FROM THE SOCIETY: PART I

GIMLEARN: FROM BUILDING BLOCKS TO NEXT STEPS

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“Why is SGIM the professional home for GIM faculty?” It is the members, the sense of community, and the support the organization provides every member.

SGIM has a long tradition of cultivating the careers of clinicians, educators, researchers, and leaders in internal medicine. This tradition drove SGIM’s vision for a learning management system to promote educational scholarship in an easy-to-access, peer-reviewed online platform. SGIM identified a need for a flexible, online career development platform tailored to clinical educators from early to mid-career, but adequately broad and inclusive for senior career educators and clinician investigators. This vision became reality in 2020 with this new platform: “GIMLearn”.

The overarching goals for GIMLearn are as follows:

1. Provide content and tools for career growth in academic medicine;
2. Provide SGIM members a platform to share content in areas unique to our community;
3. Provide a mechanism to support the work of groups and members within SGIM;
4. Provide a vehicle for peer-reviewed scholarly work for general internists’ promotion and tenure; and
5. Enhance the SGIM organizational and financial position.

In the first two years of development, the GIMLearn Steering Group, (now the Editorial Advisory Board-EAB)—led by Margaret Lo and Dawn Haglund—defined the governance structure and built the infrastructure for members’ peer-reviewed content. The Content subgroup created submission standards, content evaluation rubrics, training materials, and a Frequently Asked Questions (FAQs) document. The Evaluation subgroup conducted gap analyses to determine the content and product needs of our membership. After SGIM successfully completed the rigorous process to become an ACCME-accredited CME provider, our CME/MOC subgroup functions as the reviewing and approving body for education credits. Our entire process emphasizes clarity, consistency, generalizability, and alignment with SGIM’s values and Diversity, Equity, and Inclusion (DEI) standards.

“GIMLearn holds a value and promise of an easy-to-use, easy-to-submit, resource for educators and clinicians that holds both educational value and scholarly respect.”

continued on page 12
FROM THE EDITOR

MISTAKES AND NEXT STEPS

Michael Landry, MD, MSc, FACP, Editor in Chief, SGIM Forum

“And bad mistakes, I’ve made a few, I’ve had my share of sand kicked in my face, But I’ve come through.”

A few years ago, a colleague asked to discuss a case—this was not a normal request as something seemed different. There was a degree of tension and anxiety. This was a colleague I had known for several years and for whom I had great respect. They were an expert clinician, and I had referred many patients to them. I could sense that they needed something from me beyond the simple request to discuss a case.

We arranged to meet the next day even though the day would be filled with meetings and obligations. I told myself that my colleague’s concern was more important than any meeting that day. I arrived at the coffee shop a few minutes before our meeting time and selected an out-of-the-way table where we could talk without interruption. As my fellow faculty member entered and headed to the table, we exchanged greetings and shook hands. We ordered our coffee at the counter and returned to the table.

After some small talk, my colleague asked, “Can I get your opinion on this case?” My answer was “Of course.” Over the next hour, my friend revealed the secret that they had been struggling with—they made a significant medical mistake that had negative impacts on their patient. This was devastating to them. My colleague revealed that this was the first major medical mistake in their career. We discussed the details—major and minor—which they recounted in great detail. It was clear that this was a significant event in their medical career.

Every medical professional has likely made or will make a mistake in their medical career. In 1999, a landmark article by the Institute of Medicine highlighted that 44,000-98,000 deaths occurred in American hospitals annually and another one million patients suffered harm at the hands of the medical community. There has been significant research and commitment to improving patient safety efforts over the subsequent 25 years. Although there have been improvements, medical mistakes remain an unfortunate part of our healthcare system. Often, the physician who committed the medical error suffers in silence.

Mistakes are often categorized as errors of commission or errors of omission. As healthcare providers, we either did something that caused harm to our patients or we omitted an aspect of care that we should have implemented on page 14.
I have a profound sense of gratitude as I embark on my new journey as President of our esteemed organization. While I recognize the challenges ahead, I am filled with hope and optimism for what we can achieve together. As I began to draft my first column, I reviewed and reflected on words from my presidential platform which included supporting the organization to advocate for sustainable careers in General Internal Medicine. As we navigate the ever-evolving landscape of health care, it is important to consider the challenges and opportunities that shape the future of our profession. Over the next year, I plan to lead the organization as we focus on action—demonstrating the vital role of academic general internal medicine physicians in driving positive change.

