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## Introduction/Background

Human rights are fundamental to all individuals, and their establishment and protection are often a precondition for many factors that promote health. Health professionals have long played critical roles in recognizing the medical and psychological harm that human rights abuses cause to individuals, communities and populations, and have documented evidence of such abuses, protested human rights violations, and advocated for effective medical, public health, and policy interventions when such harm takes place.

Here at Weill Cornell Medicine, there are both well-established and novel programs that students, housestaff and faculty have contributed to in order to advance health and human rights. Through unique partnerships with community-based as well as national and internationally recognized human rights and advocacy organizations, we have helped to serve asylum seekers and refugees, prisoners, victims of trafficking, survivors of torture, war trauma, violence due to ethnicity, membership in specific social groups, gender, sexual orientation, political activity, and other factors.

We also advance this work in an incredibly interdisciplinary manner linking health professional students, clinicians including physicians from multiple specialties, psychologists, nurses, physician assistants, social workers, lawyers and rights advocates in the service of these vulnerable populations.

Individuals interested in learning more about health and human rights activities here at WCM can contact Dr. Joseph Shin at [jos9223@med.cornell.edu](mailto:jos9223@med.cornell.edu) for further information.

## Programs

### WEILL CORNELL CENTER FOR HUMAN RIGHTS

#### Weill Cornell Center for Human Rights (WCCHR)

WCCHR is a student-run, faculty supported clinic providing pro-bono medical forensic evaluations for survivors of torture and asylum applicants who have medical, psychiatric and gynecologic evidence of torture and other human rights abuses. Founded through a collaboration with Physicians for Human Rights in 2010, students and faculty/clinician evaluators have conducted approximately 400 forensic evaluations for individuals from over 60 countries. In addition to these core activities, WCCHR's commitment to service, education, advocacy and research continues to grow through a number of other initiatives and programs:

**Continuing Care:** Students help to identify client needs, establish intervention priorities and coordinate contact with community-based resources and partner organization to address medical, dental, mental health, insurance, housing, clothing, language and other needs.

**Research:** Students and faculty have and continue to be involved in research projects seeking to understand the experiences and health status of asylum seekers. Several current projects include: Trauma Exposure, Health Status and Disease Burden of Child Asylees, Gender-Based Violence, Chronic Pain Screening, Scar Database Among Torture Survivors, and others.

**Training/Education Programs:** In addition to principle trainings for conducting forensic medical evaluations and understanding asylum law and medico-legal advocacy, past trainings have addressed topics such as evaluating adolescent asylum seekers, women's health and female genital mutilation, identifying victims of sex trafficking, correctional health, vicarious trauma and resilience-debriefing experiences working with torture survivors, and others. Additionally, WCCHR has acted as a major convener and source of expertise advising other medical colleges as they start similar asylum clinics. WCCHR has hosted a Student-Run Asylum clinic Summit and developed a Asylum-Clinic Start-up Kit and handbook outlining best practices and effective strategies in partnership with PHR.



Photo Credit: Molly Chodakewitz

Spring 2017 Networking Luncheon - "Asylum and Immigration in the First 100 Days of the New Administration and Beyond." WCCHR Student Leadership with Anwen Huges-Legal Director, Human Rights First, Dr. Allen Keller- Director NYU-Bellevue Program for Survivors of Torture, and Dr. Kerry Sulkowitz-Board Chairman, Physicians for Human Rights Asylum



### Weill Cornell Medicine Primary Care Innovation



#### Experiences of Sex Trafficking Victims in Healthcare Settings<sup>1</sup>

Sex trafficking is a global phenomenon, involving over 21 million victims worldwide. Here in the United States, a large proportion of victims are domestically trafficked, and are disproportionately victims of sex trafficking and commercial sexual exploitation (87%). The limited evidence suggests that up to 88% of victims interact with healthcare providers during the period in which they are trafficked. This research project, conducted in partnership with Girls Education and Mentoring Services (GEMS), a community-based organization serving survivors of domestic sex trafficking, seeks to better characterize these encounters with the healthcare system through a series of focus groups among survivors in order to identify barriers to victim identification and appropriate linkage to services and effective interventions.

#### Health Justice Initiative

In partnership with the New York Lawyers for the Public Interest (NYLPI) and the Legal Aid Society, clinicians at Weill Cornell Medicine have provided medical expertise and insight to this program that brings a civil rights and immigrant rights focus to healthcare advocacy here in New York City and State. Specific projects have allowed clinicians to collaborate with lawyers and community advocates using a broad range of investigatory, medical and advocacy tools including medical evaluations and chart review, health outcomes reviews, community organizing, coalition building, impact litigation and legislative advocacy to advance several priorities including challenging health disparities, particularly those in setting of incarceration or the correctional and immigration detention system, and eliminate barriers to effective health care, promote immigrant and language access to healthcare, and address social determinants of health so that all New Yorkers can live a healthy life.

### NYLPI New York Lawyers for the Public Interest



**Funding Source:**

<sup>1</sup>Institute for Primary Care Innovations Pilot Grant Program

Conflicts of Interest: None

**Acknowledgements:**

WCCHR Senior Leadership: Lynne Rosenberg, Kelsey Young, Andrew Milewski, Nicholas Hernandez, Dr. Thomas Kalman. IPCI and DGIM Leadership including Dr. Fred Pelzman, Dr. Monika Safford. Sex trafficking research co-investigators Dr. Vivian Pender, Dr. Karen Mathewson, Jessica Trudeau and the program staff and clients at GEMS. Sarah Gillman from the Legal Aid Society and Lauren Quinonez of NYLPI.



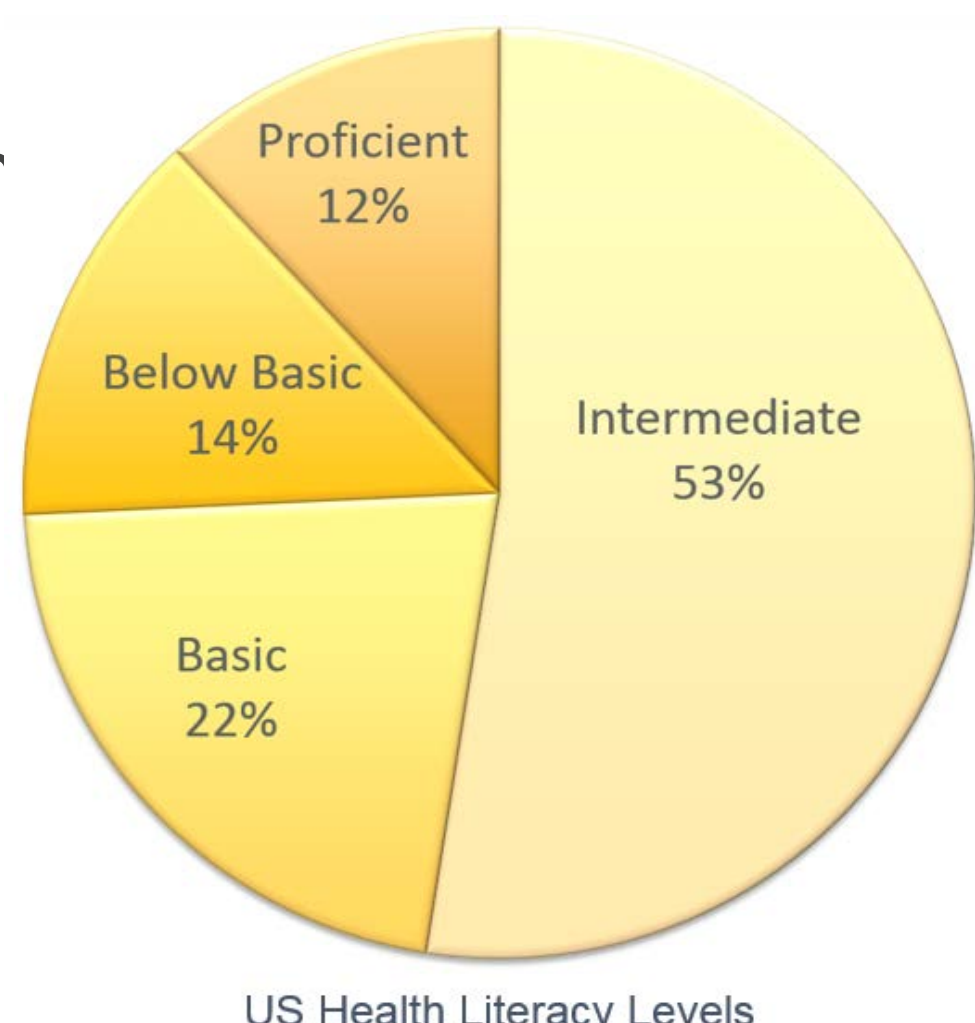
#WeAreGIM



**Introduction**

Shared decision-making is increasingly emphasized as the US healthcare system moves toward more patient-centered care. However, shared decision-making hinges on patients understanding their options. This is challenging since the US Department of Health & Human Services estimates that only 12% of the US

adult population has proficient health literacy.



While it is clear that patient education is critical for shared decision-making to be meaningful, current patient education materials often fall short, with many being too text heavy and providing insufficient visual depiction of data, overly general information, and unclear conflicts of interest.

Another important consideration is reliability. Many patients now routinely search the internet for health related information, but that information is often difficult to assess in terms of reliability. The authorship of health information is often difficult to ascertain, and the conflicts of interest of the authors are often not disclosed. Furthermore, the source of the information is usually not described.

The PALS is specifically designed to overcome these barriers by providing health information written at or below the 6<sup>th</sup> grade reading level, enriched with audiovisual presentations of short (60-90 seconds) duration, along with a well referenced, peer reviewed evidence summary. Authors are clearly identified, and their potential conflict of interests are transparently displayed.

**Objectives**

The goals of the PALS are:

- (1) To provide engaging, easily understood, and focused answers to health-related questions to a worldwide audience, targeted at populations with low literacy.
- (2) To allow patients to be the drivers, encouraging patient activation and engagement.
- (3) To support and encourage shared decision-making by enhancing patients' understanding of their conditions, thereby sparking more in-depth discussions between patients and their healthcare providers.

**Program Details**

The PALS draws on several established paradigms:

Adult Learning Theory – adult learners want focused information at the time they need it.

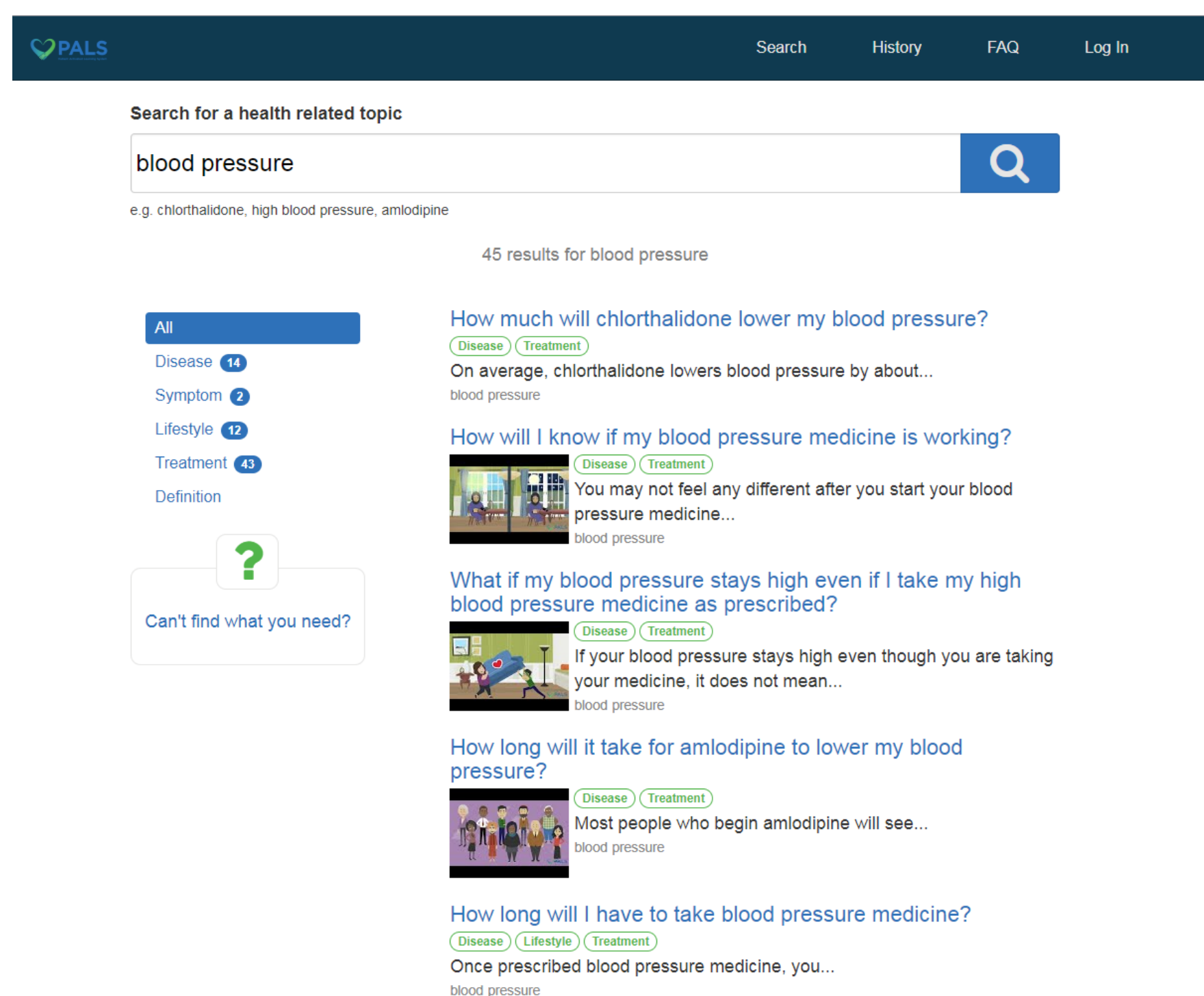
Social Cognitive Theory – humans learn by watching what others do.

Bartle's Taxonomy – the multi-billion dollar online gaming industry uses 4 basic player types (achievers, "killers", explorers, socializers) which are incorporated into the PALS.

Storytelling – because humans remember more in the context of a story.

The PALS uses Reusable Knowledge Objects (RKO), which consist of a patient-derived question, a single learning objective, a well researched answer translated into patient facing text at the 6<sup>th</sup> grade level, and an assessment question testing whether the learning objective has been met.

Users control which content they want to view, with future development of individualized curricula that physicians can customize for specific patients. The system will allow physicians to track whether patients completed assignments, and also which additional content their patients viewed, serving as a springboard for physician-patient communication.



Current content focuses on hypertension medications and rheumatoid arthritis. Additional content is being developed for end-of-life care, pediatric asthma, and hospital discharge planning.

Still in production, the site has already gotten over 30,000 hits (Figure 1) from 85 different countries (Figure 2).

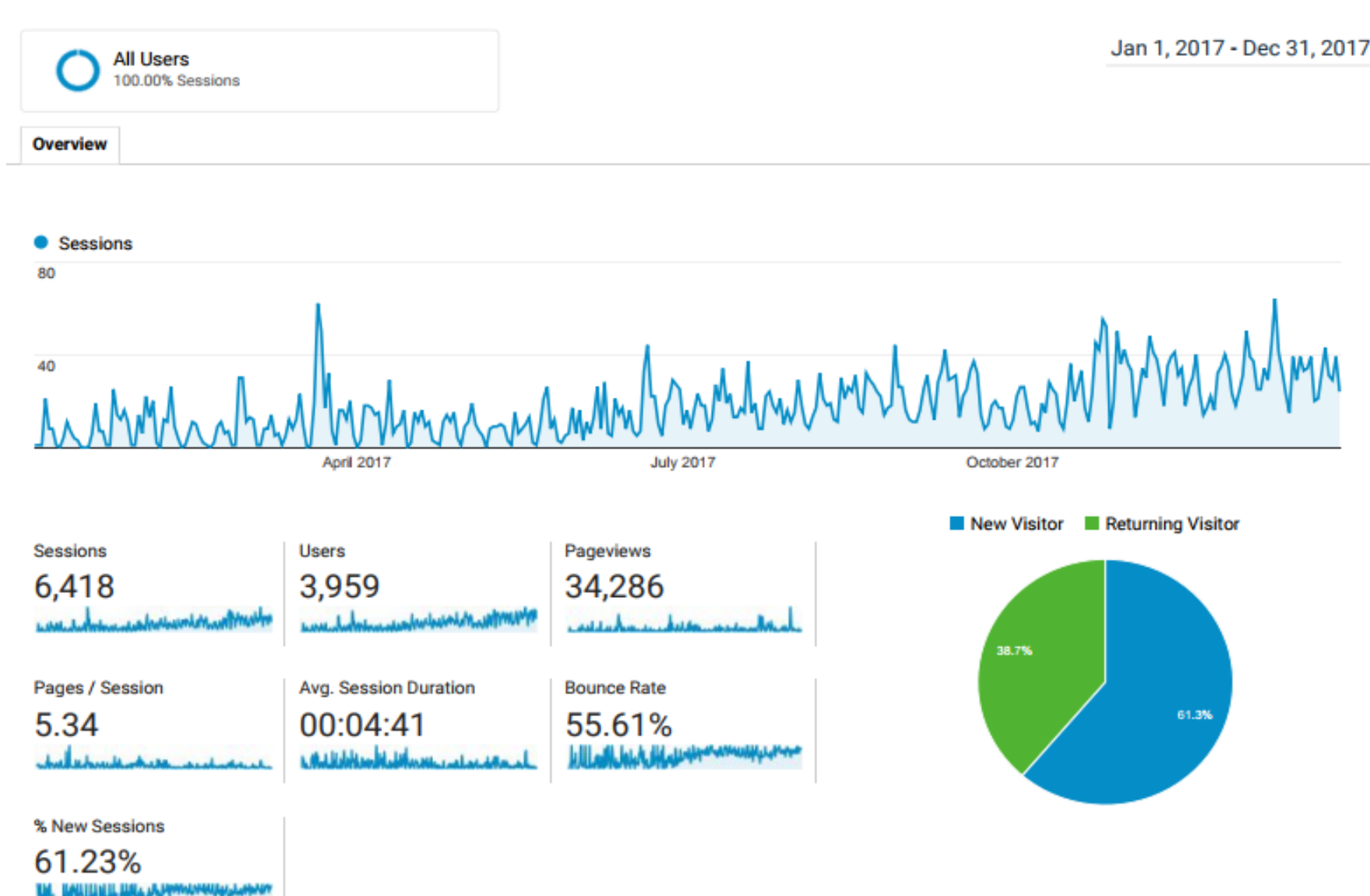


Figure 1. Google analytics – web utilization

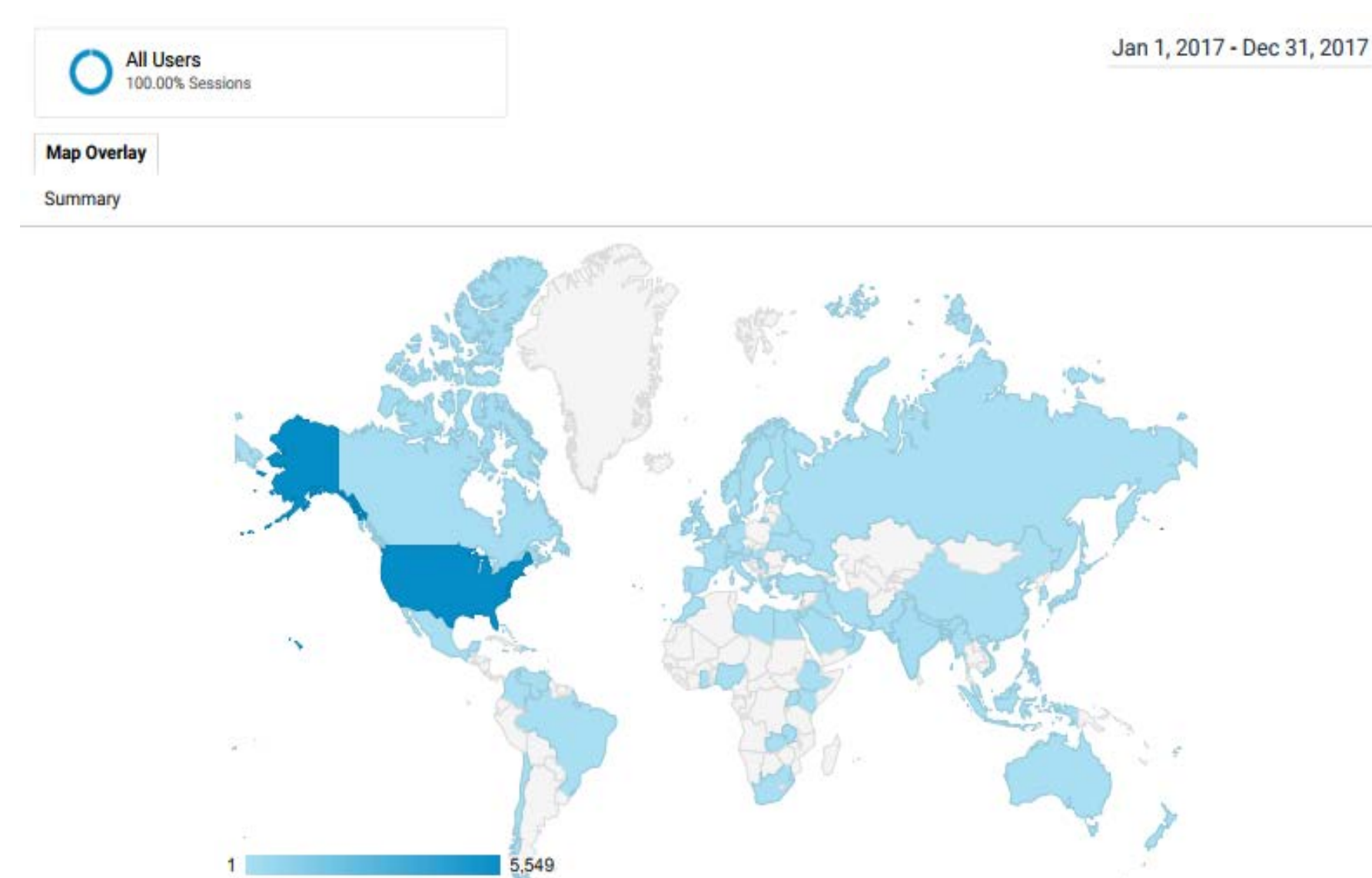
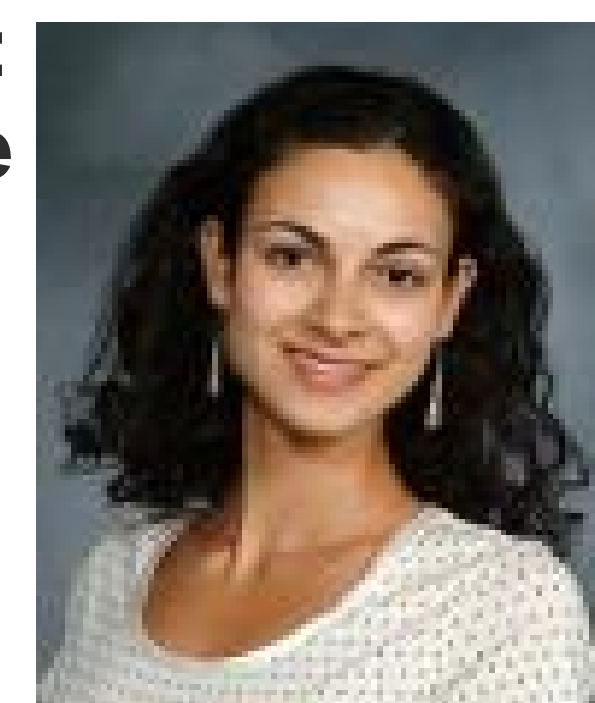


Figure 2. Countries that have used the PALS

**Opportunities for Students & Residents**

**Systematic literature review: The strength of the evidence supporting recommendations for patient education materials**  
**Masha Jones, MD, IM**  
**Primary Care Resident**



**Video content on hypertension**  
**Brittney Frankel, MD (did this work while a WCM student, Class of 2017)**



Opportunities:

- (1) Create and test PALS content:
  - Create a Reusable Knowledge Object (RKO):
    - o Start with a patient-generated question
    - o Create a single learning objective
    - o Learn how to conduct a rigorous literature review under the guidance of a research librarian and with the help of a faculty member
    - o Translate the review into patient facing text: short, easily digestible text at a 6<sup>th</sup> grade reading level
    - o Include memorable sound-bites reinforcing the learning objective
    - o Create an assessment question testing the understanding of the learning objective
  - Collaborate with Audiovisual Team to provide an accurate and engaging visual representation of RKO
  - Engage in a dynamic development process by testing your patient-facing material on actual patients
  - Provide feedback about website design to the consulting team that manages website development

(2) Design a research project using PALS content

(3) Join an ongoing research project being conducted by the PALS team

## Introduction

The main goal of Primary Care Innovations (PCI) program is to create a virtual and physical site for innovation and experimentation. Through support and inspiration, we (hope to) model and (help) mold the next generation of primary care clinicians, educators and researchers. Our mission is to bring together all the varied components needed for change in our fractured healthcare system.

