 2020, the Council approved a new strategic framework for guiding our approach to external relations. The framework explicitly focuses on strategic priorities relevant to our main organizational goals. To address our goal of advocating for a just health system, we seek to partner with organizations that share interest in improving support for primary care physicians and hospitalists, or in eliminating disparities in health care access and outcomes. To address our goal of fostering development of general internal medicine leaders, we want to collaborate with entities that will provide leadership opportunities for members or that can help to enhance and expand career development programs. To achieve our goal of promoting scholarship in person-centered and population-oriented approaches to improving health, we nurture relationships with funding agencies that can help to stimulate innovative work and increase funding for scholarship in clinical care, education, and research in general internal medicine. Consistent with the goal of fostering the health of our organization, we look for partnerships that can provide additional funding for initiatives, that can help to grow membership, or that can increase the visibility of our members.

What tactics do we employ to strengthen SGIM's external relations?

Our strategic approach to external relations relies on regular communication, with overall coordination and continuity provided by the CEO, and active engagement of the SGIM President and ACLGIM President in high priority

relationships. For some relationships, we strengthen connections by engaging other members of the Council and ACLGIM's Executive Committee and/or chairs of SGIM committees or commissions. Some relationships have grown stronger by partnering on specific initiatives. For example, we have partnered with the American College of Physicians (ACP) on the ProudtoBeGIM Campaign¹ and the High Value Care Coordination initiative.² Such partnerships require approval by the Council or ACLGIM's Executive Committee. Finally, we pursue collective advocacy by working with other organizations on high priority policy issues, most often through our Health Policy Committee, and sometimes through other committees, commissions, or interest groups.

What are some examples of relationships that have grown stronger in recent years?

Within the broad field of medicine, SGIM has always had a close relationship with the ACP, and that relationship has grown stronger through partnerships on specific initiatives and increasingly frequent communication and coordination between the ACP's health policy team and our Health Policy Committee. This past year, we expanded our annual joint leadership meeting with the ACP's leaders to include leaders of the Alliance for Academic Internal Medicine (AAIM) and the Society of Hospital Medicine (SHM). At the joint meeting, we identified areas of common interest that we plan to work on together. Although we cancelled the 2020 Academic Hospitalist Academy because of the pandemic, we plan to continue working with SHM on future plans for the Academic Hospitalist Academy. We also have been working more closely with the Association of American Medical Colleges (AAMC) and intend to do so even more in the coming years, especially given the AAMC's new strategic plan emphasizing its commitment to better health for everyone.³

As part of our efforts to work more closely with other primary care organizations, we became an executive member of the Primary Care Collaborative, a multi-stakeholder organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered med-

continued on page 5

ical home.⁴ We also have found new opportunities to collaborate with family medicine societies, including the American Academy of Family Physicians (AAFP).

In the area of governmental relations, we have continued to advocate for strong support of federal funding agencies most likely to support the work of our members, including the Agency for Healthcare Research and Quality, National Institute on Minority Health and Health Disparities, Patient Centered Outcomes Research Institute, and Veterans Affairs Health Services Research and Development Service. Our leaders have met with the lead-

ers of these agencies to offer input and learn more about their priorities.

I see our expanding external relations as evidence of SGIM's growing influence. Such relationships are more important than ever as we work toward our vision for a just system of care in which *all* people can achieve optimal health.

References

1. Society of General Internal Medicine and the American College of Physicians Announce 2019 ProudtoBeGIM Grantees. [https://www.sgim.org/File%20Library/SGIM/Career%20Center/SGIM-and-ACP-](https://www.sgim.org/File%20Library/SGIM/Career%20Center/SGIM-and-ACP-Announce-2019-ProudtoBeGIM-Grantees.pdf)
2. High Value Care Coordination (HVCC) Toolkit. <https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit>. Accessed December 15, 2020.
3. AAMC. Is America's approach to health broken? <https://strategicplan.aamc.org/>. Accessed December 15, 2020.
4. PCC. About us. <https://www.pcpc.org/about>. Accessed December 15, 2020.

SGIM

SIGN OF THE TIMES

SGIM FORUM RACISM AND MEDICINE ESSAY COLLECTION: PART III

Gaetan Sgro, MD

Dr. Sgro (Gaetan.Sgro@va.gov) is an academic hospitalist and clinical assistant professor of medicine, VA Pittsburgh Healthcare System and University of Pittsburgh School of Medicine.

In recent issues of *SGIM Forum*, we have presented a series of previously published *Forum* articles related to systemic racism and medicine. Our final installment includes four more voices from SGIM who called for the dismantling of systemic racism in American society and medicine. Their work is just the beginning.

"Disparities in Health Status and Health Care Quality by Race: Where Do We Go from Here"¹

September 1997 | Valerie E. Stone

Disparities between Black and white patients exist both in outcomes, such as mortality rates and incidences of diseases like diabetes and AIDS, and in processes of care, including the likelihood of a patient with HIV being treated with appropriate antiretroviral medications. Addressing these disparities was the focus of the Minority Health Precourse at the 1997 SGIM Annual Meeting.

"Primary Care Practice in Minority Settings – A Mission and a Profession"²

February 2007 | Carla Harwell

The author, who practices primary care in an area of

Cleveland more than 98% African American, reflects on issues of trust that complicate the relationship between a white doctor, Black patients, and a healthcare system that has done little to earn their trust.

"Multiple Traumas"³

March 2020 | Angela Suen

In this narrative essay, the author witnesses first-hand how bias impacts the delivery of care, and advocates for implicit bias training and ongoing dialogue aimed at confronting bias in residency training and beyond.

"Let's Talk About Equity"⁴

July 2018 | Giselle Corbie-Smith

In these turbulent and rapidly changing times, our core value of equity may seem at odds with the current perspectives of some stakeholders and policymakers. The author proposes the use of simple language, familiar references, a focus on solutions, and incorporating notions of personal responsibility to produce statements of purpose that resonate with a broad audience.

continued on page 14

TOP 10 REASONS TO REGISTER FOR THE SGIM 2021 ANNUAL MEETING

Rita Lee, MD; Yael Schenker, MD, MAS, FAAHPM

Dr. Lee (Rita.Lee@cuanschutz.edu) is a professor of medicine at the University of Colorado School of Medicine. Dr. Schenker (yas28@pitt.edu) is associate professor of medicine and director of the Palliative Research Center (PaRC) at the University of Pittsburgh.