I have often cited the 2007 Journal of General Internal Medicine article which found that physicians have less civic participation—voting less often than the general public.1 Fortunately, these trends have changed as voter turnout among US physicians is growing over the last two decades.2 As health care continues to evolve, our efforts may need to go beyond getting to the ballot box.

First, the function of primary care has changed and demands our attention. Primary care practices of today would be almost “unrecognizable to past generations of primary care clinicians” existing in a new administrative and technological context,3 complicated by an aging population with increased primary care needs. These changes in primary care have come at a cost of higher moral distress and levels of burnout.3 The practice of

continued on page 11

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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 an 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 AND DR. SHAMS SYED ABOUT THE WORLD HEALTH ORGANIZATION’S (WHO) STRATEGIC PRIORITIES FOR PRIMARY HEALTH CARE

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SGIM has focused a lot of its advocacy work on efforts to improve primary care. In 2020, SGIM co-sponsored the National Academies of Sciences, Engineering, and Medicine (NASEM) Study on Implementing High-Quality Primary Care.1,2 The NASEM study was intended to strengthen primary care in the United States (US) and inform primary care systems around the world. At about the same time, the WHO released a report on an “operational framework for primary health care: transforming vision into action.”3 Recently, I had the opportunity to hear Dr. Shams Syed speak about the WHO’s vision and strategic priorities and he kindly agreed to share his thoughts and perspective with SGIM members.

EB: What is the vision set forth by the Declaration of Astana in 2018?

SS: The fundamental premise of primary health care (PHC) is that all people, everywhere, have the right to the “highest attainable standard of health.”4 The Declaration of Astana’s vision is to renew dedication to PHC as the means to providing health coverage for everyone, so that all individuals can enjoy this right. It envisions governments and societies that promote and protect the health and well-being of populations and individuals by emphasizing the following priorities:

1. High-quality, safe, comprehensive, integrated, accessible, available, and affordable PHC and health services for everyone, everywhere, provided with compassion, respect and dignity by well-trained, skilled, motivated, and committed health professionals;
2. Enabling and health-conducive environments that empower and engage individuals and communities in maintaining and enhancing health and well-being; and
3. Partners and stakeholders aligned in effective support of national health policies, strategies, and plans.

EB: What are the main components of the comprehensive approach to PHC espoused by the Declaration of Astana?

SS: PHC is a whole-of-society approach to organize and strengthen national health systems to bring services closer to communities. It has three components:

1. Integrating health services throughout the life course, emphasizing primary care and public health functions;
2. Systematically addressing determinants of health through multisectoral policy and action; and
3. Empowering people and communities.

EB: What are the most important strategic and operational levers for achieving the vision for PHC?

SS: The WHO-UNICEF operational framework for PHC sets out four core strategic levers articulating the foundation for advancing the PHC vision:

1. Political commitment and leadership focused on PHC;
2. Governance and policy frameworks supporting PHC efforts and accountability;
3. Funding and allocation of resources enabling equitable, affordable access to high-quality PHC; and
4. Engaging communities and stakeholders across sectors to collaborate on problems, solutions, and policy priorities.

The 10 operational levers mutually support one another, relying on the core strategic levers as a foundation. The operational levers are:

1. Models of care;
2. PHC workforce;
3. Physical infrastructure;
Someone should write that up!” This phrase is frequently heard at the end of a case conference or morning report. Not only is publication in peer-reviewed journals an important step in the training of medical students and resident physicians, but publication also remains an important criterion for advancement and promotion for clinician-educators at most academic institutions.

“Where should I publish my medical education project?” You may hear this question repeated at faculty or national meetings. Every day, clinician-educators innovate teaching and evaluation methods, implement new curricula, and conduct original educational research. This article addresses a challenge faced by medical educators—Where should I submit my work? Choosing the right journal venue for publication can become a challenging roadblock for many trainees and junior faculty.

We provide guidance for selecting suitable journals and listing updated journal venues and provide a succinct resource for SGIM clinician educators pursuing scholarship dissemination.1

In addition, here is a list of our answers to commonly asked questions about journal selection:

Q: At what point in the writing process should I select a journal?
A: We suggest selecting several target journals early in the writing process since the format, word counts, and style of the journal will have a significant impact on the writing process.

Q: Which journals publish case reports and medical education projects?
A: To facilitate the submission of case reports and medical education projects, we update the list of journal venues published in a 2016 issue of SGIM Forum.2 Journals with an available impact factor (IF) list the five-year IF or the most recently published. Medline-indexed status was determined by inclusion in the National Library of Medicine catalogue.