How will PCI advance this mission? The major tenets of the PCI model are:

- Research in Primary Care
- Teaching Primary Care Medicine, Inspiring the Next Generation of Practitioners
- Mentoring at All Levels of Training
- Developing Models of Care
- Collaboration



## Objective

The Primary Care Innovations program aims to serve as a laboratory for innovation, and a clearinghouse for change. By investing time, the clinicians, educators and researchers of WCIMA and our partners can achieve our main goal: to inspire the next generation of medical students in the field of primary care. The PCI program will guide Internal Medicine residents (and WCM medical students) to choose primary care by creating high quality practice settings, providing opportunities to participate in meaningful research and inspiring viable future careers in a new model of healthcare. We also support and mentor junior faculty in their careers today and expand the way they practice medicine tomorrow.

## Program Details

Collaboration opportunities exist through the PCI program through multiple venues. We hope to foster collaboration by bringing together those with innovative ideas about changing primary care, and building teams to work on new and exciting research. The PCI program will give people a place to put forth new ideas and get input from others in the community and find new collaborators across multiple disciplines.

## Seed Grant Proposals

Annual requests for proposals for the PCI program seed grants go out in May. These projects are designed to support researchers while they complete early work on a new idea, with a goal of publication. They will use this work to support outside requests for future funding. The Primary Care Innovations program intends to commit \$100,000 to fund two to three 1 year projects.

Additional funding opportunities will become available throughout the year, to support medical students, residents and faculty who need additional help with ongoing projects related to primary care innovation.

Visit [careinnovation.weill.cornell.edu](http://careinnovation.weill.cornell.edu) to learn more about getting involved in research and collaborative opportunities.



## Latest News



### Interview with New Weill Cornell Medicine Faculty Member Dr. Martin Shapiro

December 19, 2017  
Dr. Fred Pelzman: We want to welcome you to Weill Cornell Medicine and have you tell us a little about what brought you here and your research, and introduce you to the Weill Cornell Community...

### Doing Translational Research Podcasts with Dr. Monika Safford

December 19, 2017  
There is No Health System Podcast  
Health Equity in the 21st Century Recording

### Interview with New Weill Cornell Medicine Faculty Member Dr. Laura Pinheiro

December 19, 2017

## Opportunities for Students & Residents

The program will provide faculty scholarships, develop a research symposium lecture series and fund scholars to attend meetings to present their research.



Scholarship opportunities will focus on improving the patient experience, advancing population health and reducing medical inefficiencies. The funding opportunities will be broken down into:

1. Student/Resident Scholarship will fund up to 3 Resident or Medical Student's research. A stipend of \$3,000 per award will be provided.
2. The PCI Symposium Lecture Series will aim to provide current information revolving around primary care to our faculty, residents, medical students and the community.
3. In addition to the scholarships any PCI program scholar who is presenting their research at a conference will be provided travel and registration reimbursement.



**Funding Source:**  
**Conflicts of Interest:**  
**Acknowledgements:**

## Introduction

The Cornell Center for Health Equity responds directly to community priorities by focusing on practical, relevant research topics. It brings together a deep talent pool at Weill Cornell Medicine and at the Cornell University Ithaca campus with a strong vision for generating new science on how to achieve health equity, engaging community members at every step of the research process from conceptualization through dissemination and implementation.

## Objective

The Cornell Center for Health Equity responds directly to community priorities by focusing on two themes of **multiple vulnerabilities to health disparities** and **stigmatized conditions**. It brings together a deep talent pool on CU's Manhattan and Ithaca campuses with a strong vision for generating new science on how to achieve health equity, engaging community members at every step of the research process from conceptualization through dissemination and implementation. This Center will accelerate Cornell's commitment to being a positive force for change to achieve health equity with our partnering communities while building capacity for health equity research, especially URM scientists, and generating new evidence for a broad national audience.

The Cornell Center for Health Equity (CCHEq) aims to:

- 1) Generate new knowledge on how to provide equitable healthcare to all;
- 2) Create a pipeline for the training of outstanding investigators focused on health equity research with a concerted effort made to engage and nurture minority investigators;
- 3) Provide education to our students, trainees, and faculty about how to achieve health equity;
- 4) Provide service to the communities with whom Cornell is affiliated to work collaboratively toward the goal of eliminating health disparities.

## Program Details

The Center pursues an integrated study of health disparities with teams based at two locations:

- Weill Cornell Medicine in New York City provides a diverse urban, multicultural perspective with a focus on the interplay of numerous health disparities. Co-director Monika Safford, MD, who is based in Manhattan, is a lifelong disparities researcher with an active NIH and PCORI-funded research program in cardio-metabolic health disparities.



- Cornell University, in the heart of rural New York State, taps into the many pervasive socioeconomic disparities endemic in rural 21st Century America. Co-director Avery August, PhD, who is based in Ithaca, is an immunologist who serves as a critical role model for minority scientists as well as basic scientists.



The Center is well-aligned with Cornell's "One Cornell" objective to enhance collaborations between the two campuses. Several institutions within each campus will extend the reach of the Cornell Center for Health Equity thereby facilitating faculty development through courses and workshops.

## Pilot Program Awards

Annual requests for proposals for Center for Health Equity pilot projects go out in February. These projects are designed to support researchers while they complete early work on a new idea, with a goal of publication. They will use this work to support outside requests for future funding. The Center for Health Equity intends to fund four \$50,000 1 year projects.

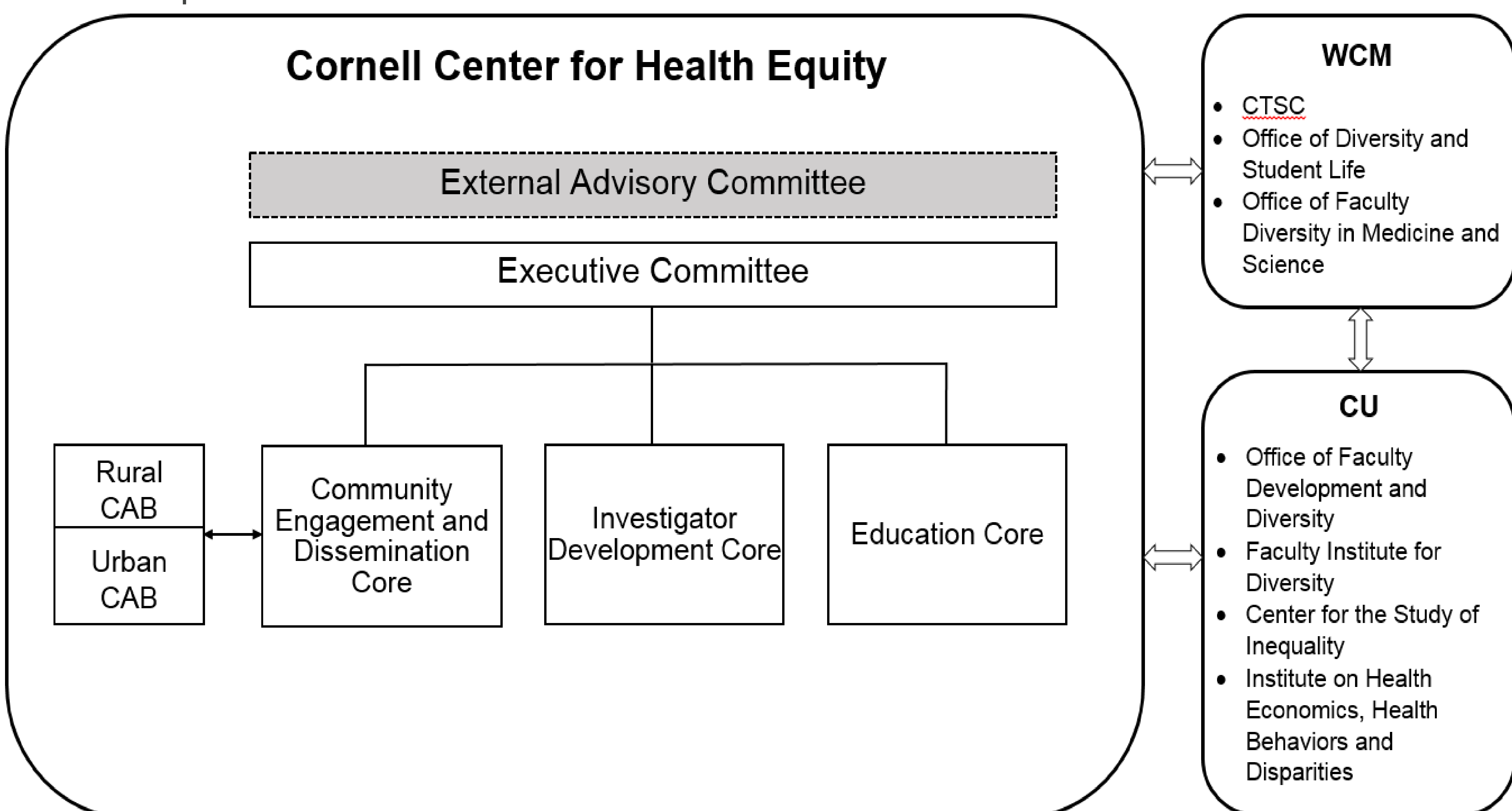
Additional funding opportunities will become available throughout the year to support medical students, residents, and faculty who need additional help with ongoing projects related to health disparities.

## Opportunities for Students and Residents

The education core of the CCHEq will include components aimed at educating learners at multiple levels on the science of health disparities, including existing faculty, postdoctoral trainees, medical and graduate students, undergraduate students, and high school students. The CCHEq will provide opportunities for Cornell students and faculty to interact with leaders in the field of health equity research.

Additional opportunities include between-campus mentoring and joining ongoing research projects being conducted by the CCHEq.

Visit [centerfortheequity.cornell.edu](http://centerfortheequity.cornell.edu) to learn more about getting involved in research and collaborative opportunities.





### Fellowship Mission

The mission of the Global Health Research Fellowship is to train general internists for academic careers in global health research. The 3-year fellowship includes field-based research, courses in research methods, and teaching and clinical service at Weill Cornell New York-Presbyterian Hospital.

### Background

Global health is a multidisciplinary field of service, research, and training that seeks to improve the health of individuals and populations to achieve worldwide health equity, especially for the resource-poor. Over the past decade there has been a heightened recognition of the need for generalist clinician-scientists in global health, reflecting the rise of non-communicable diseases in resource-poor settings and the importance of primary care for sustainable health improvements.



### Fellowship Objectives

1. Deepen trainees understanding of health care delivery systems, epidemiology of disease, and interventions to improve health in resource-poor settings.
2. Provide trainees with the skills to design and conduct patient-oriented research in global health.
3. Mentor trainees in the practice and teaching of evidence-based clinical medicine in New York and abroad.
4. Prepare trainees for NIH K-Award submission by the end of the program.

### Innovation

- Tailored for post-residency graduates in internal medicine
- Extensive field-based research in Weill Cornell programs in Haiti, Tanzania, Brazil and India
- Masters degree in Clinical Epidemiology and Health Services Research
- Intensive faculty mentorship with New York and international Weill Cornell faculty

### Program Details

**Field-based research and mentorship:** Trainees conduct research abroad in Haiti, Tanzania, India or Brazil for a minimum of 20 months over a 3 year program. This amount of field time is essential for understanding the local health context, establishing research relationships and developing preliminary data for future NIH grant submissions. The research may be translational, clinical or implementation. Trainees assigned a primary WCM faculty member with numerous secondary mentors related to their project.

**Masters in Science Clinical Epidemiology and Health Services Research:** Coursework includes biostatistics, epidemiology, decision analysis and research ethics.

**Hospital Medicine Clinical and Teaching Service:** Trainees will complete ~ 8 weeks of clinical service on resident and physician assistant hospital service at NYP each year. Trainees receive training in evidence-based medicine, ultrasound and quality improvement methods.

**Table 1: Fellowship Timeline (flexible depending on trainee’s prior experience and training)**

	Year 1	Year 2	Year 3	Total
<b>Field Research</b>	7 months	6 months	7 months	20 months (55%)
<b>MSc Courses</b>	2 months	3 months	1 months	5 months (14%)
<b>Clinical/Teaching</b>	2 months	2 months	2 months	6 months (17%)
<b>Flexible Time</b>	0 month	0 month	1 month	2 months (6%)
<b>Vacation</b>	1 month	1 month	1 month	3 months (8%)

### Fellows and Faculty

- Justin Kingery MD PhD: Cardiovascular disease Tanzania
- Katey Walsh MD: MDR TB Haiti
- Sasha Fahme MD: Women’s health Tanzania
- Daniel Fitzgerald, Molly McNairy: Fellowship Co-Directors
- Art Evans, Chief Hospital Medicine
- Monika Safford, Chief Division of General Internal Medicine



**For more information:** <https://globalhealth.weill.cornell.edu/fellowship>

# Hospital Medicine Clinical Scholars Program

## Goals:

1-year intensive fellowship program:

- Ignites the potential of highly motivated 1<sup>st</sup>-year faculty
- Generates momentum in scholarly productivity
- Provides tools to lead change

## Focus:

Personal growth and 5 foundational skills:

- Teaching
- Quality improvement
- Advanced clinical epidemiology and evidence-based medicine
- Diagnostic bedside ultrasound
- Leadership

## Expectations:

- Achieve proficiency in each of the 5 skill areas
- Spend at least 18 weeks leading an inpatient clinical team
- Identify an area of academic focus and complete a publishable scholarly project
- Area of focus can be one of the 5 foundational skills or options such as medical ethics, humanism in medicine, health equity, physical diagnosis, global health, hospital epidemiology, decision-analysis, medical informatics, physician resilience, hospital operations, meta-analysis, health services research, among others.

## Introduction

- National expectation that providers participate in reporting quality metrics
- ACGME's Clinical Learning Environment Review Program identifies 5 domains essential in training physicians.
- 2 are quality and safety with faculty engagement in quality improvement and safety initiatives
- To address these learning objectives, the Department of Medicine created Quality University.

**Quality University-Weill Cornell Department of Medicine (QU-DOM) introduces the skills, tools, and knowledge needed to successfully implement a clinical process improvement project.**

- Through applied learning, participants will gain a meaningful understanding of the project lifecycle, and learn to integrate basic Lean concepts and process improvement tools (DMAIC, PDSA, etc).
- The course will also provide a high level overview of change management and a sponsorship model necessary for successful project execution.



## Opportunities for Students & Residents

**1. Collaborate with a faculty mentor, under the guidance of the QU-DOM, on a Quality Improvement project.**

- Assist a current faculty member in collecting data, analyzing data, and reporting project outcomes
- Faculty and projects are from all over the hospital and WCMC.
- Past departments involved include: Medicine, Endocrinology, Pulmonary, Cardiology, Emergency Medicine, GI, Infectious Disease

**By assisting a QU-DOM project, students and residents are also invited to attend QU-DOM workshops where one can:**

- Acquire knowledge and understanding of all the elements of a project lifecycle
- Learn concepts and tools used for QI including:
- The Model for Improvement, Appreciating Systems, Process Map, Fishbone Diagram, Aim Statement, Measuring for Process Improvement, PDSA cycle

**3. Become a leader of the WCM open chapter of the Institute for Healthcare Improvement**

- Enroll and take free courses online at IHI
- Networking opportunities



## Objectives

- Train junior faculty within the Weill Cornell Department of Medicine rigorous QI methodology over an academic year to improve the delivery of high impact, high value care
- Lead fellows through processes of project design, development, testing evaluation and implementation
- Consistent delivery of high quality patient care
- Prevention of patient injury and healthcare errors
- Redesign of processes to support patient safety and mitigate risk
- Management of patient-related incidents, complaints, and lawsuits
- Assessment of various quality metrics to improve performance and patient safety on both the inpatient and outpatient services
- Education of faculty, staff, patients and families in patient safety and risk management

**Interested in joining our efforts?**  
Please contact  
**Jennifer I. Lee at**  
[je19026@med.cornell.edu](mailto:je19026@med.cornell.edu)



**Funding Source:** Weill Cornell Department of Medicine

**Conflicts of Interest:** No conflicts of interest to report

**Acknowledgements:** Weill Cornell Department of Medicine, Art Evans, Monika Safford, Division of General Internal Medicine, Linda Gerber, Lisa Kern



## Purpose

- To provide access to obesity medicine specialists within the primary care setting thus creating an interdisciplinary approach to managing diverse patients with obesity and complex medical conditions.
- To provide medical supervision for patients preparing for bariatric surgery and treatment of patients with weight regain or inadequate weight loss post-bariatric surgery.
- To participate in the training of physicians and students in the field of obesity medicine.

## Opportunities for Students & Residents

- 2-week-long Weight Management Elective and research elective offered to residents
- 2nd continuity practice option for primary care residents
- Mentorship in the application to the Dr. Robert C. & Veronica Atkins Foundation Research Scholarship
- Weill-Ithaca Summer Member Experience in Research (**WISER**) a 7-week summer program on health disparities and inequities research

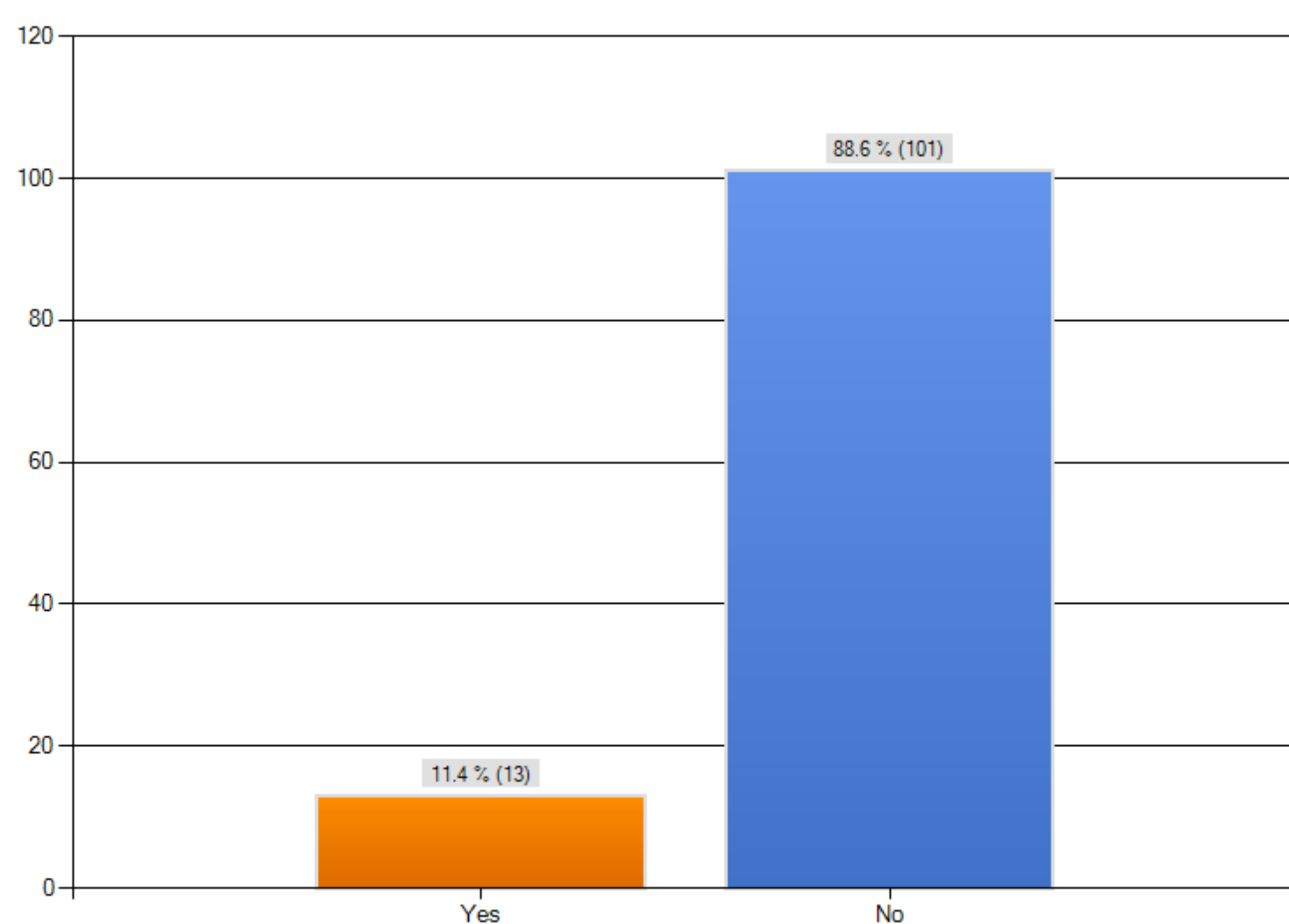
## Program Background

- Weight Management Practice established in 2012 in conjunction with a 2-week Weight Management elective. In the development of the program, an IRB-approved needs assessment survey was conducted among 177 faculty, fellows and residents within the Department of Medicine.
- Of the 121(68%) respondents, 88.6% of respondents stated that they had not received sufficient weight management education (Figure 1). While 93% of all respondents indicated that they believe obesity is an international epidemic, only 23.4% reported having successfully helped patients lose weight, and 15% of respondents felt that they could effectively prescribe pharmacological agents to assist obese patients with weight loss (Figure 2).

## Program Details

- Intensive evidence-based behavioral counseling and pharmacotherapy management offered in a team based visit (MD and dietician). Visit frequency is every 2-4 weeks for a minimum of 6 months
- Standard weight management prescription inclusive of:
  - Goal setting
  - Self-regulation of weight loss behaviors (i.e. food diary, daily weighing)
  - Pharmacotherapy Management
  - Referrals to mental health providers to address psychosocial stressors
  - Referrals to community based physical activity and support programs

Figure 1 Overall, Do You Believe You Have Received Sufficient Weight Management Education?