Happy New Year to our SGIM family!

Now is the time to register for the SGIM 2021 Annual meeting to receive Early Bird registration rates. We are excited to offer incredible content and networking opportunities for the annual meeting—we hope you will join us. Here's a Top 10 List for why you should register:

1. **Our meeting theme: *Transforming Values into Action*.** Now, more than ever, the generalist voice is critically important to informing policy, health systems transformation, research, and education to promote health and equity.
 2. **Networking and collaboration.** Do you miss the chance to connect with professional colleagues, old friends, and distance mentors? The virtual platform offers multiple opportunities for both synchronous and asynchronous networking. Interest groups will have carved out time to connect. If you see a poster or a workshop of interest, you can reach out to the presenters for a virtual chat or to set up a 1:1 meeting.
 3. **Flexible scheduling.** Have you ever been frustrated at previous annual meetings when there were three great workshops running at the same time and you could only pick one? No worries! At SGIM 2021, you can attend one live session and watch the others later.
 4. **Inspiring plenary speakers.** We have an incredible line up of plenary speakers who will speak about current trends in healthcare, highlighting opportunities for engagement by generalists at all levels. We will hear inspiration from a medical student who has used her voice to enact changes in medical education and a law school dean who is seeking a cure for racial inequality in American healthcare—demonstrating that any one of us, and every one of us, can transform our values into action.
 5. **Truly special, Special Symposia.** The submissions for the Special Symposia are incredible as always. These are great forums to learn and reflect on the rapid changes that have happened in our world in the past year.
 6. **Clinical Updates with *Jeopardy*.** Clinical updates will be pre-recorded so you don't have to miss a thing! We encourage you to watch all of them and pay attention—there will be a Jeopardy-style competition at the end.
 7. **Connect with poster presentations.** Never have enough time to see all the posters you want to during a session? Feel overwhelmed wandering through a giant hall with posters? Through the virtual poster hall, you will be able to see all of the posters without worrying about conflicting schedules or limited session times. You can even search for posters by type and category to find all the latest in your areas of interest. You can also connect with poster presenters virtually via a Chat function to ask questions and set up collaborations.
 8. **Learn about Innovations.** With so many changes in the past year, clinicians, educators, researchers, leaders, and administrators have all had to adapt quickly. Hear how others have leveraged the circumstances to innovate and create new initiatives that are advancing generalist values.
 9. **Our community.** Join your friends who have been working so hard to create an amazing virtual meeting. Please thank them for their tireless work and creativity!
- **Program Chairs:** Rita Lee and Yael Schenker
 - **Workshops:** Kate Wrenn and Jane Jih
 - **MOC:** Deborah Kwolek and Darlene LeFrancois
 - **Scientific Abstracts:** Stacey Jolly and Zirui Song
 - **Evaluations:** Robin Klein and Francois Rollins
 - **Innovations in Healthcare Delivery:** Liz Dzeng and Danielle Loeb
 - **Innovations in Medical Education:** Leilani Lee and Susan Urban
 - **Mentoring:** Utibe Essien and Era Kryzhanovskaya
 - **Symposia:** Michael Mueller and Sabrina Taldone
 - **Career Development:** Maddie Sterling and Amy Sheer
 - **Student/Resident/Fellow Programming:** Karla Williams and Dan Restrepo
 - **Updates:** Yvette Cua and Jeannine Engel
 - **Vignettes:** Rob Fortuna and Amanda Clark

continued on page 7

- **Scheduling:** Magni Hamso
- **Interest Groups:** Lydia Pace and Christopher Terndrup
- **Distinguished Professors:** Nia Mitchell
- **Hamolsky/Lipkin Awards:** Eileen Reynolds
- **VA Special Series:** Erin Krebs
- **SGIM Annual Meeting Staff:**

Corrine Melissari and Jasmine Russell

10. **Enjoy the meeting in your pajamas!** With a virtual meeting, you save time and money because you don't need to travel and you can enjoy the meeting from the comfort of your own home or

office. OK, we don't actually recommend wearing pajamas with your professional shirt, but we won't tell if you have your bunny slippers on.

We look forward to seeing in you in April for an engaging meeting!

SGIM

FROM THE EDITOR (continued from page 2)

researching the factors contributing to physician dissatisfaction and cynicism, launching interventions to mitigate these consequences, and more, small changes and shifts in perspective still are valuable. One Belgian group lightheartedly calls moments of human connection *mangomoments*, named after the kind of connection created by a journalist who asks a critical care patient, who reflected on her experiences after awakening from a coma, what she can do to make her happy. The patient replies, "I would really like to taste a mango again," and the journalist responds by literally bringing her a mango.³ This reminded me of a past essay on a related concept, *micro-moments of positivity resonance*, or a feeling of "love," characterized primarily by a flood of positive emotions, shared in connection with any other person.⁴ Readily identifying these profound moments of connection may be much easier to recognize in encounters with patients than with colleagues, especially because of the nature of physician training and work.

Tuning in to potential connections with peers and colleagues may be especially beneficial for both involved. Recently, I listened to a podcast episode that described the concept of a *double tap* when checking in with another.⁵ The first tap: ask someone, "How are you?" and listen; don't use the question only as a greeting. The second tap: if the person responds, "I'm fine" or "Okay," a potentially reflexive greeting in

response, ask again, "Really, how are you?" or "Are you sure you're okay?" Checking in with each other, as I hope that we have come to do more often in the last year, seems like a worthwhile resolution to carry into this New Year. However, these check-ins, mangomoments, micro-moments of positivity resonance—whatever we wish to call them!—need also to be practiced for ourselves.