Q: What factors should I consider when selecting a journal?
A: Manuscript Categories. Perhaps the most important criterion in journal selection is making sure the journal has a manuscript category that fits your article. Visit the “Instructions for Authors” page on the journal’s website to see what manuscript categories are available for publication. Here you will find guidance for the structure of each type of manuscript submission along with word, author, and table/figure limits. To find a category that fits your article, consider the strengths of your submission. For instance, if a major strength of your case report is an interesting image, then perhaps an “Images” category would fit best. On the other hand, if you have a case with a poignant teaching point, then a full case report with discussion may fit better. For a brand new innovative medical education topic, a brief report such as Medical Education’s “Really Good Stuff” may fit well.3 A more developed curriculum with several rounds of evaluation data would likely need a full manuscript category.

Impact Factor. A measure of the frequency with which the average article in a journal is cited. Journals with high impact factors usually have lower acceptance rates. A highly innovative single center study or a multi-center, well-designed educational research study has better chances of being considered for publication in more prominent journals. At minimum, we look for journals indexed in PubMed.

Publication Costs. Cost varies from none to $3,000, usually charged by open access journals. We usually submit to journals that do not require such cost and may consider paying publication costs for certain journals that require a small fee, or when a grant can cover the cost of a worthwhile project. Also, some figures for case reports and clinical vignettes are better displayed in color. Finally, a small publication fee is worth spending to empower the

continued on page 15
A
other year has passed since the 2023 SGIM Annual Meeting in Aurora, Colorado (#SGIM23). We continue to see the health impacts of climate change around the world and throughout the United States, including an August catastrophic fire in Maui, Hawaii, October wildfires in Canada resulting in smoke and poor air quality through the United States and Canada, severe thunderstorms and tornadoes in the central and southern United States in June 2023, and extreme heat and drought in Texas for much of the spring and fall. The frequency and severity of these extreme climate events continue to increase. Less obvious, but significant, health effects include food insecurity as well as increased geographic range and seasons for many vector-borne illnesses.

SGIM made a commitment to educate and prepare its members to care for patients in this new era of climate impacts and to improve its environmental sustainability as an organization and at the Annual Meetings. Despite evidence that climate change is already affecting the well-being of patients and communities in profound ways—as well as the calls of medical students and residents to include this content in core curricula—education about planetary health has remained minimal and often elective. Most faculty have little knowledge about this content and lack the confidence to teach it. Additionally, the US healthcare system contributes 10% of the total US greenhouse gas emissions, causing both ongoing global warming and air pollution that harms patients. Healthcare sustainability provides an approach in which healthcare systems can decrease waste and increase energy efficiency to reduce their emissions. Professional societies play a significant role in educating their members and in advocating for important changes within their specialty’s training and continuing medical education efforts.

In 2023, members of the SGIM Environmental Health Interest Group (EHIG) decided to leverage this influence and collaborated with the SGIM Education Committee to create “Society of General Internal Medicine Position Statement on Climate Change and Health in Medical Education,” a SGIM position paper advocating for professional societies to promote education in climate change and healthcare sustainability. This statement has been published electronically ahead of print.

SGIM members were first surveyed about sustainability at #SGIM23. Results indicated that awareness of SGIM’s efforts to support environmental sustainability were not recognized by attendees. Only 45% of respondents were aware of the 2021 SGIM Position Statement on Climate Change, 40% were aware that the SGIM Annual Meeting planning committee had a Sustainability Officer and 57% were aware of sustainability plans for the 2023 SGIM meeting. Among respondents, the most support was for increased advocacy training regarding climate and health, including leveraging opportunities for publications within JGIM and the SGIM Forum.

There were many successes at #SGIM23, including an inspirational Plenary Session, “General Internal Medicine: Meeting the Climate of Tomorrow,” by Dr. Howard Frumkin, and several workshops focusing on climate and health education and healthcare sustainability. At the 2023 Annual Meeting, SGIM highlighted the environmental sustainability practices at the meeting continued on page 7
venue and offered suggestions to attendees for individual best practices to reduce their carbon footprint.

At the SGIM 2024 Annual Meeting, we will build on these successes. At #SGIM24, we look forward to a Plenary Session address by Admiral Rachel Levine, a physician and the 17th Assistant Secretary for Health for the U.S. Department of Health and Human Services (HHS), who was nominated by President Joe Biden and confirmed by the United States Senate in 2021. In her role at HHS, she helped to create—and currently oversees—the Office of Climate Change and Health Equity and the Office of Environmental Justice. She actively encourages healthcare organizations to utilize the Inflation Reduction Act and make improvements that will support healthcare sustainability and climate resilience. As the first openly transgender four-star officer in the nation’s eight uniformed services and a pediatrician, Dr. Levine exemplifies the importance of diverse leadership and having a voice that can advocate for those who are historically most vulnerable and at risk of further harm from the effects of climate change.