6 month weight loss= 40 pounds, 13.1%

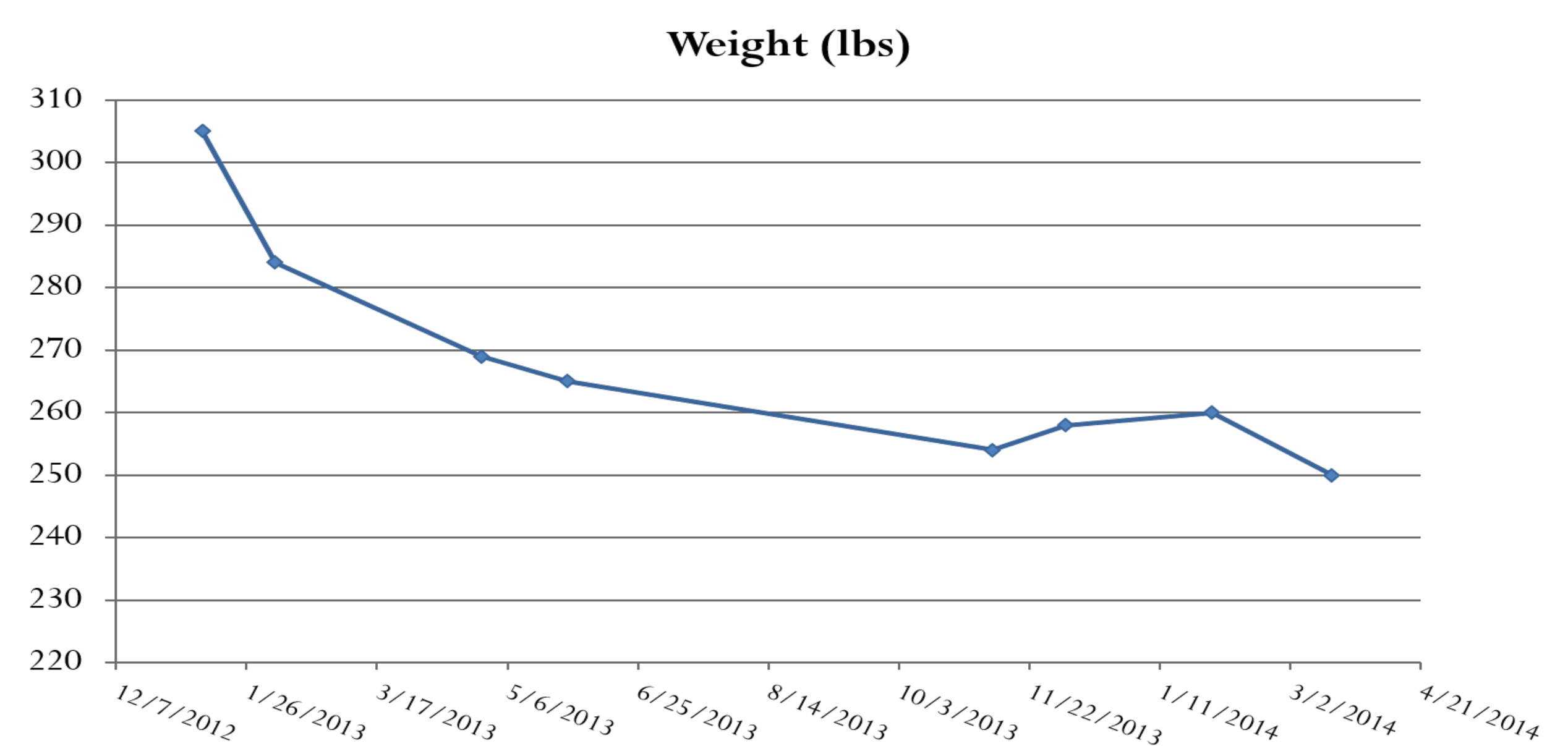
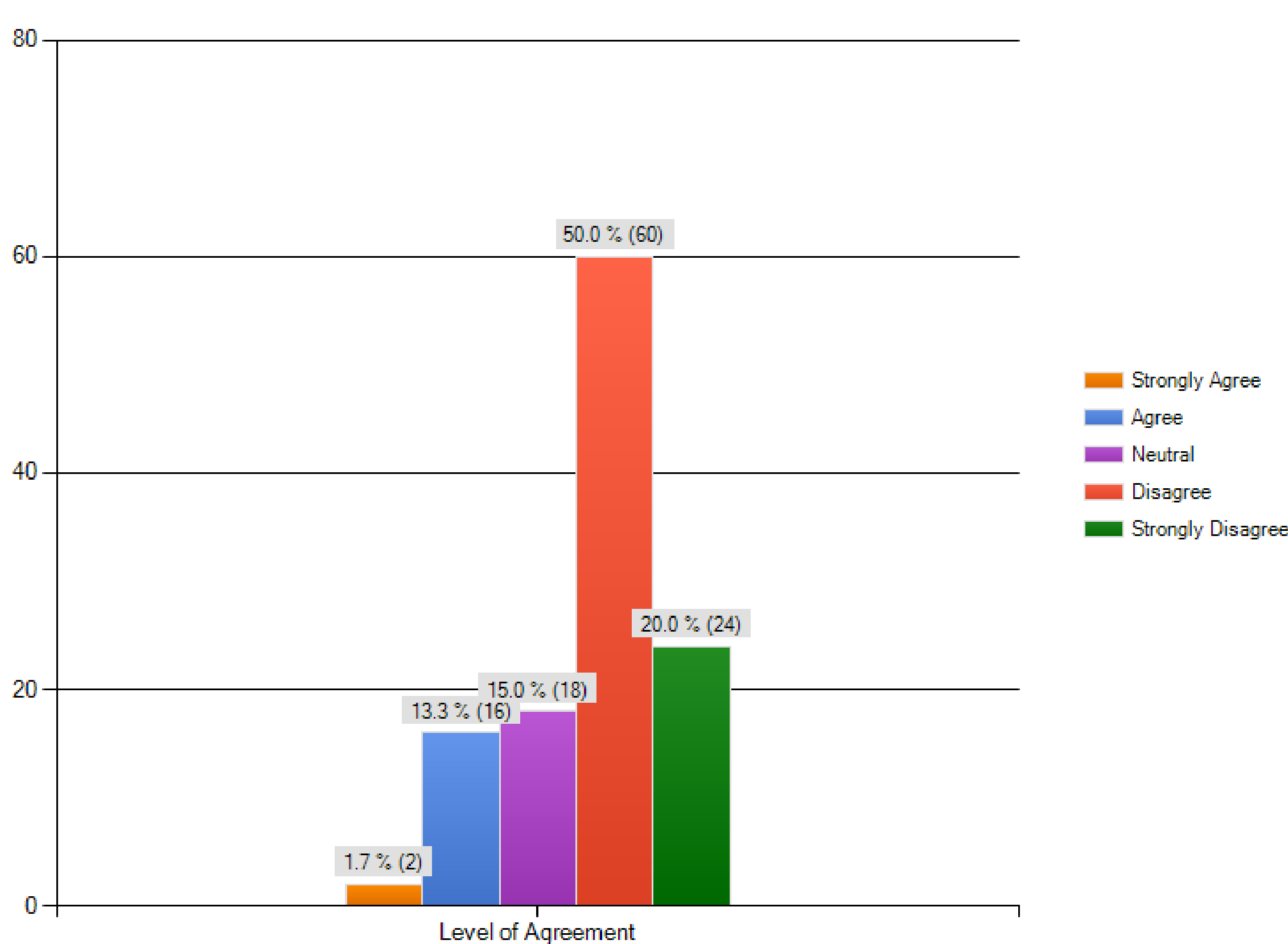


Figure 2 I Can Effectively Prescribe Medications To Help Promote Weight Loss



## Selected Past Residents & Students

**Aoife Casey, Cornell**  
WISER Summer Student 2017

**Brett Ehrmann, MD NYP-WCM 2017**  
\*WCM Primary Care East Side

**Guillermo Espinoza, MD NYP-WCM 2015**  
\*Primary Care Alaska Native Medical Center

**Katherine Saunders, MD NYP-WCM 2014**  
Obesity Medicine Fellowship at WCM  
\*Comprehensive Weight Control Center at WCM

**Jamie Mullally, MD NYP-WCM 2014**  
Recipient Atkins Foundation Research Scholarship  
\*Weight Control Center at CUMC

**Leon Igel, MD NYP-WCM 2013**  
Recipient Atkins Foundation Research Scholarship  
\*Co-Director Weight Management Elective  
\*Program Director Obesity Medicine Fellowship  
\*Comprehensive Weight Control Center at WCM

Erica Phillips, MD, MS, DABOM *Clinical Director*  
Gabrielle Siragusa, *Practice Dietician*  
Lauren B. Solomon MS, RD, CDN, CLC *Supervisor of Ambulatory Nutrition at Columbia & Weill Cornell*  
Debra Katz-Feigenbaum, *Director of Ambulatory Nutrition at Columbia & Weill Cornell*

\* Current professional positions

## Definition

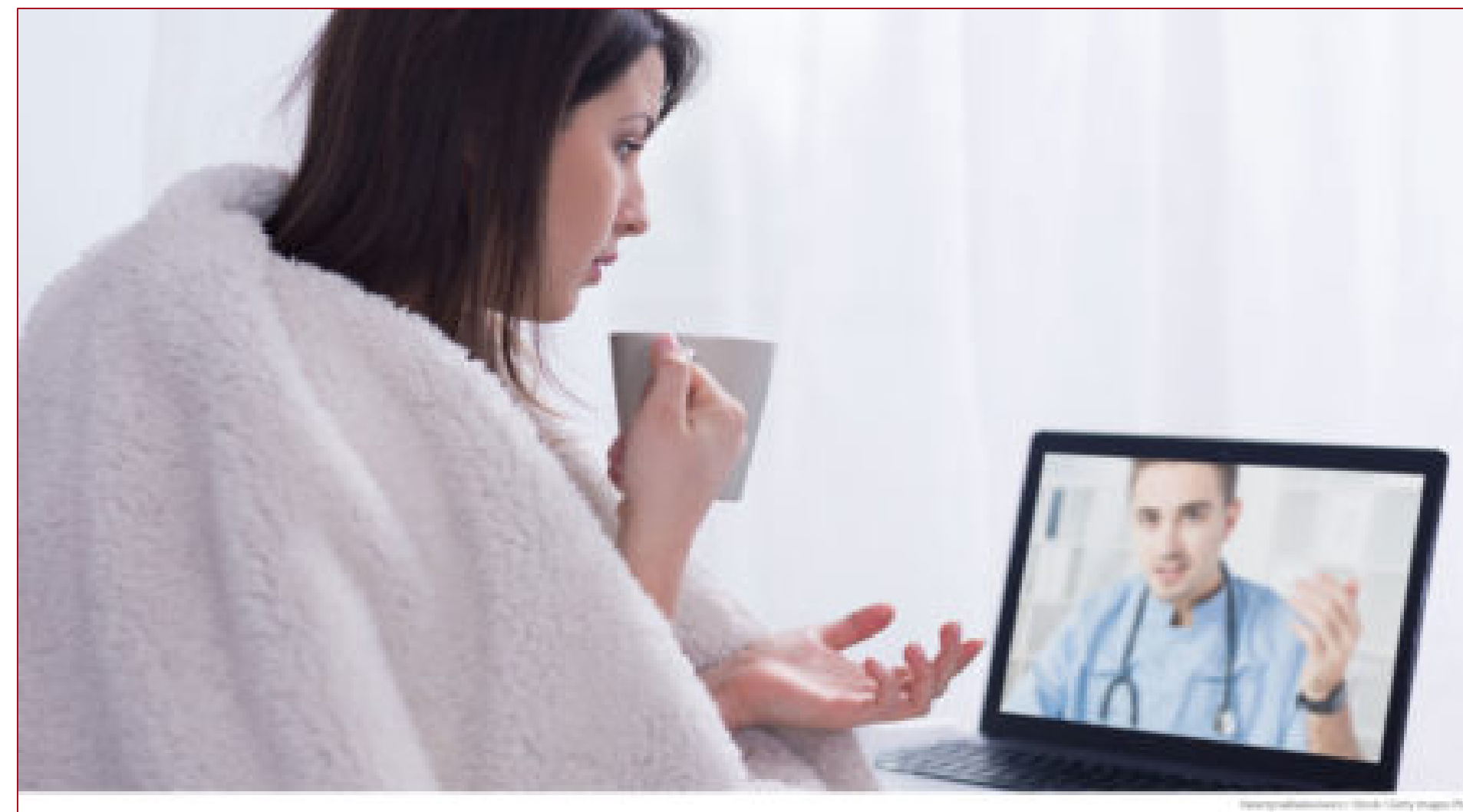
The U.S. Department of Health and Human Services defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration.

Telemedicine, a subset of telehealth, is the evaluation and treatment of patients remotely.

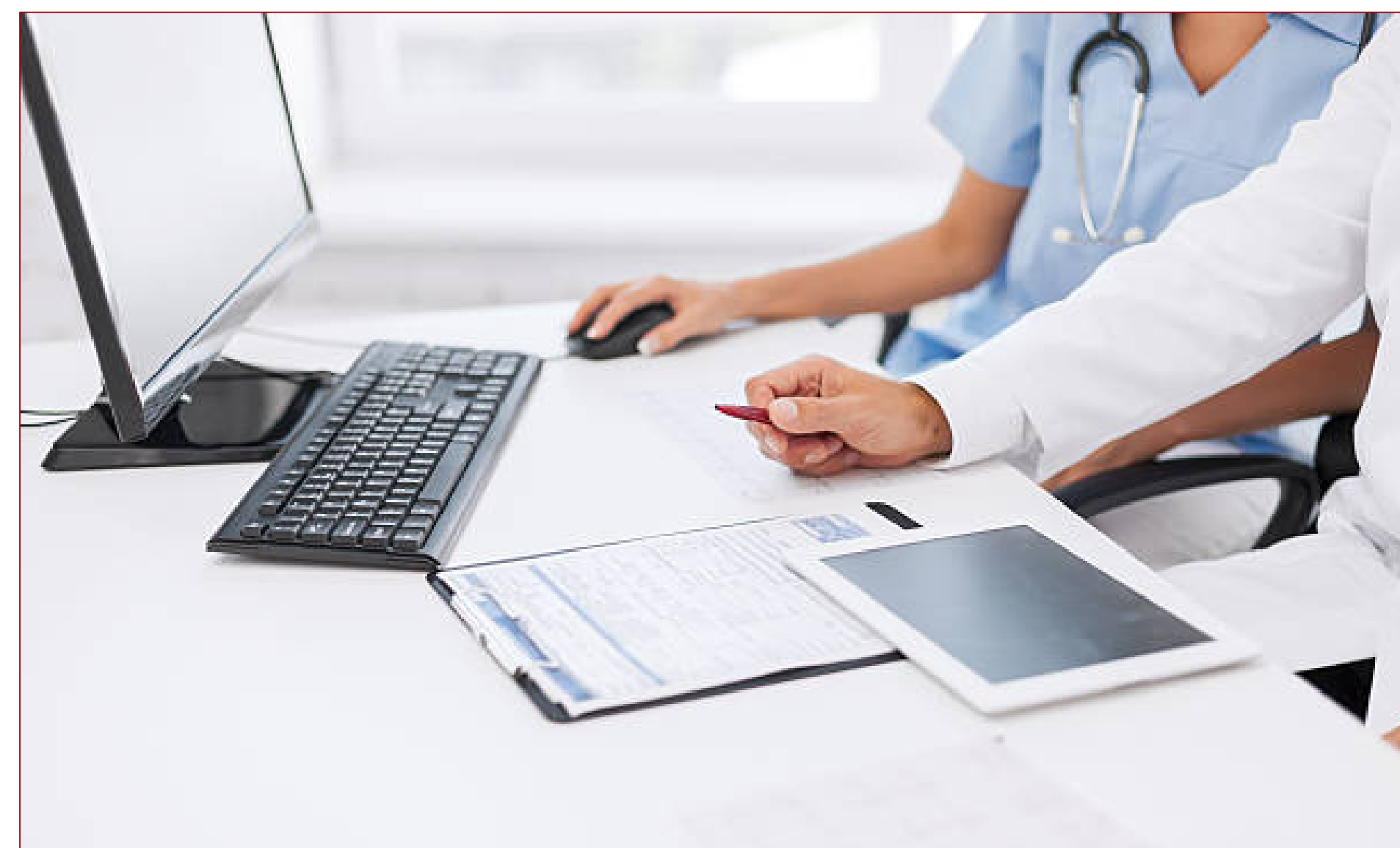
Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

## Introduction

- Originally created to reach patients in health professional shortage areas.
- Emphasis was on access to previously unavailable specialists and subspecialists.
- Movements to enhance patient-centered care and to reduce unnecessary ER visits have brought telemedicine to primary care.
- 74% of patients surveyed indicated interest in televisits.
- In 2015, 800,000 virtual visits were estimated
- At NYP/WCMC televisits have been used in the ER, at retail pharmacies and in outpatient offices.
- Specific existing programs include urgent care, mental health and neurological consultations.



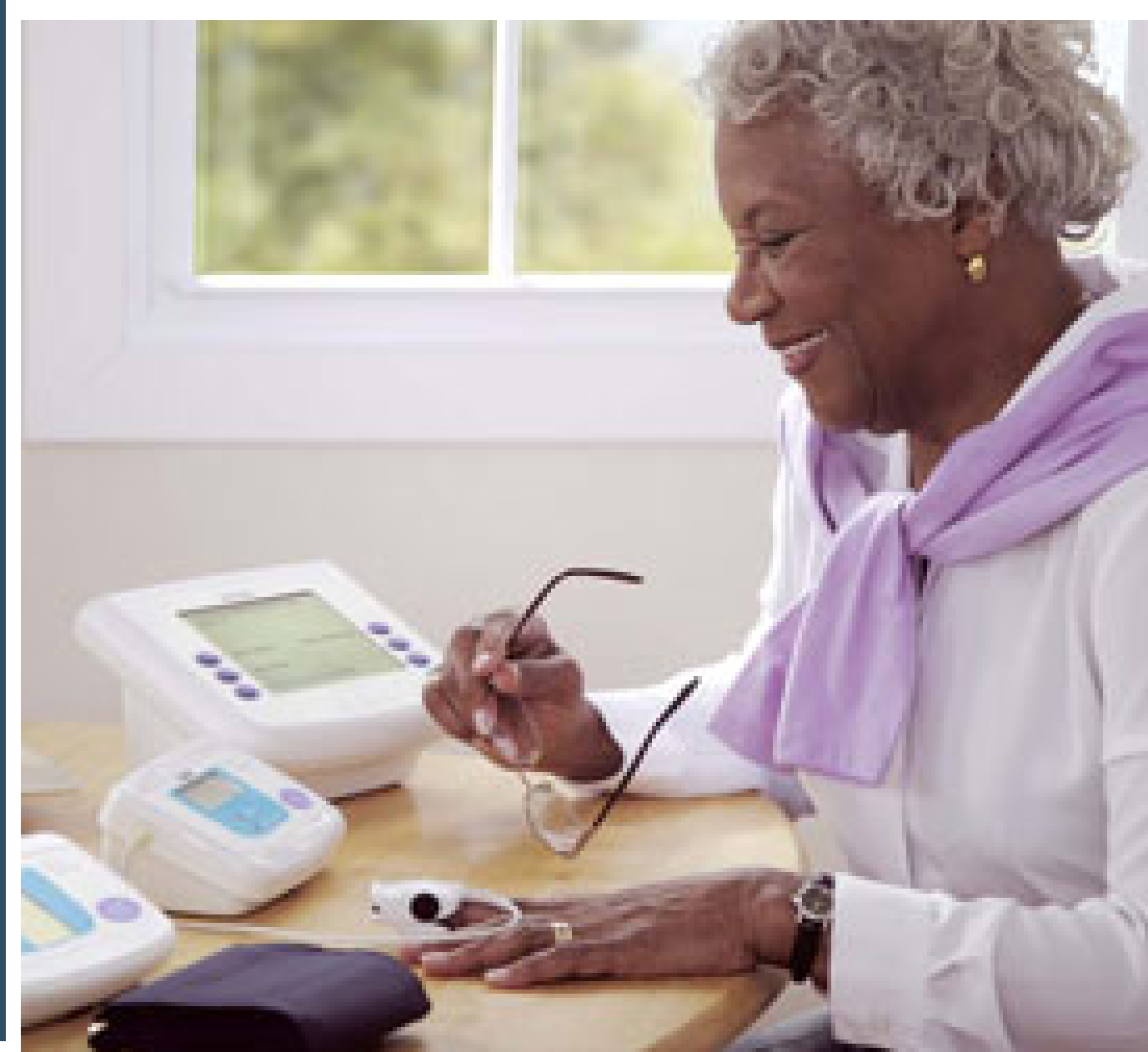
Patient's view:  
Conversing from the comforts of home.



Provider's view:  
Documenting on the EHR while conversing with the patient on an Ipad.

## Program Details

- Urgent Care- same day visits for ambulatory acute care.
- Visits that do not require physical exams- tobacco cessation, mental health, nutritional counselling, weight mgmt., annual wellness/prevention
- High frequency visits- medication titration, mental health, wound checks, CHF mgmt
- Other visits where travel might pose undue burden- post-hospitalization
- Remote monitoring- BP, glucose, HR, weights
- Asynchronous e-visits- templated HPI, patient education scripts



### Patient Requests an E-Visit

<b>Chief Complaint</b>	Jack Sheerin is a 44 year old male. His reason for visit is "Cough".
<b>History of Present Illness</b>	<p><b>Onset</b> He reported: Cough continuously throughout the day.</p> <p><b>Duration</b> He reported: Cough 16 to 20 days.</p> <p><b>Timing</b> He denied: Nocturnal cough. Seasonal cough.</p> <p><b>Context</b> He reported: Cough unproductive. Cough started after any medication change. He denied: Cough seems to occur in spasms or episodes, wakening in between. Deep breathing eases chest pain.</p> <p><b>Modifying Factors</b> He denied: Cough after exertion. Cough worse lying down.</p> <p><b>Associated Signs and Symptoms</b> He denied: Rhinorrhea. Shortness of breath. Recent cold improved then worsened.</p> <p><b>Past, Family, and Social History</b></p> <p><b>Past Medical History</b> He denied: Pneumonia.</p> <p><b>Social History</b> He denied: Cough associated with history of exposure to birds.</p> <p><b>Tobacco Use</b> He reported: Former used tobacco.</p> <p><b>Review of Systems</b></p> <p><b>Constitutional</b> He denied: Cough associated with fever. Night sweats.</p> <p><b>Ear, Nose, and Throat</b> He denied: Nostril discharge. Voice changes.</p>

Figure 11-14: Completed interview for E-visit.

## Future Considerations

- Interface between existing (nonreimbursed) care rendered via phone
- Privacy concerns and informed consent (recordings)
- Reimbursement models
- Cross- state regulations

## Opportunities for Students & Residents

- Research- Impact of telemedicine on access, satisfaction, ER utilization, hospitalizations, quality of care, etc.
- Education- Development of curriculum and/or innovations for increased use of telemedicine

## Introduction

Transitions of care – the movement of a patient from one care setting to another (e.g. hospital to home), or the transfer of a patient's care from one medical provider to another.