Offering others grace and empathy seem so much easier than offering the same in the form of self-compassion to ourselves. I lost a dear friend before COVID-19 was declared a pandemic, and that loss, combined with pandemic-related shifts in routine and mindset soon after, prompted me to seek help. Working with a psychosocial therapist, dissecting key moments in my acute responses to my friend's death, I reflected on that initial question again: What did I need? Then, if I were to see someone like me in that position, how would I offer them help?

This pandemic has unearthed such feelings in all who lost patients, friends, loved ones, and others along the way. Stopping long enough to recognize and respond to one's own needs is vital to our health and well-being and the long-term sustainability of our individual and collective pursuits. In "a just system of care in which all people can achieve optimal health," physicians are a part of the system and also are deserving of optimal health alongside and as patients also. As 2021 begins,

let us resolve, reinforce, and re-commit to our existing resolutions and to promote our health and that of our colleagues, even if only one mangomoment at a time.

References

1. A.L. The origin of the new year's resolution. *The Economist*. <https://www.economist.com/the-economist-explains/2018/01/05/the-origin-of-new-years-resolutions>. Published January 5, 2018. Accessed December 15, 2020. (Accessible with registration of a free account.)
2. Leung TI, Chen C-YA, Pendharkar S. Seeking and implementing evidence-based physician suicide prevention. *JAMA Intern Med*. 2020;180(9):1258.
3. Vanhaecht K. In search of Mangomoments. *Lancet Oncol*. 2018 Feb;19(2):165.
4. Esfahani Smith E. There's no such thing as everlasting love (according to science). *The Atlantic*. <https://www.theatlantic.com/saxes/archive/2013/01/theres-no-such-thing-as-everlasting-love-according-to-science/267199/>. Published January 24, 2013. Accessed December 15, 2020.
5. Rogers R. COVID19-The psychological trauma in healthcare workers. *Medutopia*. <https://www.mymedutopia.com/podcasts/24888503>. Uploaded April 6, 2020. Accessed December 15, 2020.

SGIM

BRIDGING THE GAP: A COVID-19 TELEHEALTH PILOT

Lauren Block, MD, MPH; Razia Jayman-Aristide, MD; Taranjeet Kalra Ahuja, DO; Samara Ginzburg, MD

Dr. Block (lblock2@northwell.edu) is an associate professor in the Department of Medicine and the Department of Science Education at the Zucker School of Medicine at Hofstra/Northwell and co-director of Patient, Physician, and Society at Zucker School of Medicine. Dr. Jayman-Aristide (razia.jayman-aristide@hofstra.edu) is an assistant professor in the Department of Medicine and the Department of Science Education at Zucker School of Medicine at Hofstra/Northwell and co-director of Ambulatory Clerkships at Zucker School of Medicine. Dr. Ahuja (taranjeet.ahuja@hofstra.edu; Twitter @DrAhuja) is an assistant professor in the Department of Pediatrics and the Department of Science Education at the Zucker School of Medicine at Hofstra/Northwell and co-leader of Communications at Zucker School of Medicine. Dr. Ginzburg (samara.ginzburg@hofstra.edu) is an associate professor in the Department of Medicine and the Department of Science Education at the Zucker School of Medicine at Hofstra/Northwell and associate dean for Case-Based Learning at Zucker School of Medicine.

The COVID-19 pandemic surge reduced the number of traditional clinical opportunities available to medical students. Concerns for student safety, rationing of PPE, and the reduction of ambulatory and elective health care utilized during the pandemic created a need to offer students alternative ways to engage in clinical medicine.¹ At the same time, the dramatic increase in numbers of ill patients during the peak of the pandemic created the need for healthcare professionals to engage in infection control, testing, and management. Among these was the need for daily check-ins by primary care physicians with patients sick with COVID-19 using telehealth for support, management, and triage. With many primary care providers in New York deployed to urgent care and hospital medicine, ill themselves, or caring for sick family members, the increased demand for primary care services overwhelmed the limited supply of available primary care providers.² Innovative roles for medical students in infection control, testing, and management may extend the healthcare workforce while providing education and social support for isolated patients.³ To both meet the needs of the patients for daily telephone care and provide students an opportunity to engage in clinical medicine at the height of the pandemic, we piloted a student telephonic check-in program for patients ill with suspected or confirmed COVID-19.

Participants and Setting

Five first- and third-year medical students engaged in a longitudinal ambulatory clerkship at one medical school in New York volunteered to call patients on a daily basis for four weeks during April 2020. Student volunteers were paired one-to-one with community physicians who were general internists employed by the large health system. Some of these students had pre-existing relationships with these preceptors and had been rotating through their offices before the onset of the pandemic.

Program Design

We trained students in use of the telehealth platform, the electronic medical record (EMR), and Centers for Disease Control and Prevention (CDC) and local guidelines for triage and care of patients with COVID-19.⁴ All students had an opportunity to practice telephonic clinical and communication skills remotely with feedback from preceptors and peers prior to initiating the pilot through a two-hour remote learning session. Feedback was focused on best practices in communication skills.⁵ Sessions with a simulated patient provided additional practice gathering histories and review of systems relevant to COVID-19, using empathic communication skills, triaging based on patient symptoms and vital signs, and referring to behavioral health and community resources. Preceptors were instructed to assign students one to five patients to call daily, aiming for continuity throughout the week where possible. Students and preceptors completed telephonic check-ins daily. Where needed, students followed up with patients after discussing the case with their preceptor, and preceptors called patients as needed to obtain additional information.

Evaluation

A pre- and post-pilot survey was sent to student and preceptors participants. The survey included multiple choice items on knowledge and skills, challenges, rewards of participation, and open-ended items on lessons learned and suggestions for future pilots.