A workshop entitled “Achieving Net-Zero Healthcare—Generalists Roles in Addressing Climate Change and Environmental Justice,” will be offered Friday, May 17, 2024. This will introduce SGIM attendees to environmental healthcare sustainability and help them envision sustainable practice improvements through a health equity lens.

This year SGIM continues to promote sustainability by using a digital app instead of printed materials; a print-on-demand badge system; use of recyclable materials and no VOC (volatile organic compounds) in signage; using reusable lanyards and digital business cards; encouraging participants to use public transportation when possible; and educating participants about purchasing carbon offsets. There is a wide variation in the transparency and efficacy of different carbon offset programs—some highly rated programs include Native Energy, Atmosfair, Climate Friendly, and MyClimate.

As the site for this year’s conference, the Hynes Convention Center is making strides towards environmental sustainability. The Hynes sources up to 75% of its catering ingredients from local farms and producers, and donates clean, usable, nonperishable items to local nonprofits around Boston through the Conventions C.A.R.E. (Community Assistance by Responsible Events) program.

New for SGIM in 2024, the default meal option at #SGIM24 contains locally sourced, plant-based foods. Plant-based diets, compared with the more meat-based diets of many Americans, directly benefit human health by lowering the risk of developing coronary heart disease, high blood pressure, and diabetes; supporting increased longevity; as well as decreasing the risk of some cancers.5 Additionally, plant-based agriculture is better for the planet. Fewer greenhouse gases are emitted into the atmosphere, less water is required, and land use is more sustainable compared with meat production.6 By some estimates, increased consumption of plant-based foods could reduce emissions by 80%.5 Using locally sourced ingredients also decreases emissions from transportation and supports local communities.

At #SGIM23, we worked to meet the promise of “tomorrow.” Today, at #SGIM24, we continue to take steps to build a “tomorrow” that promises a safe and healthy environment for all through more robust climate-related programming and expanded sustainability measures that also value diversity. As environmental hazards of climate change continue to multiply existing health inequities, we invite SGIM members to strengthen relationships within geographic and practice communities, and to value the diversity of knowledge and experience required to protect individuals most vulnerable to climate-related harms.

References


In 2022, the Accreditation Council for Graduate Medical Education (ACGME) changed their program requirements for internal medicine trainees: “The educational program for all residents must include...clinical experiences in geriatric medicine, hospice and palliative medicine, addiction medicine, emergency medicine, and neurology.”

To an internist who completed fellowship training in addiction medicine, this was welcome news. I personally recall navigating the decision to pursue this subspecialty eight years ago. Addiction medicine was still in its relative infancy in terms of the number of programs and recognition by the larger body of medical education and accreditation. Mentioning my then-unconventional career plan to some attendings was met with “Isn’t that just for psychiatrists?” I was among the first residents from my internal medicine program to arrange a dedicated addiction elective.

Upon starting the rotation, I discovered my main supervisor was absent due to a family emergency. I pivoted to working with the addiction medicine fellows to see patients in clinic, residential treatment, and the hospital. Their residency backgrounds were in family medicine and preventive medicine, fields that seemed to embrace substance use disorder (SUD) treatment before we internists did. Despite the schedule scrambling, it was an enriching and eye-opening experience that elicited a “found-my-people” impression. I will always be grateful to those patients and fellows, as accommodating unplanned learners is no small task.

From the vantage of the inpatient addiction consult team I now staff, I’ll put it bluntly: times have changed over the past eight years. Given the ACGME requirement, a near constant flow of learners rotate through our service that is often the most consulted physician team in the hospital. I logged my personal hours of educational and clinical supervision provided for 2021, 2022, and 2023 by various trainee types (medicine residents/fellows, psychiatry residents/fellows, etc.). Supervised hours for medical trainees (primarily internal medicine) were 380, 812, and 1,023, respectively (a 169% increase over two years). This occurred amid a decline in psychiatry and psychology trainee hours on our team. In total since 2021, there was a net 36% increase in annual trainee-supervision hours (> 1,600 for one attending in 2023) and 53% increase in annual number of rotating learners (>50 for one attending in 2023).