Transitions are known to be highly vulnerable points in a patient's care

- ❖ 1 in 5 patients discharged home from the hospital experienced an adverse event within three weeks of discharge.<sup>1</sup>
- ❖ 60% of these adverse events were medication related and could have been avoided.<sup>1</sup>
- ❖ On average, 19.6% of Medicare were readmitted within 30 days and 34% were readmitted within 90 days.<sup>2</sup>
- ❖ Hospital readmissions within 30 days account for \$15 billion of Medicare spending.<sup>3</sup>

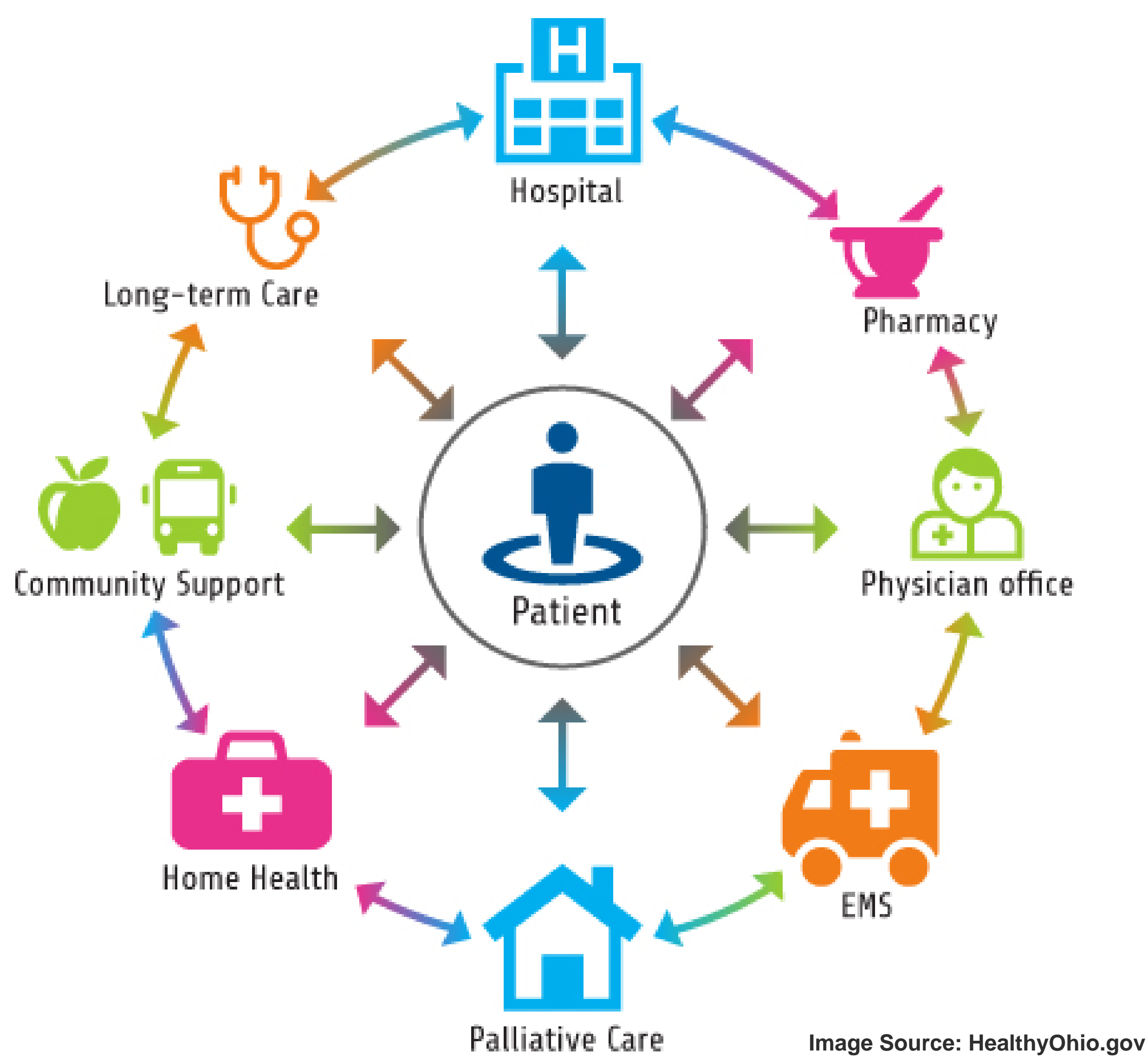
## Objective

The purpose of the Transitions of Care Affinity Group is to bring together faculty, residents, and students from across the Division of General Internal Medicine to collaborate on research projects related to transitions of care.

Transitions between the inpatient and outpatient settings are a unique and rich area for collaboration between hospitalists and primary care doctors. Understanding and improving these vulnerable transitions requires the unique expertise of both groups.

## Program Details

- ❖ The Affinity Group is led by a small core group of faculty, with the intent of engaging a wider group of interested faculty, residents and students on a project-by-project basis.
- ❖ Quarterly meetings or social gatherings are held to bring together as many interested members of the division as possible to share ideas, obtain feedback, and discover areas for collaboration and cross-pollination between diverse groups of faculty.
- ❖ Smaller group meetings are held regularly to work on particular projects.



## Current Core Project

“Do Hospitalizations Disrupt Loyalty to Ambulatory Care Providers?”

### Background

❖ The creation of Medicare Accountable Care Organizations (ACOs) is a recent strategy for containing costs in healthcare, while maintaining or improving quality. Several large commercial insurers have also created ACOs or ACO-like programs. In these programs, a group of providers takes on financial and clinical responsibility for a defined population of patients that is “attributed” to that ACO.

❖ However, although patients may be “attributed” to a particular ACO, they are not required to obtain their care from ACO providers. This creates challenges for the ACO, as the ACO is still “responsible” for this care and the costs it incurs, regardless of where the care actually took place.

### Aims

- 1) To determine whether hospitalizations disrupt “loyalty” to ambulatory care providers.
- 2) To determine if the degree of disruption varies based on whether the patient was hospitalized within or outside the provider organization that is in an ACO-like contract.

We plan to pursue these goals by analyzing claims data for patients who have been attributed to the Weill Cornell Physicians Organization (PO) by one commercial payer in an ACO-like contract.

## Past, Present, and Future Transitions-of-Care Projects in the Division

Faculty and trainees in the Division of General Medicine have a history of productive work in the area of Care Transitions. A few examples of this work is listed below (some of which was made possible through the Quality University Program).

The Transitions of Care Affinity Group hopes to further promote this work, and particularly to bring together hospitalists and primary care providers to inspire new innovative collaborations.

- ❖ A Multidisciplinary “Discharge Time-Out” utilizing a check-list to catch common preventable errors at the time of discharge.
- ❖ “What to expect that you’re not expecting: Video education to improve self-efficacy surrounding discharge medication barriers” -- An innovative mobile video educational tool used to help patients anticipate and overcome challenges around adhering to discharge medications. *(Sponsored by the DOM Quality University Program)*
- ❖ “Pod-Cards” – a visual tool to improve the continuity between residents and their patients at the CIMA primary care practice. *(Sponsored by the DOM Quality University Program)*
- ❖ “Rapid Primary Care Follow Up From the ED to Reduce Avoidable Hospital Admissions” -- A rapid-ED-to-primary-care-access program to provide a safe and reliable ED discharge option and engage patients in primary care.

For more information, or to get involved, contact:

- Laura Gingras, MD – [lfg9003@med.cornell.edu](mailto:lfg9003@med.cornell.edu)
  - Jennifer Chester, MD – [jgc9002@med.cornell.edu](mailto:jgc9002@med.cornell.edu)
- Co-leaders of the Transitions of Care Affinity Group

1. Forester, AJ, Murff, HJ, Peterson, JF, et al., “The incidence and severity of adverse events affecting patients after discharge from the hospital,” *Annals of Internal Medicine*, 2003;138(3):161-7.  
 2. Jencks, Stephen F, Williams, Mark V, Coleman, Eric A, “Rehospitalizations among Patients in the Medicare Fee for Service Program,” *New England Journal of Medicine*, 2 Apr 2009;360:1418-1428.  
 3. Medicare Payment Advisory Commission, “Report to Congress: Promoting Greater Efficiency in Medicare,” June 2007, Chapter 5

**Matthew W. McCarthy<sup>1</sup>, Ezra Gabbay<sup>1</sup>, Diego Real de Asua<sup>2</sup>, Joseph J. Fins<sup>2</sup>**

Divisions of Hospital Medicine<sup>(1)</sup> and Medical Ethics<sup>(2)</sup>  
Department of Medicine  
New York-Presbyterian - Weill Cornell Medical Center

## Ongoing Research

### Background/Relevance

Little is known about the sources of quotidian ethical conflicts encountered by hospitalists at the bedside, many of which have meaningful ethical dimensions.

**Hypothesis** The ethical problems that hospitalists confront differ in type and degree from the cases that trigger a formal ethics consult, and are not clearly characterized.

**Study Goal** To describe the frequency of the ethical problems that arise on the General Internal Medicine Hospitalist Service and compare them to those seen by the consult service of the Hospital Ethics Committee.



Left to right: Dr. Real de Asua (Fellow in Medical Ethics, '18), Dr. Fins (Chief, Division of Medical Ethics), Dr. Gabbay and Dr. McCarthy (Hospital Medicine)

**Materials and Methods** This is a cross-sectional study of all ethical problems consecutively identified during daily rounds on teaching GIM hospitalist services since September 2017. We are currently collecting data on the frequency of ethical and contextual issues pertinent to clinical decision-making with a standardized instrument on Hospitalist Service rounds. This same instrument will be used to retrospectively review and catalogue consultations received during that same period by the NYPH-WCM Ethics Consultation Service and Ethics Committee. We will then compare the baseline frequency of ethical and contextual problems between groups (Hospitalist Service v. Ethics Consultation Service).

**Results** We present here an *interim* analysis of our study. During the 3-month observation period, 150 different patients were evaluated. **Seventy-two ethical challenges and 34 contextual issues were identified in 46 of those patients (30.6% of the study sample presented ethical issues)** (TABLES 1 and 2). Seven novel, unanticipated ethical issues (10%) didn't fall into any pre-specified category. They involved, for example, questions about forgoing the recommendations of consulting physicians, or considerations about the impact of outpatient treatment non-adherence on fetal wellbeing. **During the same observational period, only three formal clinical ethics consults were brought to the Hospital Ethics Committee for these same 150 patients (30.6% versus 2%).**

TABLE 1. ETHICAL ISSUES DURING THE OBSERVATION PERIOD

Ethical issue	n (%)
<b>End-of-life</b>	
Goals of care discussions	21 (28%)
Refusal of treatment	6 (8%)
Forgoing life-sustaining treatments	3 (4%)
<b>Physician-patient relationship</b>	
Capacity	6 (8%)
Surrogate decision-making	4 (5%)
<b>Ethical issues of medical management</b>	
Pain management	5 (7%)
Substance abuse	4 (5%)
<b>Justice considerations</b>	
Resource allocation	2 (3%)
Discharge planning	7 (10%)
<b>Other</b>	
Known ethical issues	9 (12%)
Unclassified issues	7 (10%)

TABLE 2. CONTEXTUAL ISSUES

Contextual issue	n (%)
Interpersonal conflict	11 (32%)
Communication	10 (29%)
Ethnic/Cultural/Religious	3 (9%)
Socio-economic	2 (6%)
Other	8 (24%)

**Conclusion** Hospitalists confront frequent ethical problems in daily practice that differ in degree & type from those referred to the Hospital Ethics Committee. These ethical issues are meaningful to patients and present an opportunity for medical education in ethics and professionalism.

## Education & Research Opportunities in the WCM Division of Medical Ethics

### Opportunities for Medical Students

Students interested in increasing their exposure to clinical ethics, ethics case consultation and bioethics may do so through:

- Elective clinical rotations on the Ethics Consultation Service.
- Electives in bioethics research
- Area of Concentration in Medical Ethics

### Research Priority Areas

- Neuroethics and brain injury
- Palliative Care
- End-of-life ethics
- Reproductive ethics
- Research ethics
- Surrogate Decision-Making
- History of Medicine and Medical Humanities

### Opportunities for Residents

#### FELLOWSHIP IN MEDICAL ETHICS

- The **New York-Houston Medical Ethics Consortium** brings together Houston Methodist Hospital, Baylor College of Medicine, Weill Cornell Medical College, and New York-Presbyterian Hospital.
- Two-year program.
- 45% effort in clinical ethics consults, 35% mentored academic research and 20% in teaching activities.
- Weekly case seminar presentations. Monthly journal clubs and clinical case conferences with New York and Houston Faculty and Fellows.

Questions about the program or how to apply to the Fellowship: Joan Walker RN, MS [jow9033@med.cornell.edu](mailto:jow9033@med.cornell.edu)

For more information, please visit <https://medicine.weill.cornell.edu/divisions-programs/medical-ethics/education/fellowships>

**Funding Source:** Department of Medicine Seed Grant for Innovative Research (Jul 2017)

**Conflicts of Interest:** None

**Acknowledgements:** The Division of Medical Ethics thanks Drs. Augustine I. Choi, Michael G. Stewart and Laura L. Forese for their support of the Fellowship in Medical Ethics



#WeAreGIM





**Weill Cornell  
Medicine**

# MECA: Medical Education

## Collaborators Academy

Helene L. Strauss, MD and Lia S. Logio, MD

### The Mission

- To create a collaborative and cohesive community for GIM faculty interested in medical education research and scholarship
- To provide a forum for effective exchange of ideas around educational innovations and research projects
- To serve as a partner in the larger academic medical community around medical education, curricular ideas, assessment, and faculty development

### Objectives

- To facilitate the production of high quality medical education research
- To serve as an advisory group and contribute to curriculum innovations both within and outside of the MECA community
- To support medical students, residents, and fellows with an interest in medical education

### Program Details

1. Monthly Meetings focus on works in progress and skill building
2. Quarterly Social Events to build community of like-minded individuals
3. Quarterly Journal Clubs that include trainees interested in medical education
4. Social Media Tools to connect team for productive collaboration
  - SLACK: group work tool for messaging, sharing files, discussions
  - Virtual meetings with Zoom
5. Goal of producing academic products for GIM clinician educators



### Opportunities for Others Interested in Medical Education

- Participation in quarterly med ed journal club
- Collaboration with residents interested in medical education on projects
- Link to medical students enrolled in the medical education AOC in active research and curriculum development

### How to Get Involved

Email Helene Strauss for more information.

[hes9045@med.cornell.edu](mailto:hes9045@med.cornell.edu)



PROUD TO BE  
GIM

#WeAreGIM



**EDUCATION**

**Clinical Decision Making Conference**

**Description:** Noon conferences held every other month for PGY2 and PGY3 medicine residents. Residents contribute by providing real patient related diagnostic dilemmas and questions.

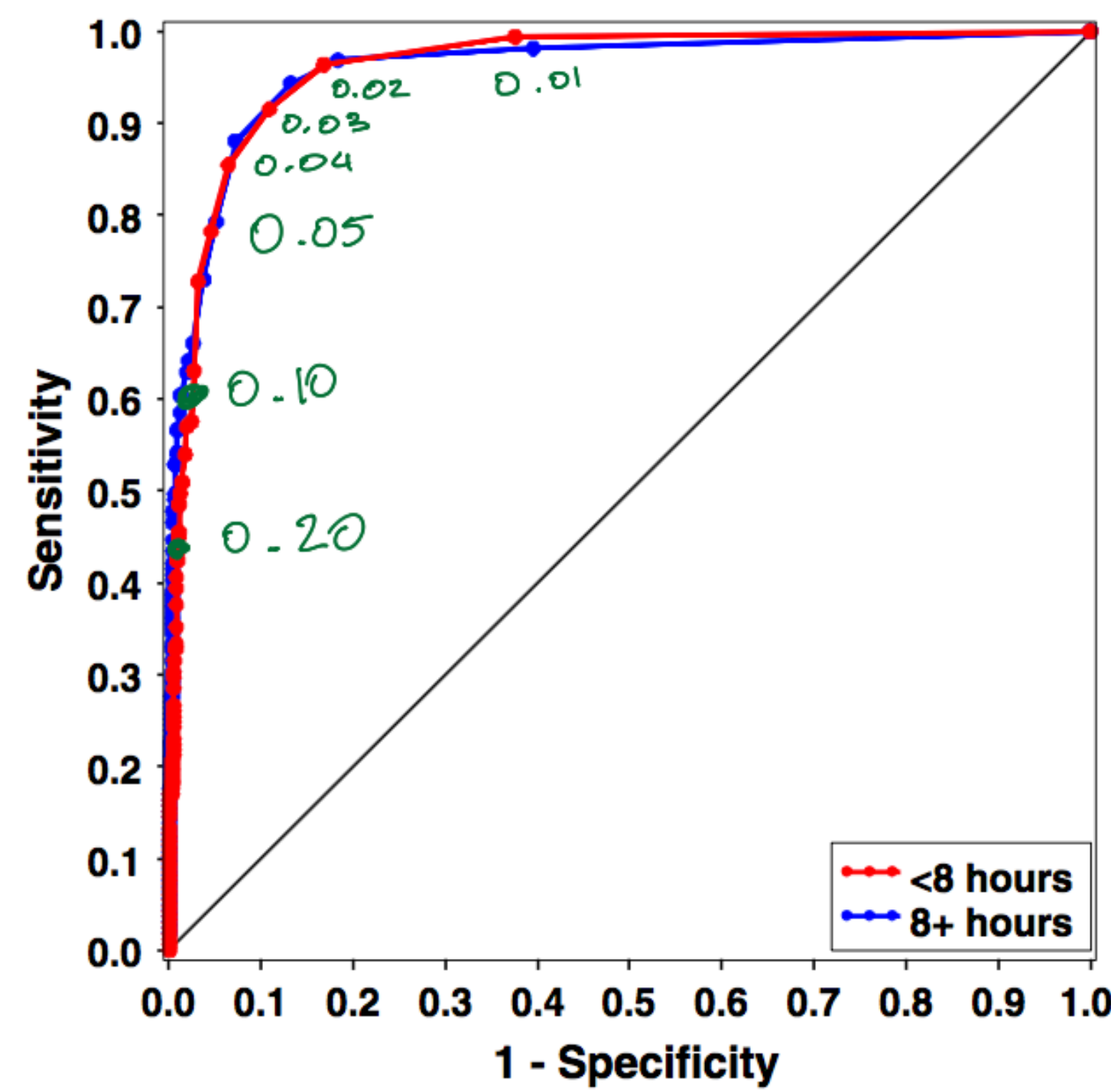
**Examples of dilemmas/questions:**

- (1) How do we interpret low B-Type Natriuretic Peptide in a patient with symptoms and signs consistent with congestive heart failure?
- (2) How do we interpret borderline troponin in a patient with suspected acute coronary syndrome?
- (3) A patient with chronic kidney disease presenting with shortness of breath has a moderate probability of pulmonary embolism. VQ scan is indeterminate. Lower extremity venous dopplers are negative for deep venous thrombosis. What is the probability of pulmonary embolism now, and how do we proceed?

**Objectives and Methods:** We use evidence based medicine to find answers to these dilemmas. Residents find answers using case based problem solving, working through each problem in small groups. Goal is to teach the best practices in clinical decision making, such as Bayesian reasoning – likelihood ratios, pre and post-test probabilities of disease, testing/treatment/action thresholds, and interpretation of receiver operating characteristic (ROC) curves.

**Case 1**

53 year old man with coronary artery disease presents with sudden onset substernal chest pressure and pain, radiating to left shoulder, associated with diaphoresis and profound shortness of breath. ECG showing submillimeter ST depressions in the inferolateral leads.

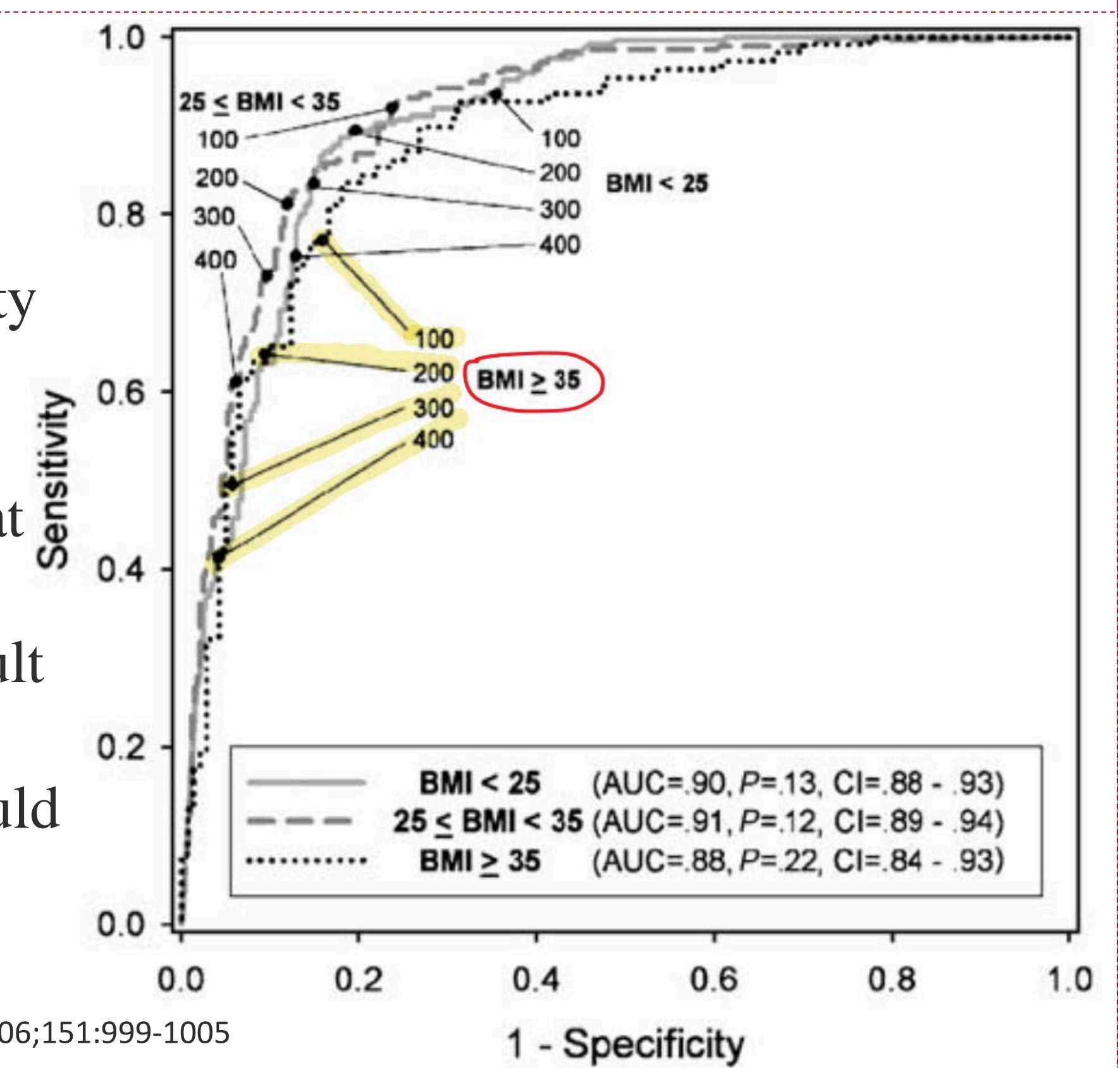


- a. Estimate the probability that this patient is having a myocardial infarction.
- b. Troponin peaks to 0.05 (normal 0 – 0.04). How does this borderline elevation change probability of MI? Use the ROC curve to answer this question.

Clinical biochemistry 48 (2015): 254-259

**Case 2**

You are caring for a patient coming in with SOB and lower extremity swelling. You're 90% confident patient has CHF. BNP returns low at 14. Patient's BMI is 40. How does this BNP result change probability of heart failure? What should be done next?



Am Heart J 2006;151:999-1005

**RESEARCH AND SCHOLARSHIP**

**Users' Guide: ROC Curve Anatomy**

Using ROC curves to answer diagnostic dilemmas such as – how do borderline positive test results change the probably of a diagnosis? When is the test result low enough to “rule out” disease?

**Understanding P Values**

Drug X found to decrease mortality by 10%, compared to placebo. P value is 0.04. What is the probability that these results are found due to chance? What is the probability that drug X does not reduce mortality? Is it 4%? If you think yes, then most clinicians, residents, and students will agree with you. Unfortunately, the answer is no. P value is widely misunderstood. This project aims to teach p value in case-based format to improve our interpretation of vastly growing medical literature.