Results

All five student-preceptor dyads remained in the pilot for four weeks. Students reported calling one to five patients daily. Neither preceptors nor students reported concerns about getting in touch with each other daily.

continued on page 9

All students reported the following: joining the pilot to learn telehealth skills and serve the community, learning about manifestations and management of COVID-19, finding the most meaningful part of participation was working with their preceptor and having patient contact, and feeling challenged by managing the experience and schoolwork. All students and preceptors hoped students would learn triage skills. While three of five preceptors joined the pilot to help students learn about COVID-19, all preceptors felt they had given students the opportunity to learn about COVID-19 following participation. All students and preceptors reported patients were open to having students call them daily. Four of five students commented on use of communication skills and empathy in response to an open-ended question on their lesson learned. All preceptors reported that medical students of any year were suited to participate. Two preceptors reported setting clear expectations for students including a daily check-in time as lessons learned. One student and one preceptor reported difficulties with EMR access delaying startup.

Lessons Learned

This pilot introduced medical students to telehealth assessment and management for patients ill with suspected COVID-19. A mentored experience and daily phone calls allowed for continuity, individualized instruction, sign-out, and feedback. Training prior to pilot initiation allowed for standardization of care and ensured students were prepared to begin work with preceptors as efficiently as possible. Students gained experience in use of the EMR that they will apply during subsequent clinical work.

The pandemic served as a catalyst for widespread use of telehealth service, including in medical education. New roles for medical students in infection control, testing, and management may extend the healthcare workforce while provid-

ing education and social support for isolated patients.⁵ Limitations of this pilot include a small sample size at one medical school and self-reported data. Next steps include a larger pilot including video assessment and evaluation of patient perceptions of student involvement in telehealth. A telehealth pilot pairing students with busy preceptors to check in on patients with COVID-19 enabled students to develop communication skills and skills in triage in a manner conducive to preceptor, students, and patient needs. Among the myriad changes to rendered by the COVID-19 pandemic, medical student participation via telehealth can be a valuable healthcare workforce extension.

References

1. American Association of Medical Colleges. Important guidance for medical students on clinical rotations during coronavirus (COVID-19) outbreak. <https://www.aamc.org/news-insights/press-releases/important-guidance-medical-students-clinical-rotations-during-coronavirus-covid-19-outbreak>. Published March 17, 2020. Accessed November 15, 2020.
2. Hollander JE, Carr BG. Virtually perfect? Telemedicine for COVID-19. *N Engl J Med*. 2020;382:1679-81.
3. Center for Disease Control. Interim clinical guidance for management of patients with confirmed coronavirus disease (COVID-19). <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>. Updated September 10, 2020. Accessed November 15, 2020.
4. American College of Physicians. Telemedicine: A practical guide for incorporation into your practice. [to-your-practice. Accessed November 15, 2020. \(publication date unknown\)](https://www.acponline.org/cme-moc/online-learning-center/telemedicine-a-practical-guide-for-incorporation-in-

</div>
<div data-bbox=)

5. Bauchner H, Sharfstein J. A bold response to the COVID-19 pandemic: Medical students, national service, and public health. *JAMA*. 2020;323(18):1790-91.

SGIM

BEST PRACTICES

(continued from page 1)

skin thoroughly prior to injection, and use with others in case of overdose. For a comprehensive review of safe injection practices we recommend the manual "Getting off right: a safety manual for injection drug users."³

Provide Information about Local Syringe Exchange Programs

Connecting patients to a needle exchange program enables them to access clean needles, other injection supplies, and, often, fentanyl test strips.

3. Prescribe or connect patients to medication for Opioid Use Disorder (OUD).

Like many other chronic diseases, OUD has highly effective medications that are associated with decreased heroin use, treatment retention, and a reduction in all-cause mortality.⁴ Despite these benefits, many hospitalized patients with OUD do not receive life-saving treatment with buprenorphine or methadone, even following an overdose event.⁴ A hospital stay is an excellent opportunity to discuss medication options for treatment with patients and to initiate the medication of their choice.

Buprenorphine

Buprenorphine is a partial opioid agonist with a high affinity for the opioid receptor. If started in the presence of full-dose opioids, bu-

continued on page 13

PATIENT-CENTERED CARE IN POST-COVID-19 RECOVERY

Ankita Sagar, MD, MPH, FACP; Thomas McGinn, MD, MPH, MACP

Dr. Sagar (ASagar@Northwell.edu; @Sagar_Ankita) is a primary care physician, director of COVID Ambulatory Resource Support (CARES) Program, and director of Ambulatory Quality for the Medicine Service Line at Northwell Health.

Dr. McGinn (Thomas.McGinn@Commonspirit.org; @TomMcGinn4) is the system executive vice president for the Physician Enterprise at CommonSpirit Health.

More than 12.16 million cases of COVID-19 have been reported in the United States as of November 22, 2020. The toll of disease in the United States and globally is extensive and unprecedented by other illnesses in recent history. Global deaths are counted at nearly 1.38 million with the United States responsible for over 256,000 of these deaths.¹ Clinical research, outcomes reporting, and innovation have focused on transmission of COVID-19 virus and management of moderate to severe COVID-19 disease. There is a growing interest in tracking outcomes and clinical innovation in managing patients with COVID-19 lingering symptoms or sequelae and identifying evidence-based treatment for patient with post-COVID syndrome.

Initial management of patients with COVID-19 takes place in one of three settings: 1) hospitals, 2) urgent care centers, and/or 3) ambulatory practices. Based on the COVID-19 experience at Northwell Health, New York's largest integrated health care provider, recovery for the majority of patients will take place in the ambulatory setting, irrespective of the initial management setting.

Thus, we created Northwell's COVID-19 Ambulatory Resource Support (CARES) Program. There are various post-COVID-19 programs across the nation.² Our CARES program is unique in that it is focused on offering a holistic approach to patients with post-COVID-19 symptoms and/or sequelae. It furthers the objective of building comprehensive expertise and collaboration between multiple specialties and clinicians to deliver patient-centered care.