Other training programs and learners began to inquire about addiction medicine rotations. Multiple podiatry residents opted for inpatient addiction medicine to satisfy a behavioral health requirement. A rotating pharmacy resident provided his insights into alcohol use disorder medications and helped publish a case report with us. A rotating advanced practice provider (APP) completing a behavioral health fellowship eventually joined our team full time. Multiple outpatient and inpatient generalist attendings have rotated to gain or maintain subspecialty experience. “Though I was looking to work mostly outpatient, I was searching for opportunities to work a few weeks a year on addiction consults...It’s rewarding to care for patients across all stages of SUD, including in acute care settings where their SUD may be most active,” e-mailed one fellowship-trained SGIM member who regularly joins our team now.

In the context of COVID-19 era spikes in alcohol and substance use plus the growing complexity of standard work developed in the hospital for our team, this broad educational surge generated a large burden of orienting and teaching while managing a busy, unpredictable consult census. In response, we implemented several changes:

• New learning objectives, with an aim to assess pre/post learner confidence in each.
  o Diagnose a severe substance use disorder in the hospital setting
  o Interpret a basic urine drug screen in a hospitalized patient
  o Compare and contrast three medications for alcohol use disorder

continued on page 9
SIGN OF THE TIMES (continued from page 8)

- Compare and contrast two medications for opioid use disorder
- List a differential diagnosis for a patient with agitation and/or sedation in the context of substance use
- Describe differences between front-loading, symptom-triggered, and fixed schedule strategies in alcohol withdrawal
- Discuss whether and how to order buprenorphine in settings of acute pain
- Brainstorm three ways stimulants are experienced as functional to those who use them
- Counsel a patient who injects drugs on safer use
- Demonstrate two types of reflections consistent with motivational interviewing
- Describe a patient who would be appropriate for residential addiction treatment according to American Society of Addiction Medicine (ASAM) criteria
- Discuss barriers to post-hospital linkage to the appropriate addiction care level.

- Early afternoon table rounds to consolidate patient staffing, care coordination, and teaching (e.g., via whiteboard mini lectures). Topics cover learning objectives, with an early rotation emphasis on motivational interviewing and SUD evaluation in the hospital setting (i.e., how do the diagnostic criteria map onto various elements of the history of present illness, social history, etc.).
- A minimum requirement of five consecutive weekdays for a rotation, with some flexibility to accommodate clinic half-days and didactics. Alternatively, one could shadow for 1-2 days, at the discretion of an accepting attending. We found that attempting to fully onboard trainees for a handful of disconnected days led to a net burden for team members and a lack of patient continuity for learners.
- A QR-code accessible orientation module via REDCap®, ideally to be completed prior to the start of the rotation.

With the implementation of these changes, the educational burden has improved, albeit slightly. Learners arrive more prepared, with one stating via anonymous feedback: “Probably the best onboarding/orientation experience I’ve had in all of residency.” After onboarding, more learners can provide near-independent addiction consultation work for multiple sequential days (aggregated learning objective data are forthcoming).

Yet this mandatory educational change will require additional monetary and logistical support to be sustainable. Inpatient training in addiction medicine is valuable in ways that are hard to replicate in outpatient settings, including patient acuity/variety, flexible teaching opportunities, and complex care coordination. Thus, more hospitals need an addiction medicine consult team to distribute educational demands for this training more equitably, and existing teams should have built-in time for education. Secondly, more funding should be prioritized to hire addiction-focused social workers and addiction-boarded (or board-eligible) attendings in all clinical settings, leveraging the swelling ranks of fellowship graduates eager to make an impact both clinically and educationally. And thirdly, more pragmatic research needs to solidify what constitutes evidence-based SUD care in the hospital setting, beyond the well-established need for medications for opioid use disorder.1 These efforts can make this ACGME policy shift more viable for academic health systems, engaging for learners, and effective at improving outcomes among some of the most vulnerable patients in the hospital.

It has been the thrill of my brief career to witness and participate in the advancement of addiction medicine, in part via supporting medical education. Generalists and addiction specialists alike can celebrate this policy milestone while ensuring its robust administrative backing for the future cohorts of internists needed to tackle this generational public health scourge. If feasible, SGIM clinicians should seize the opportunity to rotate with an addiction consult team, join the enterprise of teaching addiction medicine skills to residents, and advocate for new addiction consult teams in their organizations.