**Diagnostic Tests**

- **MRSA PCR** swab for diagnosis of MRSA infections (cellulitis, pneumonia) in hospitalized patients – ongoing systematic review and planned meta-analysis
- **Procalcitonin** – how to interpret different values of procalcitonin in variety of clinical scenarios
- **B-Type Natriuretic Peptide (BNP)** – we have learned BNP changes in obesity, renal disease, atrial fibrillation. How much does it change, and how does it affect our ability to diagnose heart failure?
- **Highly Sensitive Troponin** – FDA approved new troponin test that can rule out myocardial infarction within 3 hours of presentation to the emergency department. How can we interpret this test in different clinical scenarios (i.e. high risk patients)?

**Affinity Group Members**

**Arthur Evans, MD, MPH**  
**Amiran Baduashvili, MD**  
**Todd Cutler, MD**  
**Tanping Wong, MD**  
**Gregory Mints, MD**  
**Deanna Jannat-Khah, PhD**

**Chief, Division of Hospital Medicine**  
**Hospital Medicine**  
**Hospital Medicine**  
**Hospital Medicine**  
**Hospital Medicine**  
**Senior Data Analyst**

**Funding Source: None**  
**Conflicts of Interest: None**  
**Acknowledgements: All affinity group members and Monika Safford MD**



**#WeAreGIM**



## Introduction

The Internal Medicine Residency Program at Weill Cornell has created a digital ecosystem to enhance learning for our trainees. Every resident is given an iPad that serves as an important resource for learning with the goal of getting their “brains on fire.” Each physicians has access to everything they need to learn best practice medicine.



Since our original designation as an Apple Distinguished Education Program (2015-2017) the first ever graduate medical education program to receive this honor, the Weill Cornell Internal Medicine Residency Program at NewYork Presbyterian Hospital in Manhattan has continued to explore digital tools to keep their physicians-in-training at the forefront of learning cutting edge medicine.

The custom content with powerful search functionality combined with the mobility of the iPad have allowed us to create an invaluable resource to our trainees learning medicine on the go. Technology has helped us deliver consistent content in a multimedia format that appeals to all kinds of adult learners. It helps us deliver information to residents across different sites on different rotations and provides a way for those residents unable to make it to teaching conferences to be connected to the information covered.



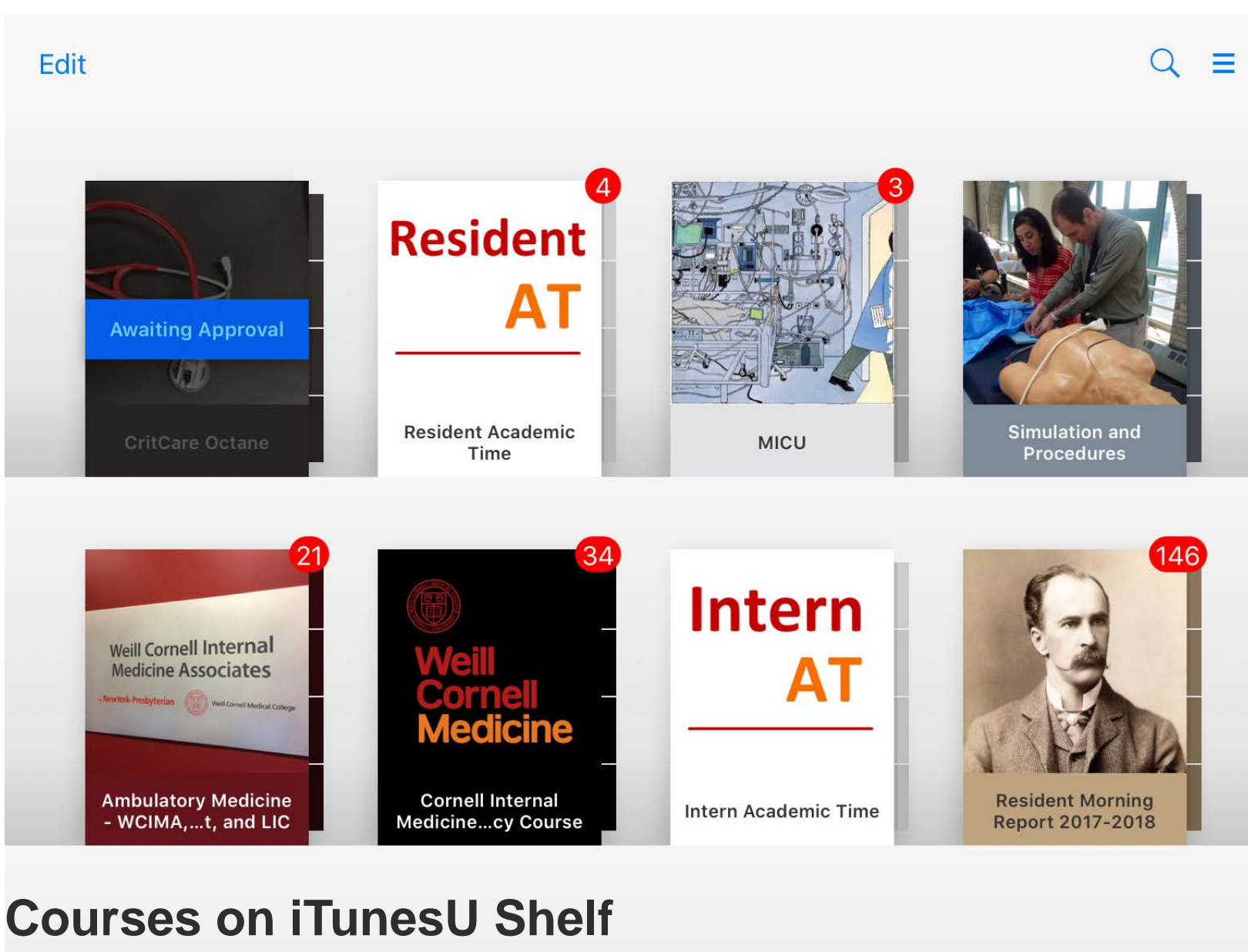
## Standard Configuration with Pre-loaded Apps and connection to network, library, WCM resources

## Program Details

The foundation of our program is the Apple ecosystem, especially the use of personal iPads provided to each resident. We use iTunesU to share educational materials and foster discussions related to didactic conferences, to share multimedia touch books with targeted resources on particular rotations and to use as textbooks for some of our core medical topics. The platform allows us to share logistical information like schedules, policies and procedures, too.



iTunesU



Courses on iTunesU Shelf



iBooks



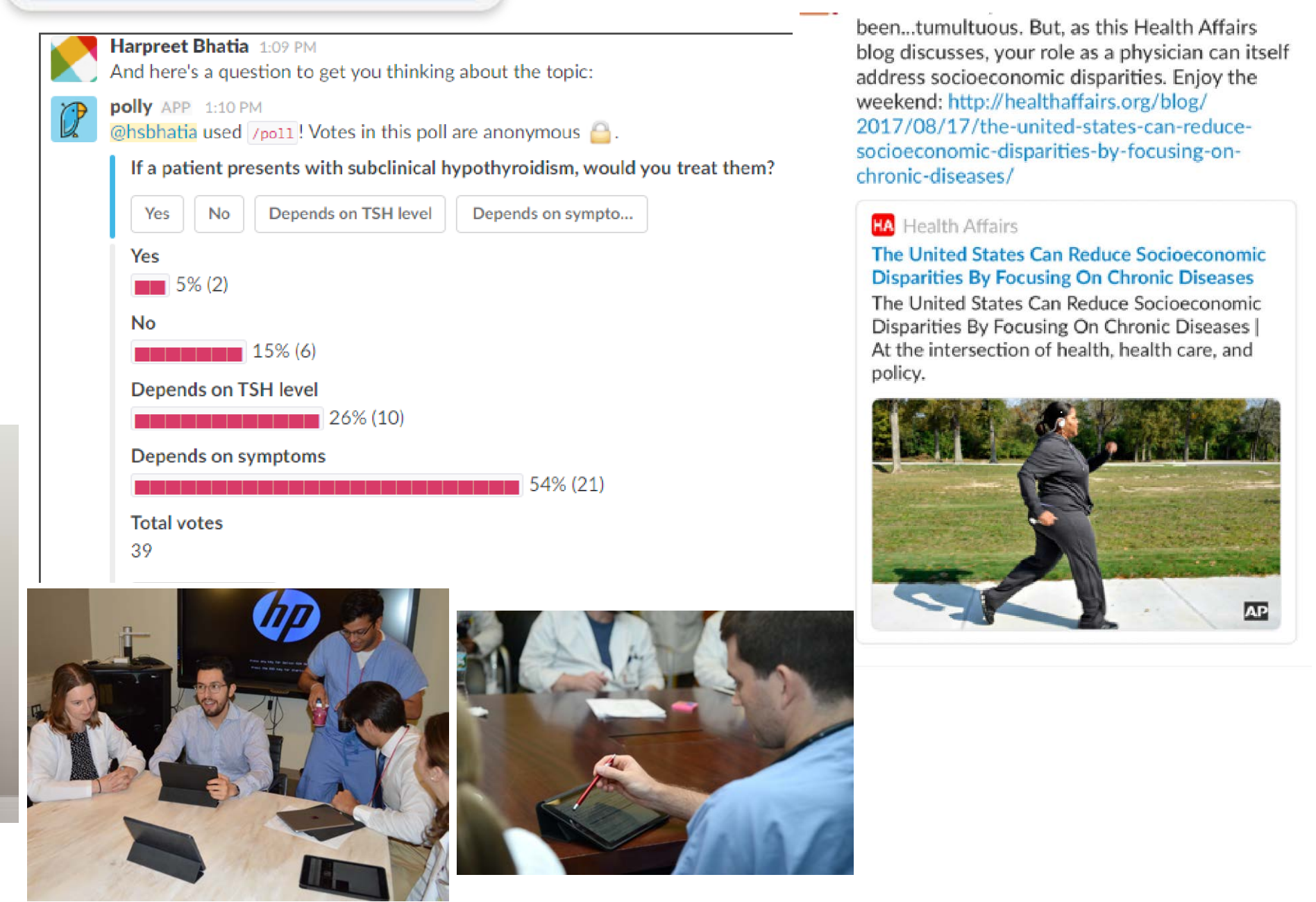
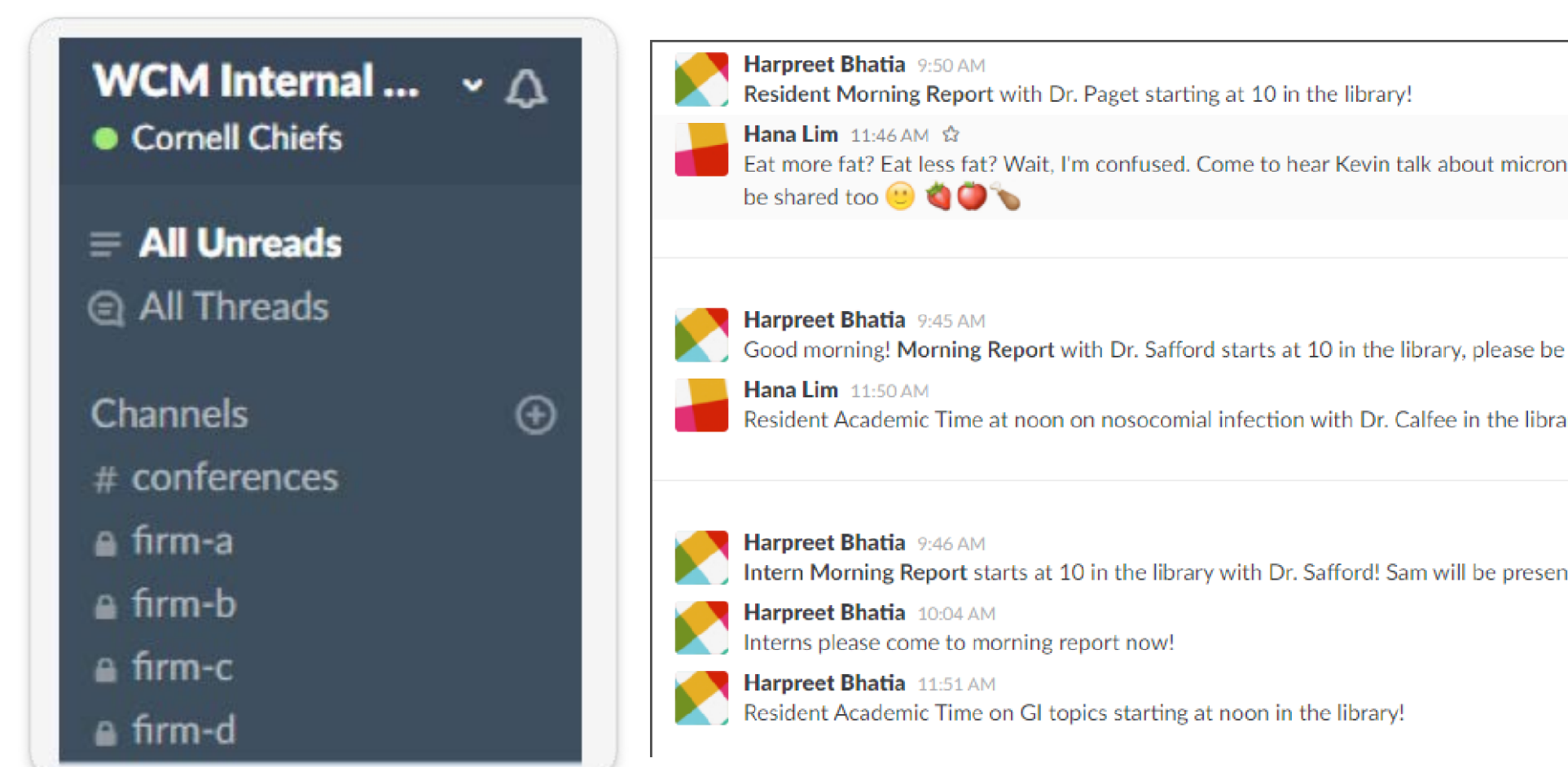
WCM-made iBooks on iBook Shelf



In the 2017-2018 academic year, we introduced the Slack tool. We have 155 individuals enrolled which includes 100% of the residents. With our current eight channels, within the first two months, we have seen an average of 110 weekly users based on the analytics available through Slack.

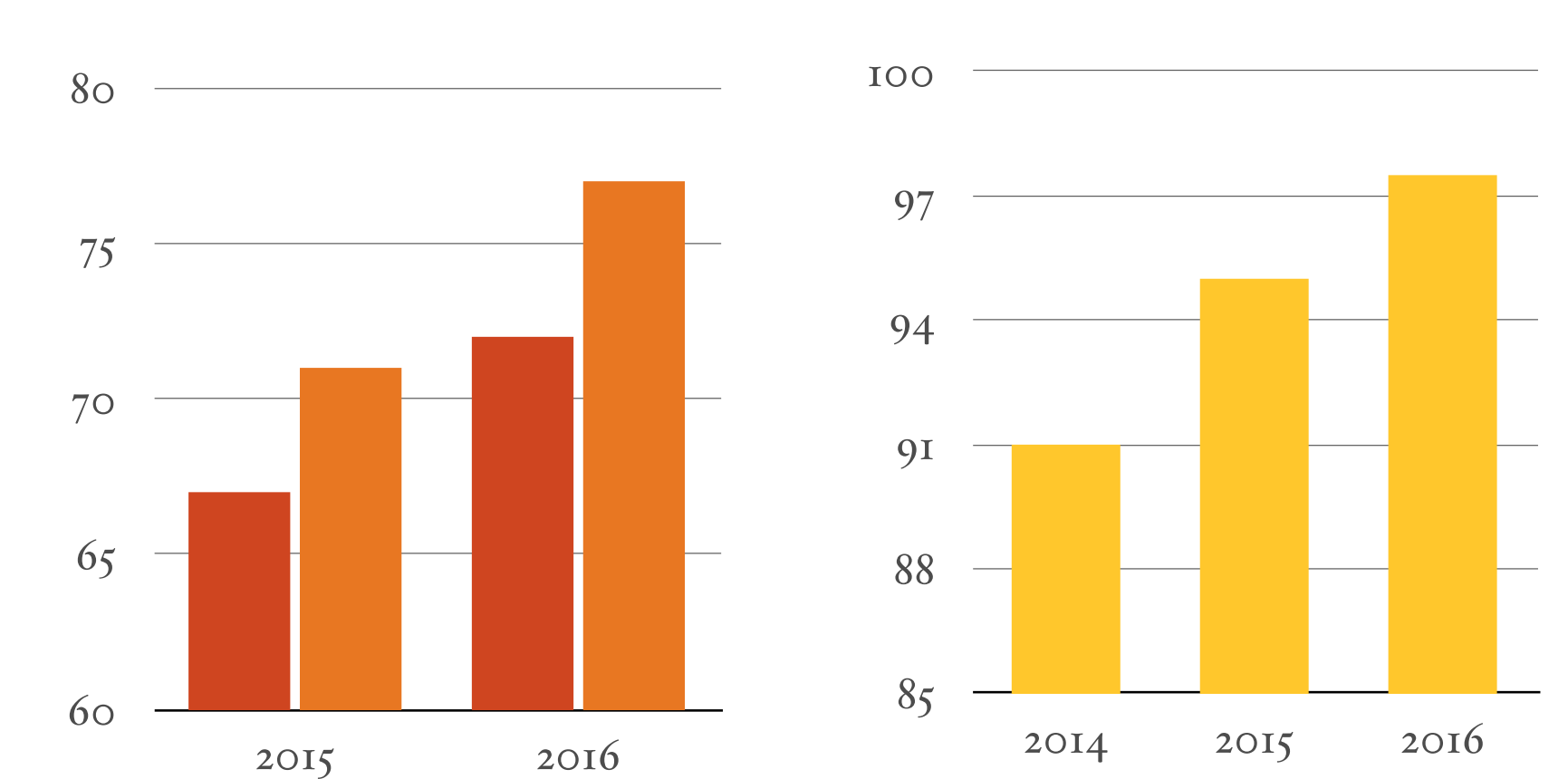
Slack serves as a way to engender open communication and exchange of ideas between all the members of the program. It serves as a vital tool to make important announcements, to share articles and start a discussion for journal clubs, and to recruit team members to specific quality improvement initiatives.

Slack has facilitated several important dialogues as well as photo sharing from the annual Housestaff Picnic, building community!

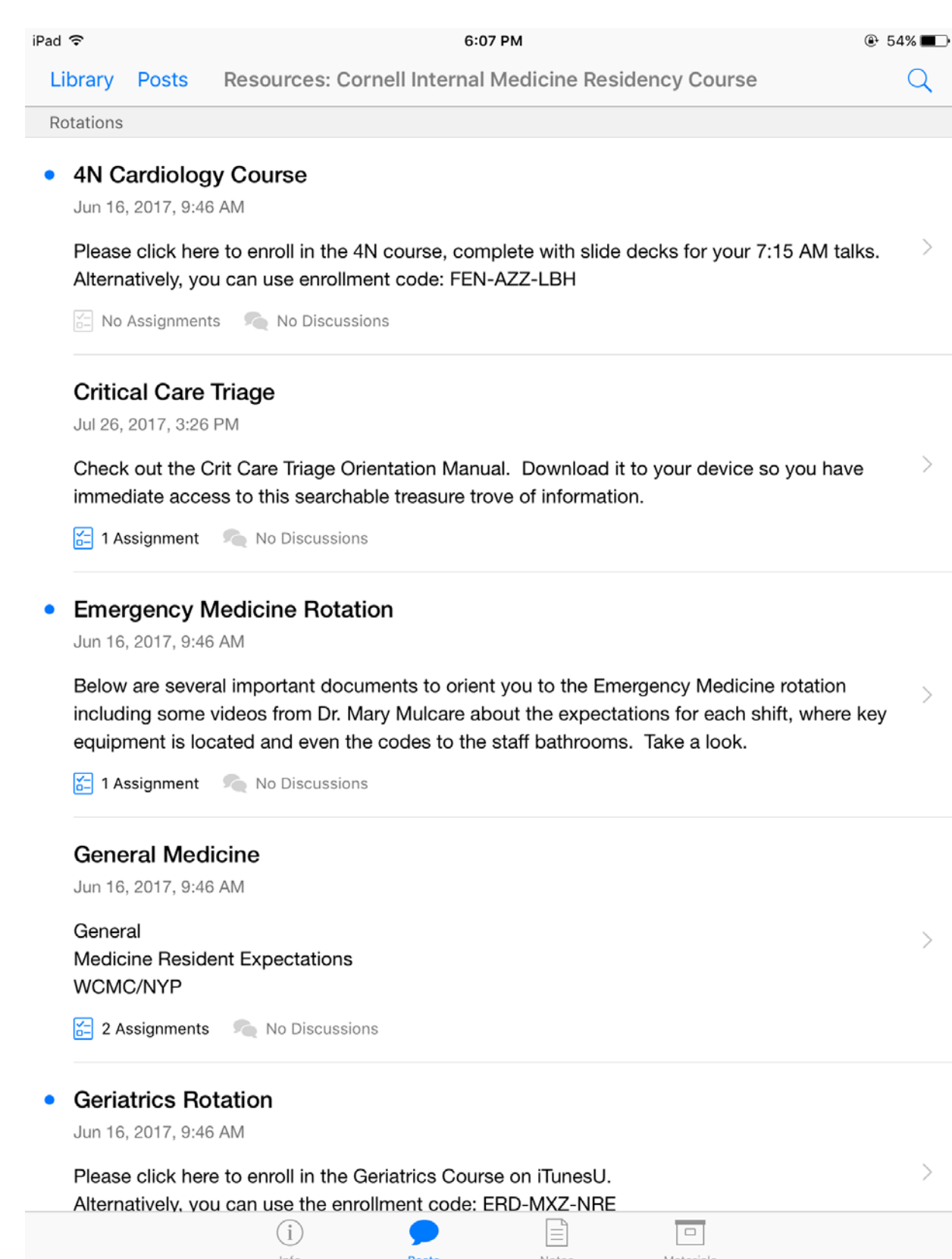


## Outcomes

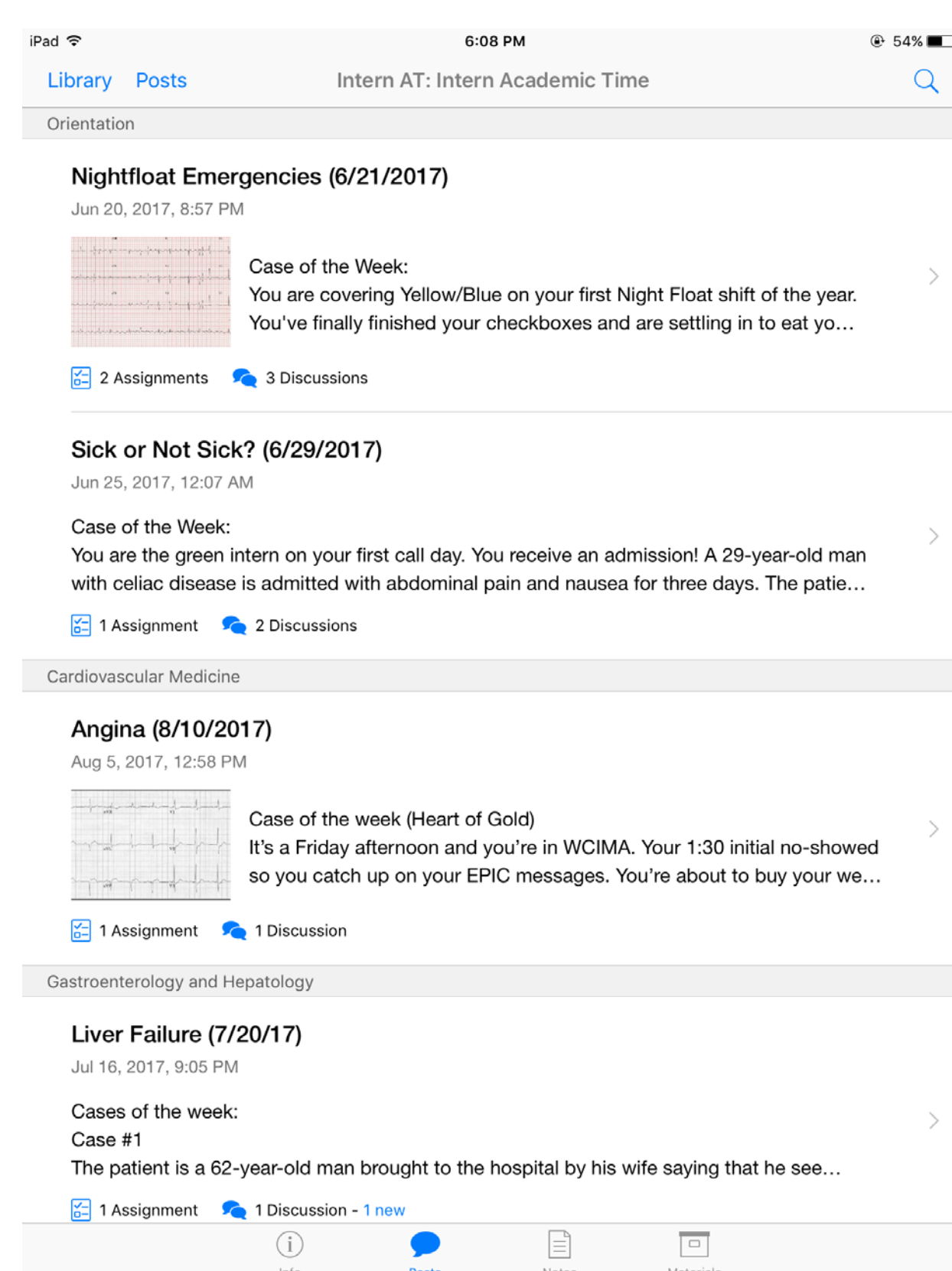
	2015	2017
Courses with Content	12	24
iBooks	2	6
Apps	2	9
Regular Users	36%	52%
iFaculty	18	26
Academic Presentations	0	4