The CARES Program is designed to be an interdisciplinary team representing the diverse group of experts and healthcare providers needed to care for patients with COVID-19. The CARES Program is comprised of two groups: a Steering Committee and Clinical Experts. Steering Committee members were intentionally chosen to represent frontline clinical experience in ambulatory and hospital settings, content expertise in COVID-19, patient navigation and care management experience, data and informatics expertise, and clinical and executive leadership. Clinical Experts were chosen through a process as follows:

The guiding principles for the CARES Program are straightforward: 1) each patient's recovery is unique, and

2) continuous learning and improvement must be a focus, similar to the learning health system.³

Based on these guiding principles, we identified five core tenets of the CARES program:

- 1. Leaning on the Patient-Centered Care model is key.** This is a model of care that has been integrated into medicine, especially primary care, in recent years. This model advocates respect for patients' desired clinical outcomes and their needs, whether they are focused on physical, emotional, social, or financial needs. Furthermore, patient-centered care emphasizes the importance of accessibility, collaboration, and coordination that would allow access to the right care, at the right time, and in the right place. The CARES program allows patients to choose their preferred providers, location, appointment day and time, and the setting in which they receive the care.
- 2. Navigating patients to access care is important.** With more than 22 hospital and 700 ambulatory practices, we decided it was important to create a model of care that navigates patients through the process of accessing care and beyond. We partnered with our nurse navigation team, Northwell NetworkCare, to allow patients to access care via a single-entry point: phone call to a toll-free number. Furthermore, clinicians can refer patients utilizing the electronic health record, where the order entry allows for multiple specialties to be chosen within a single order. Northwell NetworkCare nurses would subsequently triage patients for acute COVID-19 vs. post-COVID sequelae. Upon completion of intake, the nurse navigators would coordinate scheduling of appointments as well as post-appointment follow-up needs.
- 3. Patient needs are varied and access to experts needs to equally wide ranging.** The sequelae of COVID-19 are wide ranging, from semi-acute to chronic, including fatigue, myalgias, myopathy, vasculitis, anxiety, depression, and neurological changes such as cognitive decline, to name a few. The same symptoms have been described in the recovery from mild COVID-19 illness.^{4,5} Furthermore, the persistent symptoms

continued on page 11

and delayed recovery are not the only COVID-19 sequelae. It is hypothesized that among patients and families recovering from COVID-19, the burden of social determinants of health has significantly increased. Also, the community and care management needs of patients recovering from COVID-19 are significant. Thus, we wanted to include experts across a wide range of medical, surgical, and behavioral specialties. We asked the respective leaders at Northwell Health to identify COVID-19 ambulatory experts in their specialties, practices, and programs (see figure).

4. **Access to care needs to be across the geographic footprint.** Northwell Health is a large integrated system with a diverse patient population and it serves multiple counties in New York including: Suffolk, Nassau, Queens, Brooklyn, Manhattan, Staten Island, and Westchester. Upon identifying needed specialties, the next step was to ensure we had access to experts across the footprint. In areas where expertise was physically available in a timely manner, telehealth technology was leveraged when appropriate and preferred to expedite access to clinical expertise. Furthermore, our partnership with home care allows patients to access care in multiple settings: at office, in person, telehealth, and home-based.
5. **Clinical expertise needs to be built in a collaborative and continuous manner.** Current understanding of post-COVID sequelae is quite limited. Thus, the CARES program is focused on continuously building our expertise in managing post-COVID sequelae. To aid in continuous learning, the CARES program features a virtual collaboration platform for the previously mentioned COVID-19 clinical experts called the Learning

Collaborative. This is a biweekly virtual meeting featuring discussion on post-COVID cases and newly published evidence in diagnosis, management, or mitigation of post-COVID sequelae. In addition, program services and offerings are routinely reviewed to disseminate up-to-date information on the CARES Program.

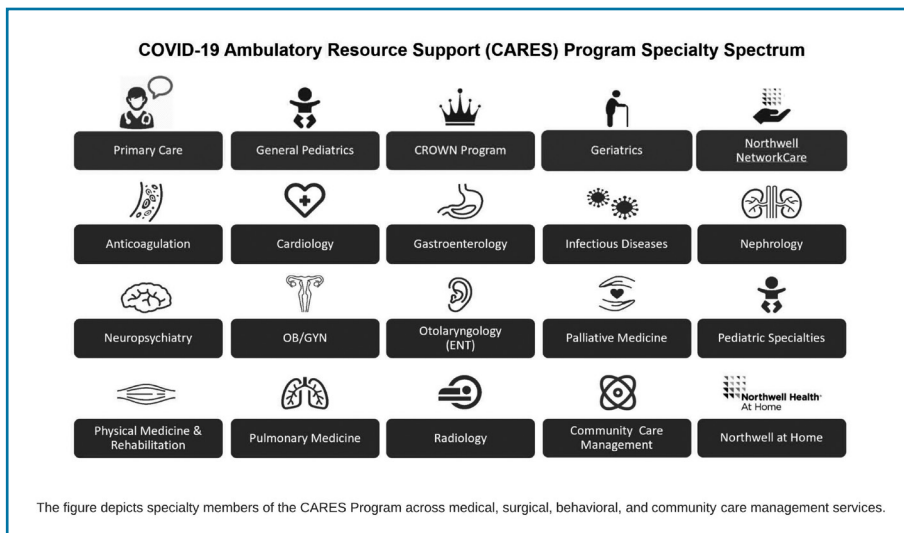
The majority of patients with COVID-19 will continue their diverse, and at times challenging, journeys to recovery in the ambulatory setting. Northwell Health's experience with the management of COVID-19 is consistent with this, regardless of whether initial diagnosis and management happened at home or in a hospital setting. Given limited studies of the prolonged recovery from COVID-19, we anticipate that the CARES program will offer unique insights related to long-term effects of COVID-19 on physical, emotional, social, and overall wellness recovery. Future studies will be focused on detailed evaluation of the program, enrolled patient characteristics, patient and clinician satisfaction of program, and more. Post-COVID recovery is a new process and we have yet to understand the view of COVID-19 recovery 1, 5, and 10 years from now.

For further information on CARES, refer to this site: www.Northwell.edu/CARES.