References
The emergency department (ED) is the gateway to the hospital, a conduit for most patients requiring acute care admission to the hospital. Patients who do not require admission, but do require urgent care and interprofessional services, receive their care in the ED. It is also where many patients without primary care providers receive health care. According to the Veteran’s Healthcare Administration (VHA), more than 45% of patients entering the emergency department are older adults. Patients aged 65 and older with frailty, sensory limitations, cognitive impairment, and co-morbidities face many challenges in the ED as care delivery can be distressing. Frequent and unplanned visits and examinations or procedures by physicians, nurses, and technicians can lead to confusion. Overstimulation or understimulation in a different environment with unfamiliar care providers can be intimidating and, for some patients, threatening.

The American College of Emergency Physicians (ACEP) shaped criteria to guide emergency departments to improve and standardize care delivery for geriatric patients. Geriatric Emergency Department Accreditation (GEDA) has three levels of care to meet the needs of older adults in the ED. Levels are categorized into: Bronze (requires four geriatric specific care processes), Silver (requires 10 geriatric care processes, dedicated staff for 56 hours/week, unit champions, continuous tracking of outcomes and quality metrics) and Gold (requires 20 geriatric care processes, multidisciplinary champions, a patient advisor, dedicated staff, and continuous tracking of outcomes and increased quality metrics).

In 2021, the Cincinnati VAMC resolved to make emergency medical care Age-Friendly for older adults. Older adults >65 years old are screened with the ISAR (Identification of Seniors at Risk) tool. Those who screen positive for functional or cognitive decline, polypharmacy, frequent hospitalizations, or sensory challenges receive a specialized nurse consult called GERI-VET. The geriatric nurse explores the Age-Friendly 4Ms in more detail, assessing fall risk and functional abilities (ADLS/IADLS) (Mobility), cognitive changes and depression (Mentation), polypharmacy (Medications), caregiver burden, nutrition risk, and what Matters most to the patient.

The Geriatric ED is uniquely equipped to handle the needs of aging veterans. Veterans at risk of falling are seen by a physical therapist in the ED and can receive adaptive devices if needed. Home health services can be ordered from the ED and social workers can provide resources to care partners. If a patient requires acute care admission, the geriatric nurse specialist communicates findings from the GERI-VET visit to inpatient nurse case managers and geriatricians so that optimal Age-Friendly care can be delivered from hospitalization through discharge. The veteran’s needs, goals, and values are explored and addressed at every step in the process. For patients with cognitive impairment, frailty, and other geriatric syndromes, consults to geriatric medicine are placed—geriatricians will see these patients in the hospital or in outpatient specialty clinic, depending on the disposition from the ED.

In the hustle and bustle of the ED environment, taking time to talk to the patient and provide comprehensive Age-Friendly care can be a relief for older adult patients and their care partners. Geriatric nurse consults may make the difference between an older adult getting admitted to acute care versus returning home from the ED with a comprehensive Age-Friendly disposition plan. When veterans are discharged from the inpatient setting, their Primary Care team calls to follow up within 48 hours. However, if the patients are discharged from the ED and not admitted, primary care may be unaware of their visit. Patients seen by the geriatric nurse who are discharged from the ED receive a follow-up phone call by that nurse within 48 hours of discharge and again within two weeks. This ensures that the patient has their continued on page 13
primary care in its current form, therefore, requires reassessment of the primary care clinician’s work, team structure, and function to support our patients’ care. Increased work that is not patient facing (e.g., answering electronic messages, addressing insurance and formulary constraints, and adhering to regulatory and quality documentation requirements) threaten the joy in our profession and the pipeline of learners choosing this career. I look forward to an ongoing collaboration with the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) to operation-alize their work from this year’s annual Hess Institute. ACLGIM made recommendations related to team composition and function, leveraging technology, aligning compensation with primary care work, and directly and indirectly, improving learner experience in primary care.

Secondly, the safety of physicians has become a growing concern—threats, attacks, and intimidation towards physicians increased over the last decade. From the rising incidence of workplace violence, (particularly in practices managing women’s health and reproduction), to the mental health challenges exacerbated by the demands of our profession, physicians are facing unprecedented risks. Additionally, physician leaders of Justice, Equity, Diversity, and Inclusion programs are increasingly under scrutiny and at risk for harassment and intimidation. As an organization, we should prioritize and advocate for physician well-being, implementing strategies to mitigate these occupational hazards.