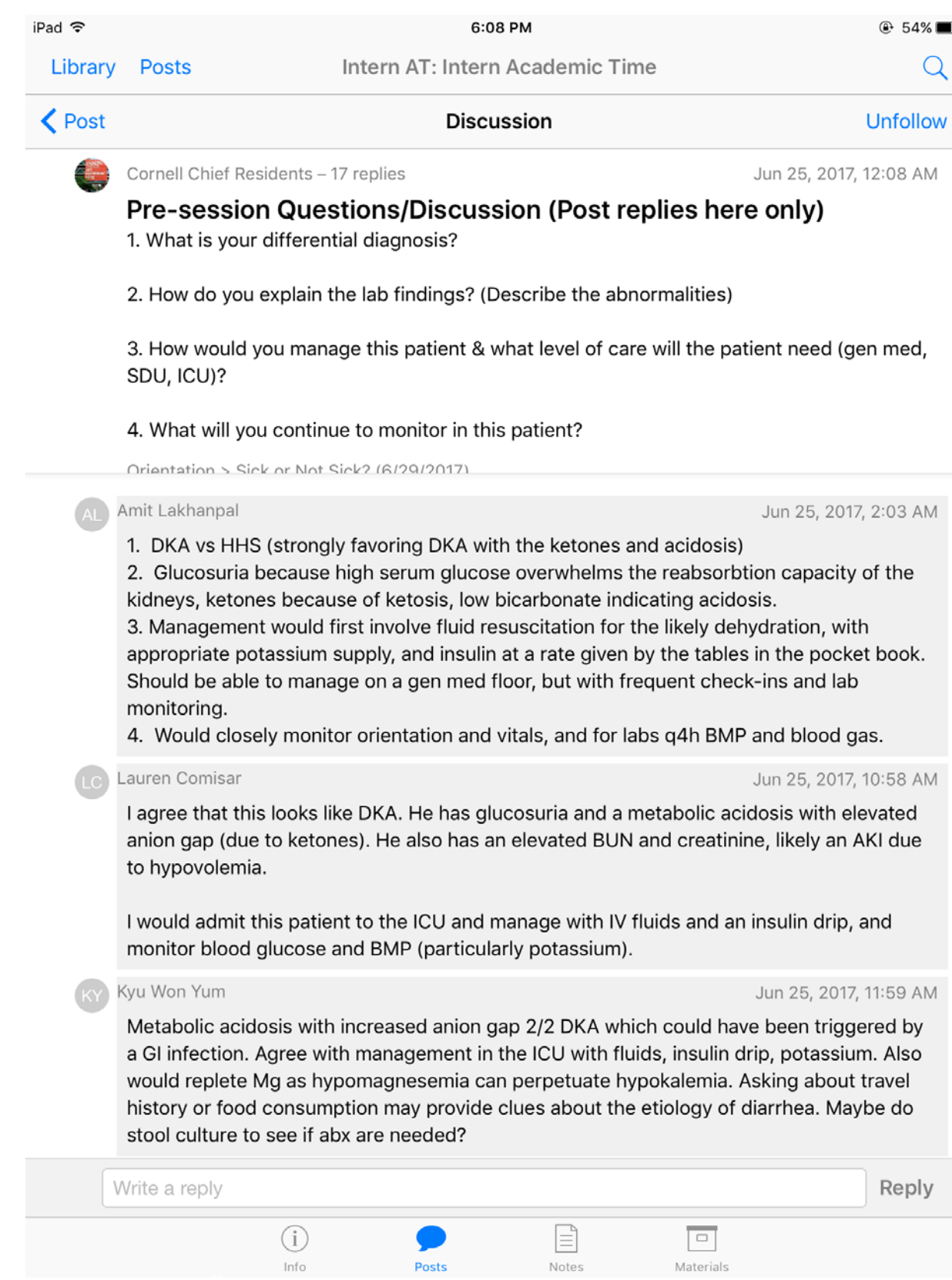
## In-Training Exam Scores and Board Pass Rate Rising since Digital Ecosystem Introduced in 2015



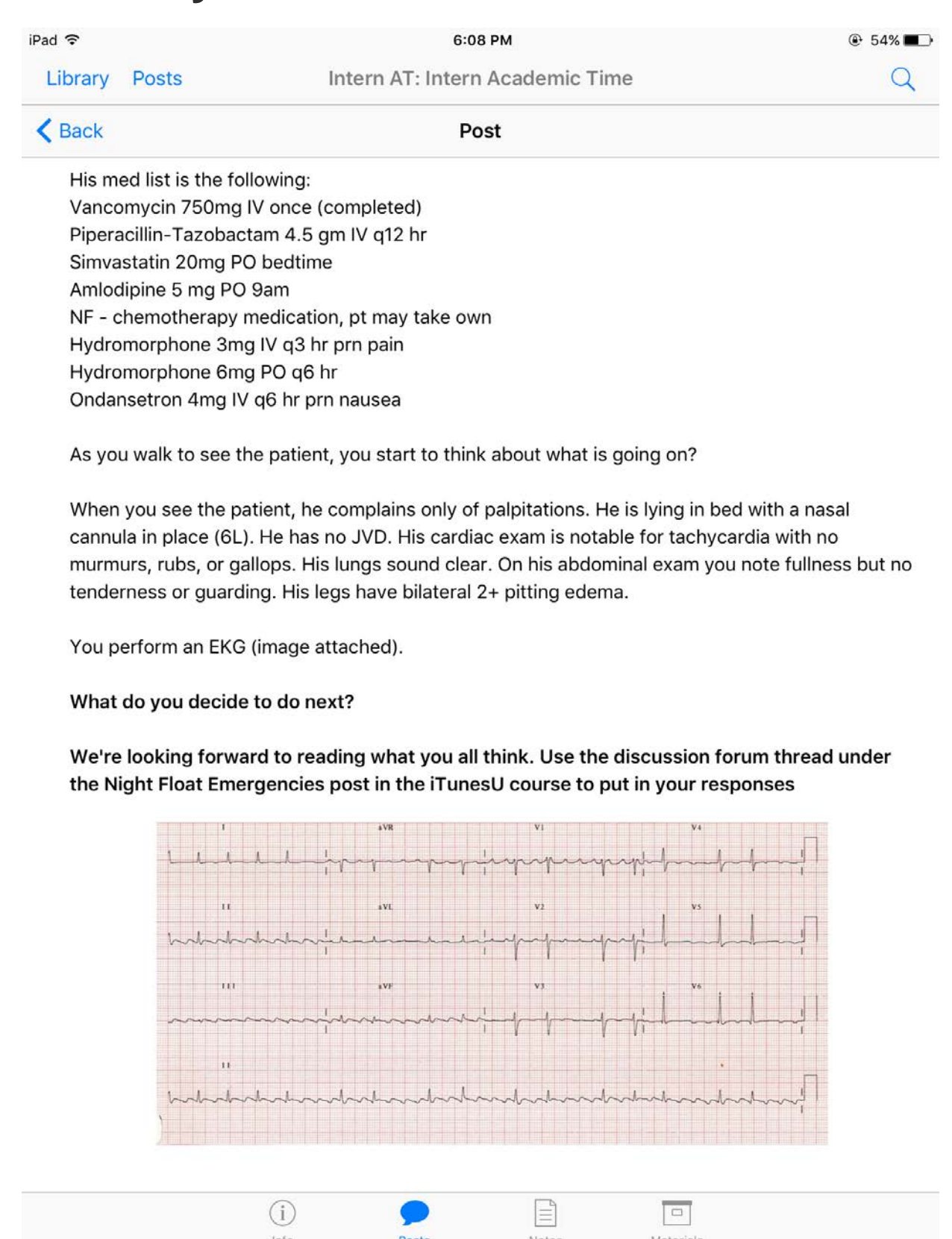
A



B



C

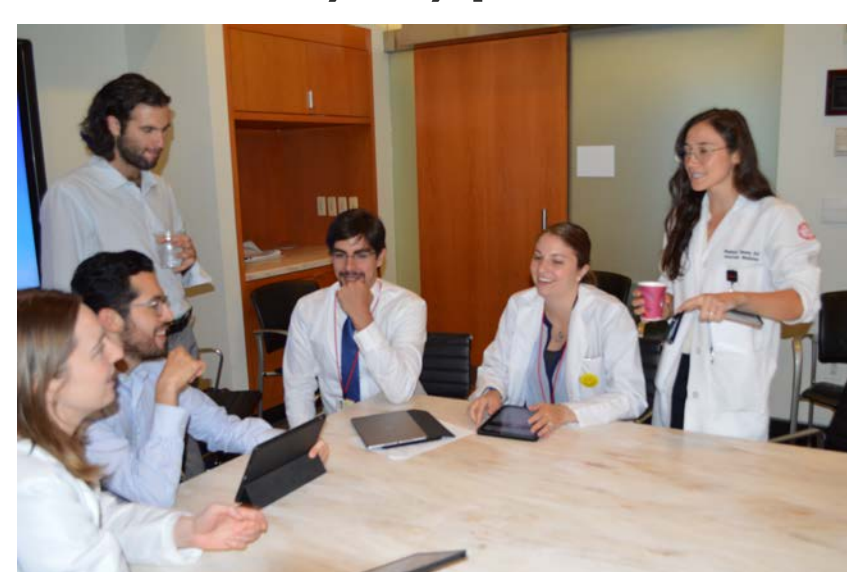


D

Screen shots of iTunesU including A) rotation list B) Conference Cases (flipped classroom), C) pre-session discussion blog and D) post conference teaching points of the case.



Recognized by Apple as a distinguished program for innovation, leadership, and educational excellence.



#WeAreGIM



WEILL CORNELL  
**COMMUNITY CLINIC**

### Introduction

- WCCC began functioning 11 years ago, created and sustained by medical student volunteerism with medical and social work faculty support.
- In the last two years, we have become even more interdisciplinary and have nutritionist volunteering as well as pharmacy students with faculty supervision.
- The majority of Weill Cornell medical students volunteer at WCCC over their four years.
- Applicants to our medical school are enthusiastic about participating.

### Mission Statement

The Weill Cornell Community Clinic (WCCC) is a student-led initiative aimed at providing high-quality and equitable health care to uninsured individuals in New York City. Under the supervision of an attending physician, we offer comprehensive primary healthcare services at low- or no-cost to adults, including preventive care, treatment for acute and chronic conditions, and referrals to appropriate and affordable specialty services. We aim to extend healthcare access to underprivileged populations while encouraging volunteerism and philanthropy, and we welcome all students to participate in the clinical, research, and organizational opportunities that are available.



## Three Clinical Centers within WCCC: Medicine, Women's Health, & Mental Health

### Program Details

We all meet usually on Monday evenings in the Helmsley Medical Tower at either the Weill Cornell Community Clinic or at the Women's Health Center. At each session there are medical students at different levels of training collaborating and presenting to an attending physician. Each patient is seen by a junior clinician (pre-clinical student) and senior clinician (clinical student) with initial history obtained by the junior clinician supplemented by the junior clinician who also examines the patient. They together present to the attending. Many WCCC patients also have a "COC or Continuity of Care, preclinical student" who comes to appointments and has regular contact with the patient, at least once a month. There has been a special effort to have foreign speaking patients be linked with a COC student who is fluent in their language. To support WCCC there is a junior board of over 20 medical students who take on a year commitment to facilitate WCCC functioning. The WCCC Senior Board are involved in direct patient care and supervising other medical students providing that care. The core administrative group consists of two MD-PhD students our Executive Directors (each has a two year term) and two Medical Student Co-Directors (one year term). All patient care provided is reviewed by the WCCC Medical Director, Dr Pam Charney with the Medical Student Co-Directors and this team is also responsible for coordination of interim care and assuring follow up of outstanding results. The Medical Clinic Director is Dr Pam Charney; the Director - Weill Cornell Community Clinic Women's Clinic is Dr Patricia Y Allen and the Director of the Weill Cornell Community Clinic Mental Health Clinic is Dr Akshay Lohitsa. There have been multiple Quality Improvement projects focused on clinical care and educational efforts.



### Opportunities for Medical Students

- WCC is a community of students and attending's committed to providing best care to underserved patients.
- > Students can participate in a wide range of tasks required to provide clinical care and personally learn about the challenges and benefits to providing care for individual patients
  - > WCCC provides the opportunity to provide direct care to patients in need w attending supervision
  - > Senior clinicians not only increase their ambulatory clinical experience and improve their competency but have substantial opportunity to teach classmates and future physicians
  - > Collaborating has strengthened the WCCC community as well as its functioning.
  - > Many students have lead initiatives that have improved patient care!
  - > Multiple innovations have lead to publications and presentations.



**Funding Source:** Fundraising Activities by WCM Students.

**Conflicts of Interest:** None

**Acknowledgements:**  
 Dr. Patricia Y. Allen, MD, Director of WCCC Women's Clinic  
 Dr. Akshay Lohitsa, MD, Director of WCCC Mental Health Clinic

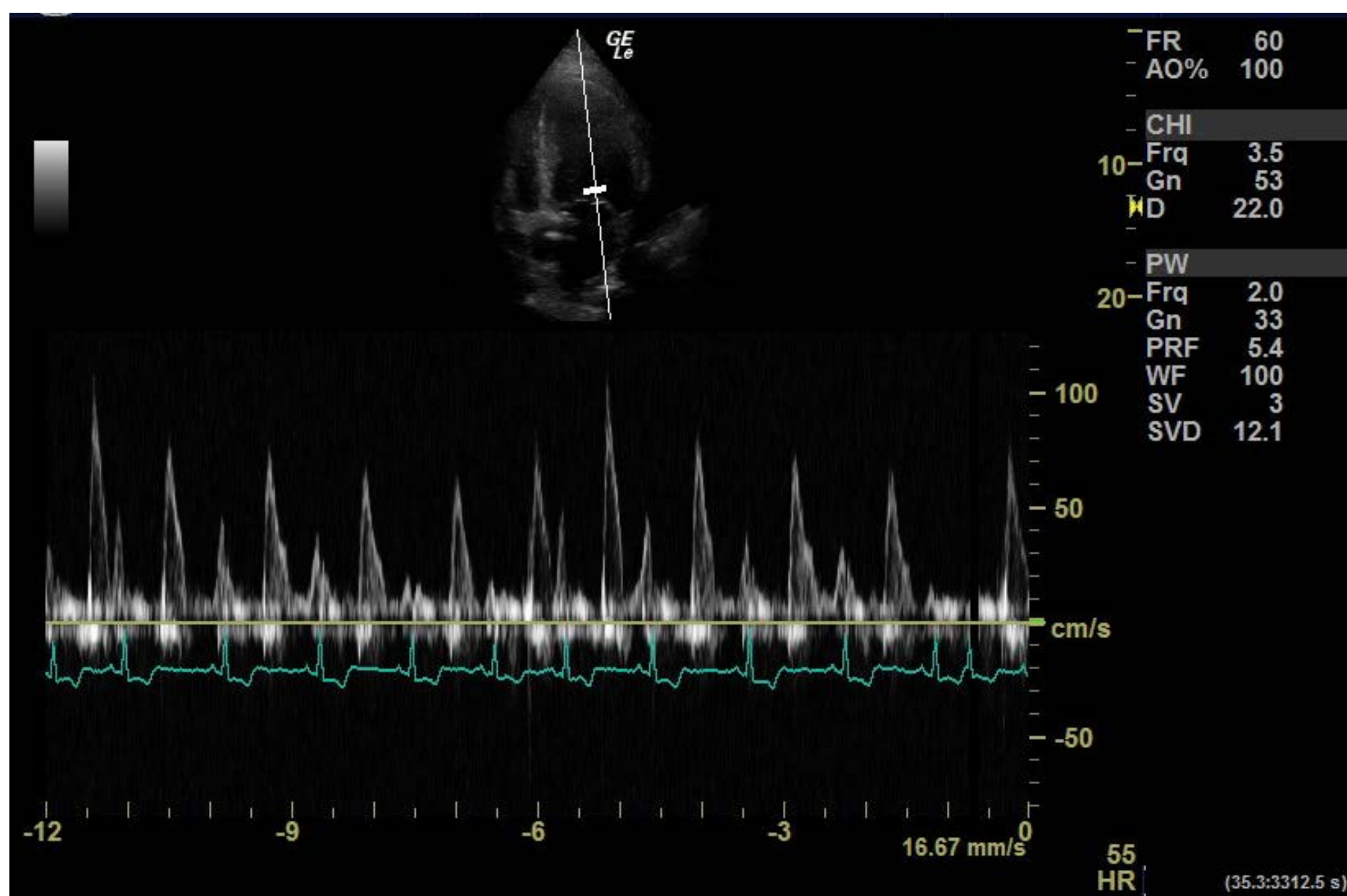
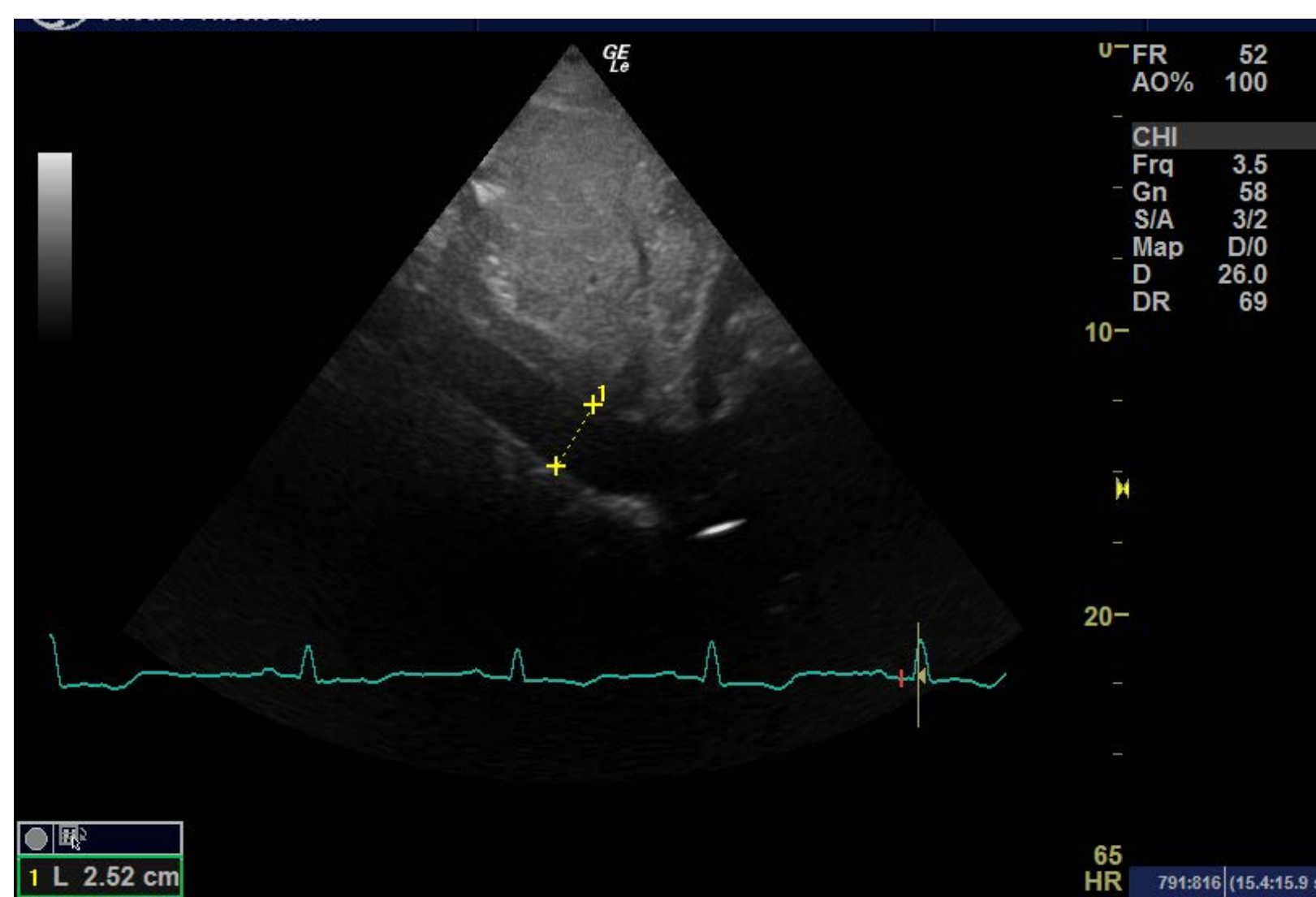
**Executive Medical Directors:**  
 Andrew Iannone, MD/PhD, entered 2014  
 Maria Passarelli, MD/PhD, entered 2015