References

1. John Hopkins University. Coronavirus Resource Center. <https://coronavirus.jhu.edu>. Updated October 30, 2020. Accessed November 22, 2020.
2. del Rio C, Collins LF, Malani P. Long-term health consequences of COVID-19. *JAMA*. Published online October 05, 2020. doi:10.1001/jama.2020.19719.
3. Agency for Healthcare Quality. About learning health systems. <https://www.ahrq.gov/learning-health-systems/about.html>. Updated May 2019. Accessed December 15, 2020.
4. Greenhalgh T, Knight M, A'Court C, et al. Management of post-acute Covid-19 in primary care. *BMJ*. 2020;370:m3026. doi:10.1136/bmj.m3026.
5. Tenforde MW, Kim SS, Lindsell CJ, et al. IVY network investigators; CDC COVID-19 response team; IVY network investigators. Symptom duration and risk factors for delayed return to usual health among outpatients with COVID-19 in a multistate health care systems network: United States, March-June 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69(30):993-998. doi:10.15585/mmwr.mm6930e1.

SGIM



- we have learned from the “gift” of repetition, and from science
- the evidence base to inform our care for COVID patients is much improved
- while much is still unknown, we understand the disease, its manifestations, and how to treat it much better
- we are seeing better outcomes and lower mortality
- we are dusting off and refining procedures and processes that were developed in prior surges rather than started afresh
- we are less reactive and more proactive.

For those of you familiar with the *Groundhog Day* film, back in March we were repeatedly stepping into the icy pothole and glaring at Ned Ryerson when he says “Watch out for that first step. It’s a doozy!”¹ After repetition, or multiple Groundhog Days, we now (mostly) avoid the COVID-equivalent of the icy pothole.

There are also negatives, such as:

- the human toll is significant and real—fatigue, both physical and emotional
- the level of distress that I see is prevalent across all domains
- the sense of heroism and community recognition so prevalent in the spring surge has significantly waned
- clinical research that was just getting back on track is again stalled
- educational and training programs are once again threatened as trainees are pulled into helping cover clinical services.
- with higher community spread, more of our colleagues are getting sick themselves or having to quarantine, furthering staffing shortages, and concern for the health and wellbeing of our colleagues.

So, what are we doing with this Groundhog Day “opportunity”? In the film, the lead character, Phil Connors, learns over time to think

of others instead of himself and discovers his purpose. During the first surge in the spring, it felt like we were so busy blocking and tackling as we dealt with this entirely new situation and all of its incumbent unknowns that we missed out on some of the “people” aspects. As I am living the Groundhog Day of this surge, I am hoping that, like Phil, I am continuing to improve as a leader, and as a person, with each repetition. Some of my lessons learned as we face the current surge are as follows:

1. Communicate, communicate, communicate—through as many means and venues as possible. In uncertain times, people want to know what is going on, and what their organization is doing to address the situation.
2. Be present—physically, mentally, and emotionally for those on the front lines
3. Show vulnerability—none of us has all of the answers and we are all affected by this in both our professional and personal lives. It is OK to admit this!
4. Pay attention to peoples’ basic needs—provide them with what they need to feel safe and cared for
5. Practice patience and grace—give people the benefit of the doubt and assume good intentions, even in the most tense interactions
6. Take care of ourselves and each other—as healthcare professionals, we tend to give and give and give, until we have nothing else to give. During the first surge, our entire executive team worked for something like 82 days straight through. We have now purposively created depth at each of our positions and are enforcing time away from the front line leadership intensity.
7. Seek out and celebrate even small acts of kindness and positivity.

What does this have to do with SGIM? I am here to share my reflec-

tions as a leader during this turbulent and unprecedented year. This past year has certainly highlighted the many critical ways in which general internists are leading and contributing—in the clinical, policy, public health, research, and educational arenas. There is no doubt that general internists, and SGIM, have been cemented as key and steady voices and experts as the nation, our communities and our institutions have faced this pandemic. As we look ahead to 2021, I remain hopeful that we will continue to learn, grow, and contribute to achieving our envisioned future together. To paraphrase Phil Connors from *Groundhog Day*:

When Chekhov saw the long winter, he saw a winter bleak and dark and bereft of hope. Yet we know that winter is just another step in the cycle of life. But standing here among the people of [SGIM] and basking in the warmth of their hearths and hearts, I couldn’t imagine a better fate than a long and lustrous winter.¹

Thank you, SGIM, for providing warmth of (virtual) hearths and hearts as we have weathered this winter together.

References

1. Rubin D, Ramis H. *Groundhog Day [film]*. Los Angeles, CA: Columbia Pictures. February 12, 1993.
2. *Cambridge Dictionary*. Groundhog Day. <https://dictionary.cambridge.org/us/dictionary/english/groundhog-day>. Accessed December 15, 2020.
3. Nierenberg A. Groundhog day again. *Psych Annals*. <https://www.healio.com/psychiatry/journals/psycann/2020-9-50-9/%7B0ca17105-d535-4a3a-a4d2-4e936ab3c3f7%7D/groundhog-day-again>. <https://doi.org/10.3928/00485713-20200810-02>. 2020;50(9):371.

SGIM

prenorphine will precipitate withdrawal symptoms. Once patients are exhibiting symptoms of withdrawal, as measured by the Clinical Opioid Withdrawal Scale >8 (COWS), buprenorphine/naltrexone 4 mg can be started, followed by additional doses of 4 mg buprenorphine for continued symptoms of withdrawal. For an excellent stepwise protocol of how to initiate buprenorphine or methadone in the hospital, we recommend Project SHOUT's: Inpatient Management of Opioid Use Disorder: Buprenorphine.⁵

Methadone

In our practice, we usually administer 20-30 mg of methadone as the first dose with a maximum of 40 mg on the first day and while the patient is in the hospital. Though methadone for OUD treatment is typically administered in opioid treatment programs (OTP), it can be used in the inpatient setting for the prevention of opioid withdrawal. If you are prescribing methadone to prevent withdrawal during a hospital stay, you cannot prescribe methadone at discharge. In the outpatient setting, methadone that is being used to treat opioid use disorder must be prescribed by a SAMHSA approved Opioid Treatment Program (OTP). Ideally, a hospital stay is an opportunity to engage patients in treatment with linkage to an OTP where they can continue to receive care as an outpatient.