Despite these challenges, I remain optimistic about our organization and the future of our profession. It is within this context that I start my tenure and affirm my commitment to SGIM’s mission to cultivate innovative educators, researchers, and clinicians in academic general internal medicine, leading the way to better health for everyone. As we plan our meeting in Florida, a state with LGBTQIA+ legislation and reproductive policies that are not aligned with the values of many of our members, I am proud of the SGIM’s careful deliberation process. After intentional member engagement, data collection, and transparent communication, SGIM made the difficult decision to meet in Florida. I have asked a wonderful group of committed members to lead the 2025 SGIM Annual Meeting program (#SGIM25), including Drs. Dominque Cosco, Thomas Radomski, and Dianne Goede. Dr. Goede, a health policy expert based in Florida, will take on an elevated leadership role in collaboration with our Annual Meeting leaders and the Health Policy Committee to guide meeting planning to support state and local advocacy at the Annual Meeting. She will lead and connect us to advocacy and action in the Florida community.

The bottom line is this... ACTION is needed. Our SGIM membership has a unique blend of expertise, compassion, and resilience that equips us to navigate these political and healthcare challenges. As academic general internists, we have a responsibility to advocate for policies that empower physicians and learners alike. By harnessing our collective voice and action, SGIM members can drive meaningful change and shape a healthcare system that aligns with our values and aspirations. With your support and collaboration, I am confident we can navigate these challenges and emerge stronger than before. Let’s do this...

References

After defining the themes, subgroups, and infrastructure over the prior two years, GIMLearn leaders shifted to content delivery and quality in 2023. With guidance from SGIM Council, the initial Call for Submissions focused on content that supports SGIM members in career growth as advocates and educators. GIMLearn opened its first Call for Submissions in May 2023 and received 30 submissions. All submissions underwent peer review with critiques and comments shared with the authors. Several high-yield products have been released on the GIMLearn platform and several more accepted submissions are under revision for future release.

Upcoming content will expand to topics that support clinical practice and licensure and an emphasis on topics that capture our nation’s attention, (e.g., care for persons needing abortion and treatment of substance use disorders). Future directions may include publications that describe and support clinical operations and health system improvement to support practices. Content may include clinical tools, curricula and teaching guides, open online courses, or core clinical topics. GIMLearn can support a variety of formats: live webinars, video content, sharing of materials/handouts/checklists, and online testing.

There were several lessons learned through this inaugural call for submissions that have helped GIMLearn leaders define future steps. We recognized the need for greater clarity in the submission guidelines to ensure educational activities are tailored to the end-user and a virtual audience. We plan to provide exemplars, videos, tutorials, and an in-person workshop at the 2024 Annual Meeting (#SGIM24) in preparation for and prior to the next submission cycle.

The potential and value of GIMLearn to our members are far-reaching! For its continual success, SGIM needs you—our valuable members—to engage in the wealth of GIMLearn opportunities.

How can you become involved? Here are some opportunities:

1. **Volunteer to be a GIMLearn board member!** You can review and curate content, review and approve CME/MOC credits, or join our Editorial Advisory Board to craft the direction of this new platform. Doing so offers networking on the national level and provides external committee engagement which is great for promotion and curriculum vitae.

2. **Submit your educational work for review and potential publication on GIMLearn.** All publications on this online platform are peer-reviewed and count as peer-reviewed scholarly activity for promotion at many institutions. Doing so further disseminates your work to SGIM members and to the broader community of lifelong learners in internal medicine. GIMLearn holds a value and a promise of an easy-to-use, easy-to-submit, resource for educators and clinicians that holds both educational value and scholarly respect that we desire.

3. **Access or participate in the variety of educational offerings currently on GIMLearn** for your professional growth, career development, and day-to-day clinical or teaching needs. Current topics include trauma-informed care, allyship, managing up, and content from prior SGIM Annual Meetings. Most content on GIMLearn offer CME/MOC credits and are free to SGIM members or low cost to non-members.

The future of GIMLearn is bright and exciting! Our members identified topics critical to the practice of medicine and gave clinical educators a tool to reach a global audience by offering access to those eager to learn or incorporate new tools in their clinical practice, educational programs, or clinical operations. The GIMLearn Editorial Advisory Board plans for the release of new content monthly for SGIM members aiming to distribute their work and advancing the needs of the GIM community. GIMLearn may integrate with the Annual Meeting content and serve as a platform to facilitate collaboration between Commissions or Interest Groups.

As we advance into a digital age where multimedia products are widely used, the GIMLearn platform will transform the way SGIM delivers educational content and professional development. GIMLearn has the potential to be the premier learning management platform. We invite all SGIM members to submit their ideas and educational work. GIMLearn will enable SGIM to achieve our mission of cultivating and promoting innovative educators, researchers, and clinicians in academic GIM.