**Medical Co-Directors:**  
 Catlin Finn, Class of 2018  
 Amanda Su, Class of 2018



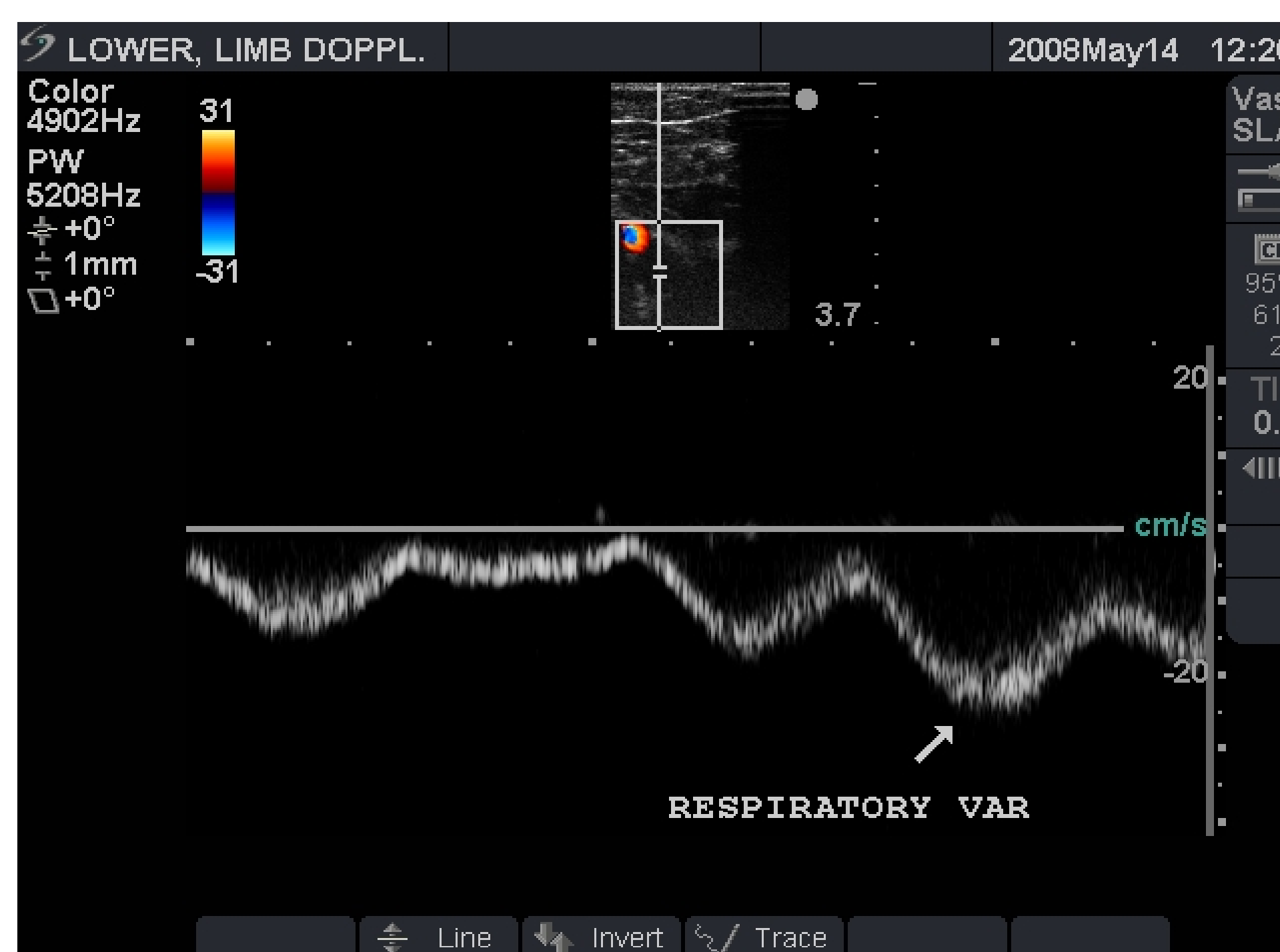
## Introduction

- Hospital Medicine Point of Care Ultrasonography (HM-POCUS) is a relatively new and dynamic field.
- The idea is simple: bring US - a powerful, portable, real time imaging technique - to the bedside.
- Point of Care Ultrasonography is always by definition a focused study intended to answer a very specific question under a very specific clinical circumstances.
- It is performed and interpreted by a clinician, caring for the patient in real time by the bedside.
- At the center of the field is the appreciation that the same sonographic finding may mean completely different things, depending on the clinical context.
- As hospitalists at Weill Cornell/New York Hospital, we are proud and excited to be part of this emerging field



## Objectives

- *The goal of program is to gain proficiency in basic point of care ultrasound, including image acquisition, interpretation, clinical decision-making, and its evidence-based diagnostic accuracy.*



## Opportunities for Students & Residents

### 1. Learn Ultrasonography at one of our various classes for residents, or fellows/faculty

- Classes consist of didactic material, extensive image review and hands-on scanning of life models.
- During the scanning our student-to-faculty ratio is set not to exceed 3-1, but has not yet exceeded 2-1.
- Our last class learners had 15 hours of one-on-one supervised "probe time" per week!
- We have implemented longitudinal year-long curriculum which includes hands-on supervised scanning sessions and image review.
- Participants must also complete a portfolio of images and teach entry-level POCUS to others

### 2. Create and develop a research project under the guidance of one of the HM-POCUS faculty

### 3. Present a case at our monthly interdisciplinary POCUS conference.

- IM, ER, Critical Care, Radiology and Cardiology comes together to discuss cases.
- Conference is open to all interested, regardless of level of training or departmental affiliation.



Interested in joining our efforts?

Please contact

Gregory Mints at [grm9032@med.cornell.edu](mailto:grm9032@med.cornell.edu)

Tanping Wong at [taw9047@med.cornell.edu](mailto:taw9047@med.cornell.edu)

Elaine Gee at [eyg9001@med.cornell.edu](mailto:eyg9001@med.cornell.edu)

**Funding Source:** Section of Hospital Medicine

**Conflicts of Interest:** No conflicts of interest to report

**Acknowledgements:** Art Evans, Weill Cornell Department of Medicine, Division of General Internal Medicine

## Introduction

Currently, chronic diseases are linked to at least 70 percent of our nation's deaths and disability. Many of these conditions are preventable or reversible with reliable and early education. Emphasizing the basic tenets of healthy eating, emotional wellbeing, and an active lifestyle can lead to a better quality of life and greater vitality later in life.

Integrative therapies can help to prevent and treat chronic disease, reduce stress and anxiety, and relieve symptoms associated with disease or its treatment. Currently over half of medical schools in the U.S. contribute to the clinical, scholarly, or educational advancement of topics in integrative medicine.

## Clinical Services

Mindfulness based therapies, Meditation

Nutrition counseling

Yoga therapy

Acupuncture

Massage therapy

Pilates instruction

Hypnosis

Physician consultation

## Program Objective

The Integrative Health and Wellbeing team brings long-known and newly discovered principles of nutrition, psychologic care, mind-body therapies such as meditation and breath work, and physical practices such as acupuncture and massage therapy to the medical setting.

Through this interdisciplinary and novel model, the program creates a focus on prevention, education, and wellbeing.

## Common Clinical Applications

Chronic pain

Irritable bowel syndrome &  
Inflammatory bowel disease

Coronary artery disease

Metabolic syndrome

Diabetes

Symptoms of cancer or cancer treatment

Mental Health

Autoimmune disorders

## Opportunities

Shadowing and e-learning opportunities may be available for students interested in Integrative Medicine.

To learn more, please visit our website: [www.nyp.org/integrativehealth](http://www.nyp.org/integrativehealth) or contact [agupta@med.cornell.edu](mailto:agupta@med.cornell.edu)

## Clinical Team



**Alka Gupta, M.D.**  
Co-Director, Integrative Health



**Oleg Fabrikant, DAOM, Lac**  
Acupuncturist



**Jacqueline Herbach, LMSW, LMT**  
Massage Therapist & Pilates Instructor



**Chiti Parikh, M.D.**  
Co-Director, Integrative Health



**Manna Lu-Wong, RN**  
Integrative Health Nurse



**Jackie Topol, RD, CSO, CDN**  
Integrative Nutritionist



#WeAreGIM



### Fellowship Objectives

1. Train post-residency physicians to conduct their own, methodologically rigorous health services research, which is focused on improving clinical practice and improving our health systems' ability to provide high quality, high value, effective health care.
2. Teach post-residency physicians how to perform question-driven, multidisciplinary research, in an area of their own interest.
3. Prepare physicians to become independent investigators.

### Program Details

- Two-year program.
- Didactic curriculum of 30 courses designed to provide conceptual and practical foundations and core competencies in health services research.
- Master's Degree in Clinical Epidemiology and Health Services Research from the Weill Cornell Graduate School of Medical Sciences at the completion of the required coursework.
- Independent research project(s).
- Faculty mentorship in health services research, clinical epidemiology, behavioral science, biostatistics, health economics, informatics, health policy, and medical ethics.
- Weekly seminar presentations, where mentors, program directors, and fellows provide group feedback to the fellow(s) presenting their research.
- Monthly journal club, led by fellows.
- T-32 AHRQ-NRSA Trainee Conference.



### Coursework

- **Clinical epidemiology**
- **Health services research**
- **Survey design**
- **Qualitative research methods**
- **Biostatistics**
- **Informatics**
- **Decision Analysis**
- **Behavioral Science**
- **Health policy**
- **Implementation Science**
- **Quality Improvement**
- **Grant Writing**



### Research Priority Areas

- Healthcare Disparities
- Patient Safety
- Quality Improvement
- Translating Research into Practice and Policy
- Patient-centered Care and Education

### Fellows Presenting Research



Top Row: Dr. Symer '18 (Left), Dr. Sterling '18 (Right), Bottom Row: Dr. Gade '19 (Left), Dr. Abelson '17 (Right)

### Current Fellows

#### Second Year Fellows

- |                                   |                                  |
|-----------------------------------|----------------------------------|
| <b>Madeline Sterling, MD, MPH</b> | <b>General Internal Medicine</b> |
| <b>Matthew Symer, MD</b>          | <b>General Surgery</b>           |

#### First Year Fellows

- |                           |                         |
|---------------------------|-------------------------|
| <b>Patrick Dolan, MD</b>  | <b>General Surgery</b>  |
| <b>Greg Eckenrode, MD</b> | <b>General Surgery</b>  |
| <b>Lindsey Gade, MD</b>   | <b>General Surgery</b>  |
| <b>Nicole Shen, MD</b>    | <b>Gastroenterology</b> |

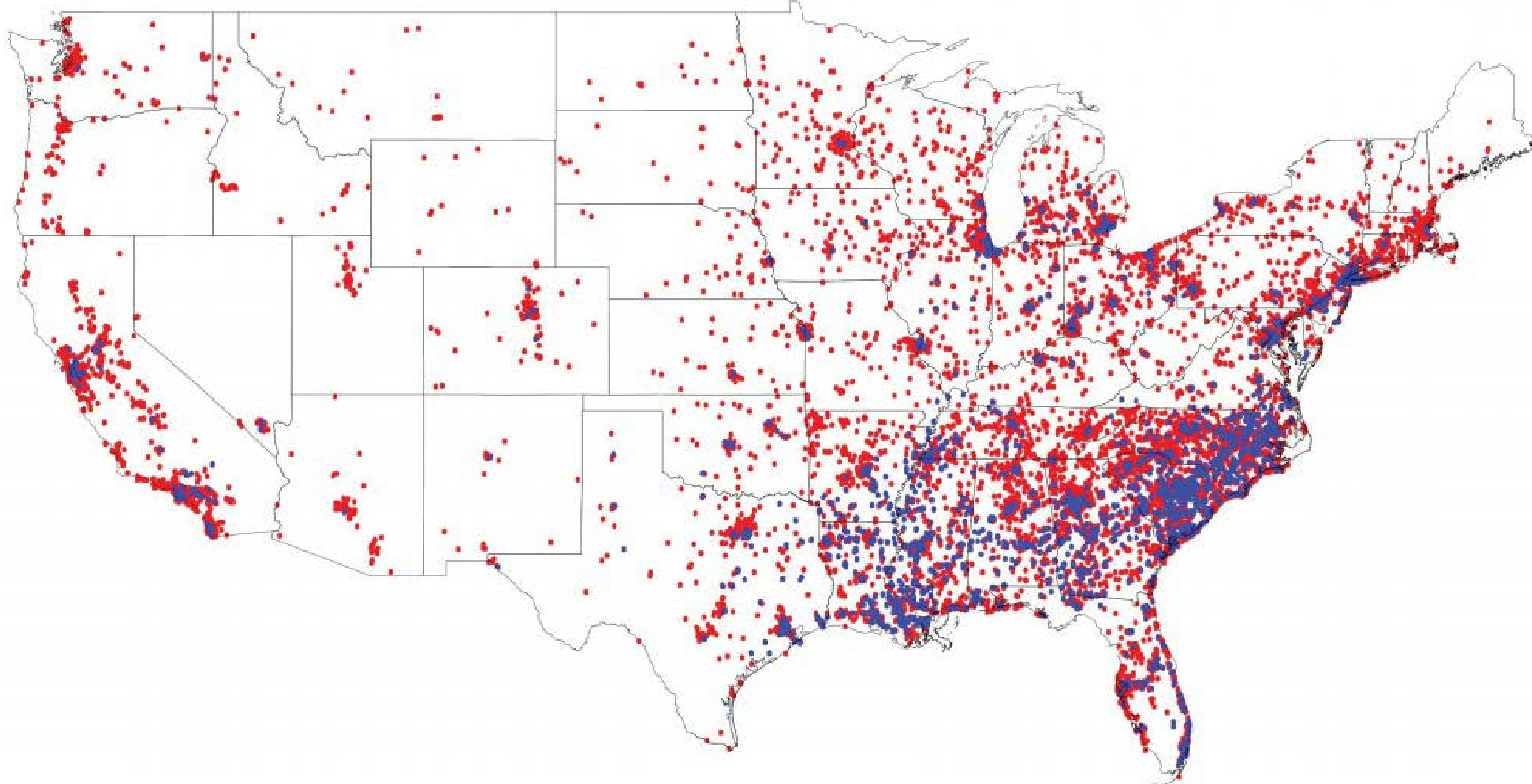
Mary E. Charlson, MD, Fellowship Program Chair  
Carol Mancuso, MD, Fellowship Program Director  
Robin Andrews, Program Coordinator

Applications are accepted on a rolling basis. Apply early as fellowship slots are limited. To apply, please visit <https://weillcornell.liasoncas.com>

# The REasons for Geographic And Racial Differences in Stroke (REGARDS) Study: Research opportunities for students and trainees in health disparities

## Background

- Cardiovascular disease (CVD) affects more than 92 million Americans.
- By 2030, ~44% of the population will have some type of atherosclerotic cardiovascular disease (ASCVD).
- CVD remains a leading cause of morbidity and mortality in the US.
- Health disparities by race, sex, and socioeconomic status (SES) persist.



Map of where REGARDS participants live. Blue = Blacks. Red = Whites

## Objectives and Design

- REGARDS is a prospective cohort study of 30,239 individuals examining regional and racial influences on stroke mortality.
- REGARDS-MI is an ancillary study examining similar issues for myocardial infarction (MI).
- The REGARDS and REGARDS-MI studies' purpose is to better understand why regional and racial disparities exist in stroke and coronary heart disease (CHD), and to learn how to reduce the number of people with stroke and CHD outcomes.
- Black and White English-speaking, community dwelling adults aged 45 years or older, living in the continental US were enrolled between 2003 and 2007.
- Blacks and Southeastern residents were oversampled by design.
- Baseline data collection included computer-assisted telephone surveys assessing medical history and health status as well as in-home examinations by trained health care professionals.
- Endpoints are rigorously adjudicated by experts.
- Living participants or proxies are followed up every 6 months by telephone with retrieval of medical record for hospitalizations.
- Deaths are detected by report of kin and through online sources; next of kin are interviewed about the circumstances surrounding the demise of the participant.

## Highlighted Work From Students, Residents, and Fellows

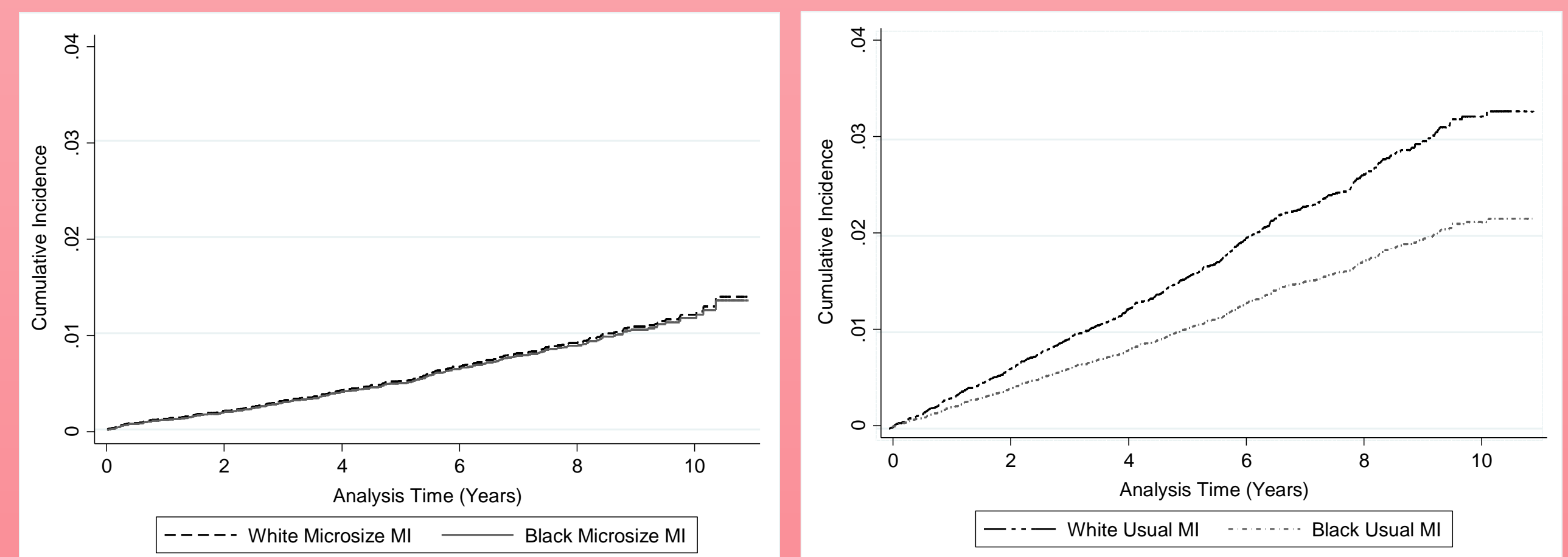


### Risk Factor for 'Microsize' Myocardial Infarction Zaid I. Almarzooq, MD, Chief Medical Resident, et al

**Objective:** To compare risk factors for microsize MI (peak troponin <0.5 µg/L) versus usual MI events in a competing risk analysis.

**Results:** 279 Microsize MI and 612 usual MI events occurred. In cause-specific hazard analyses, age >65 years, diabetes, and urinary albumin:creatinine ratio were associated with higher risk, and being a woman was associated with lower risk of both microsize MI and usual MI. Residence in the Stroke Belt and Buckle regions and current smoking were associated with a higher risk of usual MI but not microsize MI. Black race was associated with a lower risk of usual MI but not microsize MI. Low physical component summary score (PCS) scores were associated with higher risk of microsize MI and to a lesser extent usual MI.

### Fully Adjusted Cumulative Incidence Curves of Microsize MI (Left) and Usual MI (Right) for Blacks and Whites



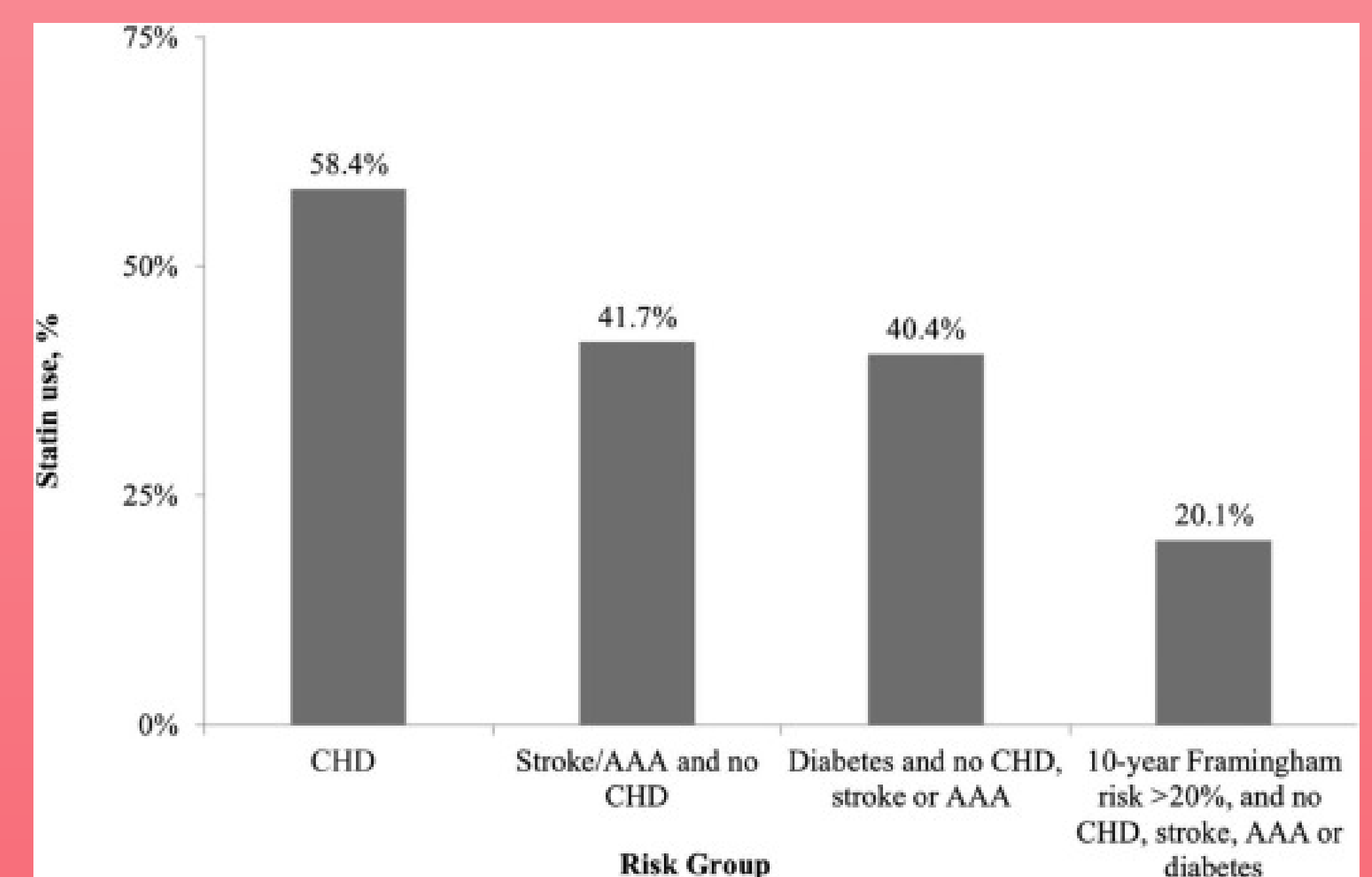
### Statin Underuse and Low Prevalence of LDL-C Control Among U.S. Adults at High Risk of Coronary Heart Disease Chris Gamboa, MPH, WCM Class of 2020, et al.

**Objective:** Statins reduce the risk of CHD in individuals with a history of CHD or risk equivalents. A 10-year CHD risk > 20% is considered a risk equivalent but is frequently not detected. Statin use and low-density lipoprotein cholesterol (LDL-C) control were examined among participants with CHD or risk equivalents.

**Results:** Statins were used by 58.4% of those in the CHD group and 41.7%, 40.4% and 20.1% of those in the stroke/aortic aneurysm, diabetes mellitus, and Framingham risk score > 20% groups, respectively. Among those taking statins, 65.1% had LDL-C < 100 mg/dL, with no difference between the CHD, stroke/aortic aneurysm, or diabetes mellitus groups. However, compared with those in the CHD group, LDL-C < 100 mg/dL was less common among participants in the FRS > 20% group (multivariable adjusted prevalence ratio: 0.72; 95% confidence interval: 0.62-0.85). Results were similar using the 2013 American College of Cardiology/American Heart Association cholesterol treatment guideline. These data suggest that many people with high CHD risk, especially those with an FRS > 20%, do not receive guideline-concordant lipid-lowering therapy and do not achieve an LDL-C < 100 mg/dL.