4. Offer treatment for alcohol use disorder. While alcohol use disorder causes severe morbidity and early mortality, it remains widely untreated. Naltrexone and acamprosate are two medications used for alcohol use disorder and have been strongly sup-

ported by placebo-controlled clinical trials.⁶ Oral naltrexone is one pill daily and extended release naltrexone is one injection monthly as compared to acamprosate's two pills three times a day. Thus, naltrexone, as a daily and monthly formation, promotes adherence.⁶ In rare cases, and at high doses (>50 mg daily), naltrexone has been associated with hepatotoxicity; thus, we suggest acamprosate rather than naltrexone if patient has acute hepatitis, liver enzymes ≥ 3 to 5 times normal, or liver failure. If a patient is taking prescribed opioid medication, we suggest prescribing acamprosate rather than naltrexone as naltrexone is an opioid antagonist.

5. Connect patients to community resources. In addition to medication-assisted treatment, connecting patients to available community resources is essential for their success. During the COVID-19 pandemic, most treatment programs are continuing their services, but many have moved to an online or phone-based format. Another valuable resource is peer support programs, including the 12-step facilitation which introduces patients to the 12-step philosophy and encourages 12-step engagement. We recommend utilizing social workers and other ancillary resources to assist patients in navigating the various community resources and their availability based on location, insurance, and cost.

As more patients present with substance use disorders in the setting of the COVID-19 pandemic, these 5 steps will help clinicians to provide appropriate treatment and connect their patients to community resources. One specific and important way that physicians can be prepared

to treat patients with OUD is to complete their X-waiver training and then prescribe buprenorphine as appropriate in their practice. To develop familiarity and experience with these modalities, physicians should seek out additional information via the buprenorphine waiver training and various educational opportunities at the Substance Abuse and Mental Health Services Administration (SAMHSA).

References

1. Ochalek TA, Cumpston KL, Wills BK, et al. Nonfatal opioid overdoses at an urban emergency department during the COVID-19 Pandemic. *JAMA*. 2020;324(16):1673–1674.
2. Pollard MS, Tucker JS, Green HD. Changes in adult alcohol use and consequences during the COVID-19 pandemic in the US. *JAMA Network Open*, 2020. 3(9): p. e2022942-e2022942.
3. Coalition, N.H.R. *Getting off right : A safety manual for Injection Drug Users*. 2020 [cited 2020 Nov 20]; Available from: <https://harmreduction.org/issues/safer-drug-use/injection-safety-manual/>.
4. Sordo L, Barrio G, Bravo M, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017. 357: p. j1550.
5. Coffa D, Harter K, Lee S, et al. Inpatient management of opioid use disorder: Buprenorphine. *CHCF*. <https://www.chcf.org/wp-content/uploads/2018/03SHOUTGuidelinesInpatientOpioidTreatment-Buprenorphine.pdf>. Published December 1, 2017. Accessed December 15, 2020.
6. Jonas DE, Amick HR, Feltner C, et al. Pharmacotherapy for adults with alcohol use disorders in outpatient settings: a systematic review and meta-analysis. *JAMA*. 2014 May 14;311(18):1889-900.

SGIM

An increase in opioid overdose and alcohol use is an effect of the COVID-19 pandemic. Greater isolation, unemployment, and decreased access to treatment resources and support groups are likely contributing to these findings. In the face of this worsening epidemic, there are proven tools to help clinicians treat patients with use disorders.

JOURNAL VENUES FOR QUALITY IMPROVEMENT: 2021 UPDATE

Joshua Hamer, PhD; Carlos A. Estrada, MD, MS

Dr. Hamer (Joshua.Hamer@va.gov; @JoshuaphDHamer) is a second-year postdoctoral Health Professions Education Evaluation and Research (HPEER) fellow and course director for the national coordination center of the VA Quality Scholars Program, Michael E. DeBakey VA Medical Center in Houston, Texas. Dr. Estrada (Carlos.Estrada@va.gov; @EstradaElJefe) is chief for the Section of General Internal Medicine, senior scholar at the Birmingham VA Quality Scholars Program, and director for the Division of General Internal Medicine at the University of Alabama at Birmingham, Alabama.

The dissemination of well-designed quality improvement/patient safety (QI/PS) interventions advances scientific knowledge and patient care. Publications in quality improvement require an integration of existing knowledge to support a diversity of theories, strategies, and contexts.¹ There are excellent guidelines available to standardize reporting quality improvement interventions^{2,3} and critically assess the validity of the contributions.¹

Promotion guidelines at professional schools require scholarship productivity. While the forms of scholarship productivity vary between graduate and postgraduate schools, publishing original work in high profile peer-review venues remains a cornerstone of academic achievement. As an example, chairs of medicine viewed QI/PS work favorably for promotion, especially when scholarly productivity is demonstrated.⁴ However, identifying suitable journal venues and audiences is sometimes challenging.

In this report, we update a list of peer-reviewed journal venues for quality improvement indexed in Medline.⁵ We hope the list will facilitate the dissemination of QI/PS work: The message is “publish your QI/PS work.” We acknowledge that the list is incomplete and other forms of scholarship of dissemination are available.

Acknowledgements: We acknowledge the work of fellows and faculty of the national Veterans Affairs Quality

Scholars (VAQS) program (www.vaqs.org).⁶ VAQS is a two-year, inter-professional postdoctoral fellowship that trains leaders and scholars in healthcare improvement. Current fellows are from professions that include medicine, nursing, psychology, pharmacy, social work, physical therapy, behavioral health, and dentistry.