Acknowledgements: We thank all our members of the GIMLearn Steering Committee and GIMLearn EAB for their hard work, insight, guidance, and wisdom.

References
FROM THE SOCIETY: PART II (continued from page 4)

4. Medicines and other health products;
5. Engagement with private sector providers;
6. Purchasing and payment systems;
7. Digital technologies for health;
8. Systems for improving quality of care;
9. PHC-oriented research; and
10. Monitoring and evaluation. Put together, these interdependent levers provide a compass for countries as they reorient their health systems towards PHC.

EB: What gives you hope that the US can achieve this vision?
SS: There are many examples of PHC excelling in the US context. The Indian Health Service, for instance, developed a Community Health Representative program that resembles other countries’ successful Community Health Worker programs, training and mobilizing community members to connect people to health promotion and disease prevention activities and healthcare resources. Support for the PHC model has grown significantly in the US, especially over the last decade. Equity in healthcare is a concept being integrated into the US health system at several levels and is consistently demonstrated as a key component of quality. The US is a leader in studying PHC and working to improve the quality of care, setting an example for others to follow. While challenges are of course numerous, the health policy environment is increasingly highlighting the need for PHC orientation, as seen in recent NASEM publications.

EB: What is the best way for SGIM members to support the global vision for high-quality comprehensive PHC?
SS: Individuals and institutions from all levels should share their success stories and learnings from implementing PHC-oriented health efforts. Highlighting and documenting these examples can help to maintain the momentum of PHC efforts as a mechanism to deliver quality healthcare to everyone, everywhere.

Further information is available at the WHO’s website on PHC.5

Acknowledgement: We thank Dr. Laila Zomorodian for helping to facilitate this virtual interview.

References

IMPROVING CARE (continued from page 10)

care needs met, reconnects them to primary care, and connects them or their care partner to other resources. The Cincinnati VA ED is working toward Level 1 (Gold) Geriatric ED Accreditation. In a retrospective matched case-control study of Level 1 Geriatric Emergency Departments, it was found that “older adults who received a consult from a geriatric nurse specialist in a Level 1 geriatric emergency department had a 13% reduced absolute risk of admission.”4 In a cross-sectional study of almost 25,000 Medicare beneficiaries at two emergency departments, geriatric ED nurse consults resulted in a significant reduction of costs with savings of $2,905 per beneficiary after 30 days and $3,202 per beneficiary after 60 days of the ED visit.4

An integral part of the geriatric nurse assessment is creating an optimized and Age-Friendly discharge plan for each patient. Understanding a patient’s learning style, family support, transportation needs, and communication preferences all play an important part. The geriatric nurse can utilize the time a patient is waiting for disposition in the ED to review screenings, care coordina-

continued on page 16
Mistakes are part of the game. And what’s important is what we do next.
regularly publishes in the topic may be interested in innovative approaches to examine the same problem. A journal venue that has never published a related topic may or may not have an interest in publishing in the topic. If still in doubt, contact the editors with a short summary of the purpose of your work. Such communications are not “binding,” and we have found them useful.

Q: How many journals should I select?
A: We usually pick several journals with similar requirements of varying impact factors. If our article is rejected from the first journal, we will take the suggestions/feedback to see if it can be improved for subsequent submission. This improves the overall chance of successful publication; however, you can only submit to one journal at a time.

Q: How else can I get advice on journal selection?
A: Ask your co-authors and colleagues about journals that have published their work. Additionally, ask if they will share which journals have rejected their submissions. This information can be valuable as you gain experience with different journals in your area.

In summary, this article serves as a compass for SGIM clinician-educators, promoting successful scholarship dissemination through strategic journal selection.

References
tion, and work with the ED staff to create a safe and effective disposition plan.

The Cincinnati VAMC has created a thriving collaborative community to help older adult patients from the moment they walk in the door. Coordination between the geriatric nurse and ED team, geriatricians, bedside nurses, social workers, physical and occupational therapists, pharmacists, primary care providers, administrative staff, community agencies, and patients and care partners have changed the way older adults experience care in the ED.

During a resident’s geriatric rotation, they may rotate with the geriatric ED team and complete a geriatric ED consult for other older adults. These learning opportunities allow trainees to gain direct experience in participating in comprehensive and compassionate care delivery for older adults at the very beginning of an older adult’s healthcare journey in the hospital. SGIM readers interested in replicating a Geriatric ED model in their emergency department can learn more by visiting the ACEP (American College of Emergency Physicians) Geriatric ED accreditation site.2

References