References

1. Hempel S, Shekelle PG, Liu JL, et al. Development of the Quality Improvement Minimum Quality Criteria Set (QI-MQCS): A tool for critical appraisal of quality improvement intervention publications. *BMJ Qual Saf*. 2015 Dec;24(12):796-804.
2. Ogrinc G, Mooney SE, Estrada C, et al. The SQUIRE (Standards for QQuality Improvement Reporting Excellence) guidelines for quality improvement reporting: Explanation and elaboration. *Qual Saf Health Care*. 2008 Oct;17 Suppl 1(Suppl_1):i13-32.
3. Ogrinc G, Davies L, Goodman D, et al. SQUIRE 2.0 (Standards for QQuality Improvement Reporting Excellence): Revised publication guidelines from a detailed consensus process. *BMJ Qual Saf*. 2016 Dec;25(12):986-992.
4. Staiger TO, Wong EY, Schleyer AM, et al. The role of quality improvement and patient safety in aca-

continued on page 15

SIGN OF THE TIMES (continued from page 5)

References

1. Stone V. Disparities in health status and health care quality by race: Where do we go from here? *SGIM Forum*. <https://www.sgim.org/File%20Library/SGIM/Resource%20Library/Forum/1997/forum9709.pdf>. (1997) 20(9): 1,7. Accessed December 15, 2020.
2. Harwell C. Primary care practice in minority settings—A mission and a profession. *SGIM Forum*. <https://www.sgim.org/File%20Library/SGIM/Resource%20Library/Forum/2007/Forum200702.pdf>. (2007) 30(2): 7. Accessed December 15, 2020.
3. Suen A. Multiple traumas. *SGIM Forum*. <https://www.sgim.org/File%20Library/SGIM/Resource%20Library/Forum/2020/SGIM-MAR-5.pdf>. (2020) 43(3):6-7. Accessed December 15, 2020.
4. Corbie-Smith G. Let's talk about equity. *SGIM Forum*. <https://www.sgim.org/File%20Library/SGIM/Resource%20Library/Forum/2018/SGIM-July-3.pdf>. (2018) 41(7):1-2. Accessed December 15, 2020.

SGIM

Journals Venues for Quality Improvement		
Journal Name	Journal URL	Impact Factor
<i>Academic Medicine</i>	http://www.academicmedicine.org/	5.03
<i>The American Journal of Managed Care</i>	https://www.ajmc.com	1.0
<i>American Journal of Medical Quality</i>	https://journals.sagepub.com/home/ajm	1.57
<i>Annals of Internal Medicine</i>	https://www.acpjournals.org/journal/aim/authors1	19.32
<i>BioMed Central (BMC) Health Services Research</i>	https://bmchealthservres.biomedcentral.com	0.8
<i>BMJ Quality and Safety</i>	https://qualitysafety.bmj.com/	7.04
<i>Clinical Infectious Diseases</i>	https://academic.oup.com/cid	9.06 8.84 (5yr)
<i>Health Services Research</i>	https://www.hsr.org/	2.7
<i>Healthcare: The Journal of Delivery Science and Innovation</i>	https://www.journals.elsevier.com/healthcare-the-journal-of-delivery-science-and-innovation/	1.83
<i>Home Healthcare Now</i>	https://journals.lww.com/homehealthcarenurseonline/Pages/aboutthepublication.aspx	NA
<i>Implementation Science</i>	https://implementationscience.biomedcentral.com	4.53 (2yr) 5.74 (5yr)
<i>International Journal for Quality in Health Care</i>	https://academic.oup.com/intqhc/	1.8 (1yr.) 2.4 (5yr.)
<i>JAMA</i>	https://jamanetwork.com/journals/jama/pages/for-authors#fa-about	51.27
<i>JAMA Internal Medicine</i>	https://jamanetwork.com/journals/jamainternalmedicine/pages/for-authors	20.77
<i>The Joint Commission Journal on Quality and Patient Safety</i>	https://store.jcrinc.com/the-joint-commission-journal-on-quality-and-patient-safety/	NA
<i>Journal of General Internal Medicine</i>	http://www.jgim.org	4.61
<i>Journal for Healthcare Quality</i>	https://journals.lww.com/jhqonline/pages/default.aspx	1.09
<i>Journal of Nursing Care Quality</i>	https://journals.lww.com/jncqjournal/pages/default.aspx	1.5
<i>Journal of Oncology Pharmacy Practice</i>	https://journals.sagepub.com/home/opp	1.83
<i>Journal of Oncology Practice</i>	http://jop.ascopubs.org	2.83
<i>Journal of Pain</i>	http://www.jpain.org/	5.42
<i>Journal of Patient Safety</i>	https://journals.lww.com/journalpatientsafety/pages/default.aspx	3.39
<i>Journal of Surgical Research</i>	https://www.journals.elsevier.com/journal-of-surgical-research	1.9
<i>Journal of the American College of Surgeons</i>	https://www.journalacs.org	4.45
<i>PLOS One</i>	https://journals.plos.org/plosone/	NA
<i>Quality Management in Health Care</i>	https://journals.lww.com/qmhcjournal/pages/default.aspx	0.76
<i>Women's Health Issues</i>	https://www.whijournal.com/	1.96

demic promotion: Results of a survey of chairs of departments of internal medicine in North America. *Am J Med.* 2011 Mar;124(3):277-80.

- Peña A, Taylor B, Patrician P, et al. Researchers' corner:

Journal venues for safety and quality improvement publications. *SGIM Forum.* <https://www.sgim.org/File%20Library/SGIM/Resource%20Library/Forum/2011/SGIM-August-2011-Web-1-.pdf>. 2011 34 (8):

10-11. Accessed December 15, 2020.

- VA Quality Scholars. <https://www.vaqs.org/>. Accessed December 15, 2020.

SGIM



SGIM *Forum*

Society of General Internal Medicine
Society of General Internal Medicine
1500 King Street, Suite 303, Alexandria, VA 22314
202-887-5150 (tel) / 202-887-5405 (fax)
www.sgim.org



Street harassment is about power. Photo by Dr. Tiffany Leung, Brooklyn, NY, July 2019. Unknown street artist.



SGIM ANNUAL MEETING
2021 APRIL 20-23

Registration Now Open

Transforming Values into Action

connect.sgim.org/annualmeeting