### Percent of "high-risk" REGARDS participants taking statins.

AAA = abdominal aortic aneurysm; CHD = coronary heart disease.

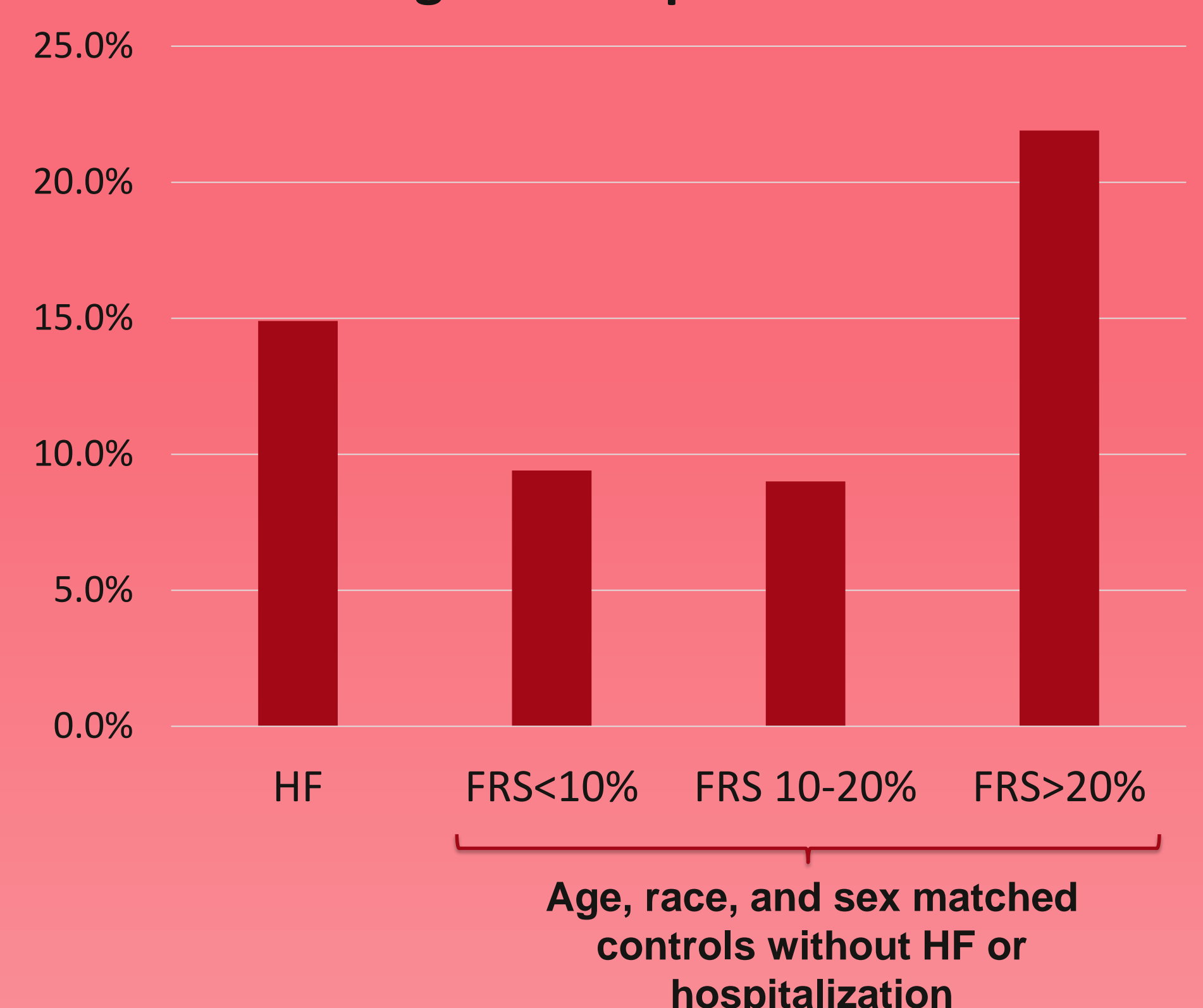


### Cognitive Impairment among Adults with Incident Heart Failure Madeline R. Sterling, MD, MPH, GIM Fellow, et al.

**Background:** Although cognitive impairment is present in as many as 70% of patients with HF, little is known about the prevalence of cognitive impairment early in the course of HF. We examined the prevalence and correlates of cognitive impairment among adults with incident HF.

**Results:** Of the 436 participants with HF included, 14.9% had cognitive impairment as assessed with the Six Item Screener at the time of their first hospitalization for HF. The prevalence of cognitive impairment among participants with incident HF was higher than the prevalence of cognitive impairment among age, race, and sex – matched controls with low Framingham risk score (FRS) (9.4%) but was less than the prevalence of cognitive impairment among controls with high FRS (21.9%). The majority of the high cognitive impairment associated with HF may occur after initial hospitalization, suggesting that study of the trajectory of cognitive impairment over the course of HF is needed.

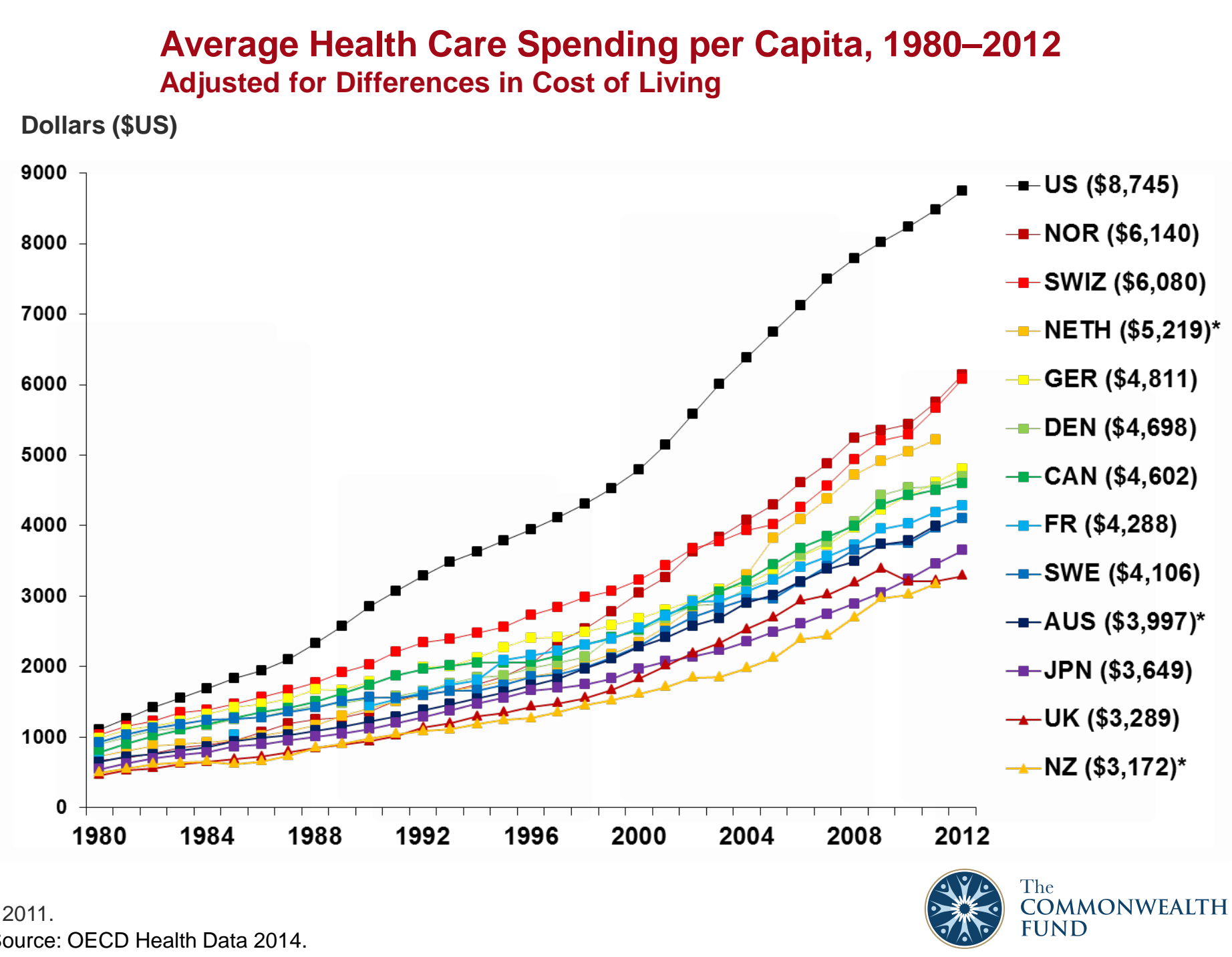
### Cognitive impairment



## Overview

- **Have you ever wondered about the forces outside your exam room that affect the way you deliver care?**
- General internal medicine is a great field for those interested in the way healthcare is organized, delivered, and financed.
- General internal medicine is also a great field for those seeking to evaluate the effectiveness of large-scale interventions designed to improve the quality and value of healthcare broadly.
- Topics within this field include:
  - Models of care delivery, such as the patient-centered medical home
  - Financial incentives, such as pay-for-performance
  - Alternative payment models, such as accountable care organizations and value-based purchasing
  - Health insurance and benefit design
  - Patterns of utilization, including patterns that suggest fragmentation of care
  - Advancing measures of quality and value
- **The organization, delivery, and financing of healthcare is currently changing dramatically, in unprecedented ways with unknown consequences.**
- **More physician-scientists are needed to evaluate the impact of these changes.**

## Background



**Commonwealth Fund: Mirror, Mirror on the Wall, 2017**  
Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>OVERALL RANKING</b>	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

Source: Commonwealth Fund analysis. The COMMONWEALTH FUND

THE NEW ENGLAND JOURNAL OF MEDICINE

SOUNDING BOARD

**Phasing Out Fee-for-Service Payment**  
Steven A. Schroeder, M.D., and William Frish, M.D.,  
for the National Commission on Physician Payment Reform

N ENGL J MED 368:21 NEJM.ORG MAY 23, 2013

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**Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care**  
Sylvia M. Burwell

## Selected Contributions by Our Team

- An intervention to teach physicians how much medications cost to patients out-of-pocket was effective in increasing physician knowledge.



- When providers look up clinical data in electronic health information exchanges (HIEs), hospitalizations, readmissions, and repeat testing decrease, compared to when they do not look up clinical data in the HIEs.



- Measures reported directly and automatically from electronic health records need to be validated before being used for financial incentives.

### Annals of Internal Medicine

- The patient-centered medical home may lead to modest changes in quality and cost – due to the combination of electronic health records and organizational changes.

### Annals of Internal Medicine

- Patients with the most fragmented ambulatory care have twice as many radiology tests as patients with the least fragmented care, regardless of how many chronic conditions they have.



## Methods

- These studies and others like them used data from:
  - Administrative claims (billing data)
  - Physician directories
  - Electronic health records
  - Electronic health information exchanges
  - Surveys
- These studies also used advanced techniques from the fields of epidemiology and biostatistics, including:
  - Time-to-event analyses,
  - Adjustment for potential confounders,
  - Adjustment for clustering and repeated measures, and
  - Sensitivity, specificity and other measures of accuracy,
  - Among others

## Next Steps

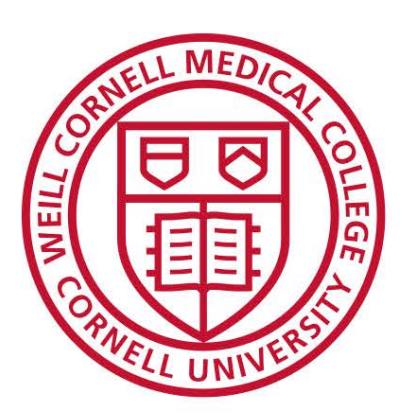
- Get involved in research as a medical student, resident, or junior faculty member.
- Consider a GIM fellowship to learn research methods and healthcare policy.
- Follow the health policy debates by reading newspapers, social media, and data-driven foundation websites.



- For more information, contact Lisa M. Kern, MD, MPH, [lmk2003@med.cornell.edu](mailto:lmk2003@med.cornell.edu).



# #WeAreGIM



### Background

- There is unequivocal evidence that exercise improves health
- ↓ Mortality (20-35%), colon cancer (30-40%), breast cancer (20-80%), type II diabetes (30-50%), coronary artery disease (30-40%), stroke (25-30%), HBP (25-30%)
  - Prevents falls (up to 54%), reduces depression, prevents disability
  - ↑ Cognitive function (executive function, attention, cognitive speed, and memory)

### Program Objectives

1. Develop and test methodologically rigorous, theoretically-derived behavioral approaches to motivate initiation and maintenance of physical activity.
2. Promote implementation of evidence-based physical activity interventions, education, and research.
3. Mentor junior investigators in behavioral medicine research aimed at promotion of healthy physical activity and other lifestyle changes.



### Studies in high-risk population

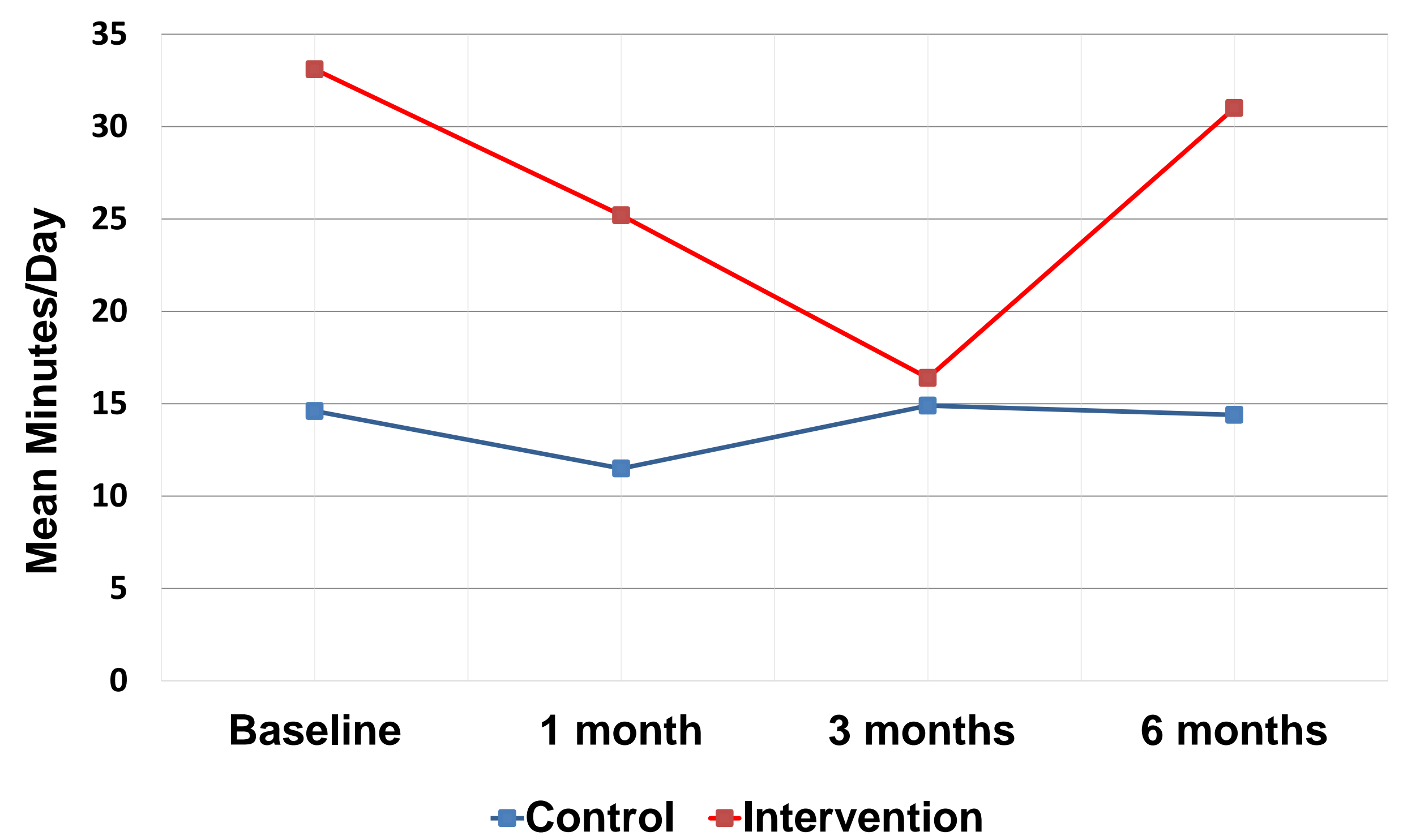
- Older adults with multimorbidity
- Chronic pain
- Cardiovascular disease (post-coronary angioplasty)
- Cancer survivors

### Assessment with FitBits and Accelerometry



### Prospective evaluation

FitBit Moderate-High Intensity Daily Activity Expenditure, p<0.03

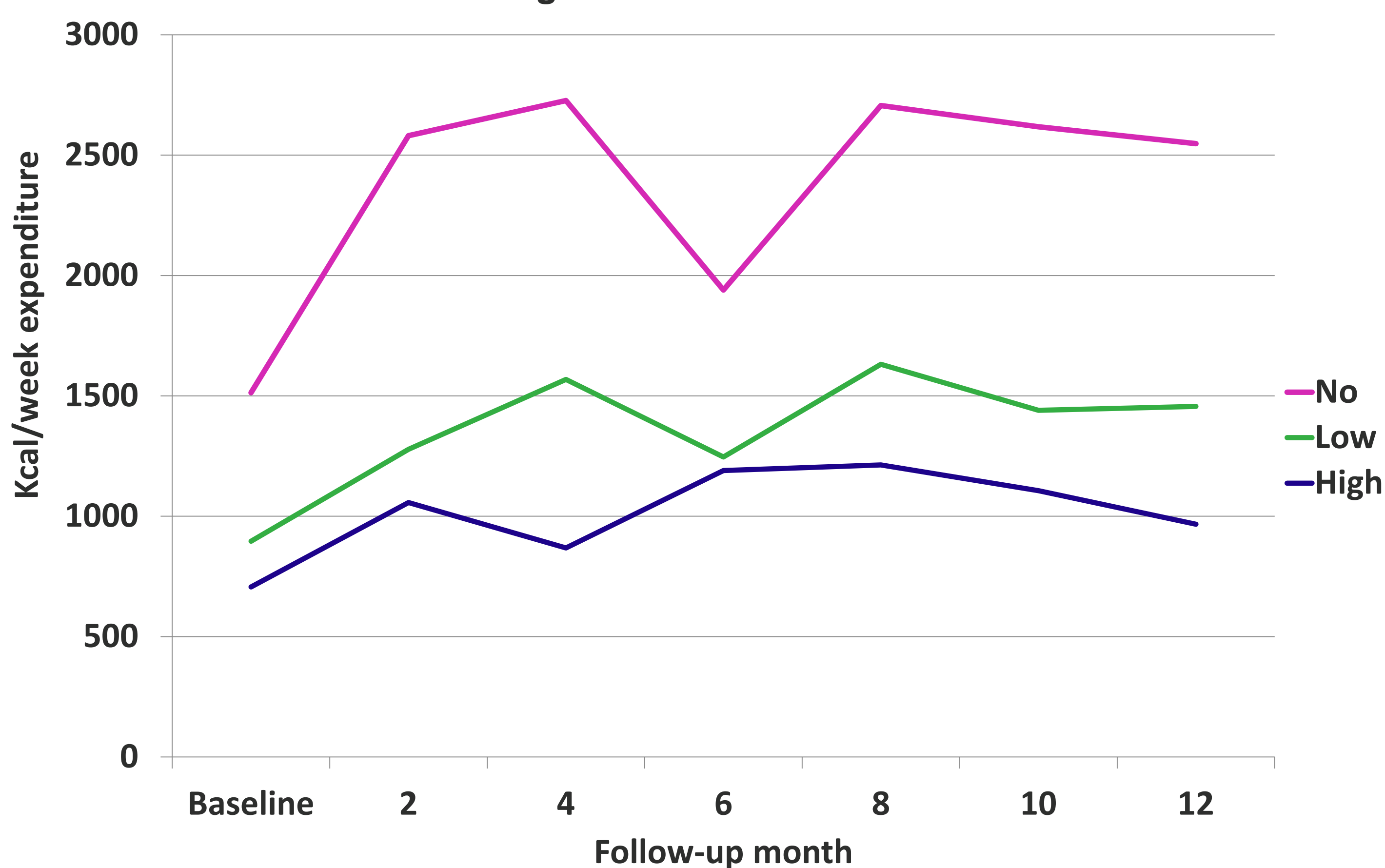


### Funders

- National Institutes of Health (NHLBI, NIA)
- American Federation for Aging Research (AFAR)
- Lung Cancer Research Foundation

### Physical activity levels decrease with age and number of chronic diseases

Physical activity over 12 months in older adults according to chronic disease burden



### Join Us!

Contact Dr. Janey Peterson for additional information  
[jcpeters@med.cornell.edu](mailto:jcpeters@med.cornell.edu)

### Research Objectives

#### Overall description

As a rheumatologist, my goal is to generate new knowledge that will allow patients with arthritis to live and age with dignity. This is an ongoing effort that will be accomplished through the following objectives:

- Develop cardiovascular risk reduction strategies for patients with rheumatoid arthritis (RA), the most common cause of death in these patients
- Identify gaps in quality of care for patients who are disabled with arthritis based on their race and ethnicity.
- Improve disease activity measurement in the clinical setting in order to facilitate shared decision making and better collaboration among physicians caring for a patient with arthritis

#### How does being in GIM allow you to pursue your research objectives?

I have found over the years that working with a diverse group of investigators and clinicians has led to more innovative research questions. Being part of GIM has made my research program more relevant, not only to the rheumatology field, but also to internal medicine.

### Opportunities for Career Development

#### Medical Students and Residents

- Learn about research design, both qualitative (hypothesis generating studies) and quantitative (hypothesis testing studies) research methods
- Collaborate in projects aiming to develop new knowledge regarding challenges facing patients with arthritis and the physicians who treat them
- Opportunities for abstract and manuscript authorship and presentation
- Conduct literature reviews to assist with manuscript and grant preparation

#### Fellows

- Mentoring and guidance in developing fellows' own research projects in either health services research, outcomes or qualitative studies
- Expand their network of investigators locally, with other institutions and investigators at a national level
- Clinical guidance in the care and management of patients with rheumatic diseases
- Opportunities for abstract and manuscript authorship and presentation

#### Faculty

- Collaboration in research questions for patients with arthritis with special attention to cardiovascular risk reduction and quality of care
- Expand research network and opportunity to work with a multidisciplinary team (epidemiologists, biostatisticians, qualitative researchers, cardiologists, internists, orthopedists, and rheumatologists)

### Research Presentation



Dr. Navarro-Millán presenting preliminary results on the project "Patient Reported Outcomes in Rheumatoid Arthritis: electronic data collection tool" at the Rheumatology Research Foundation Investigators Meeting in 2016

### Research Projects

#### Optimization of Hyperlipidemia Management Among Patients with Rheumatoid Arthritis (RA): A Patient-Centered Intervention Development

##### Research Objectives

- **Aim 1:** Identify patient and physician barriers to CVD risk reduction among patients with RA
- **Aim 2:** Develop a patient-centered intervention designed to reduce cardiovascular risk among patients with RA
- **Aim 3:** Pilot test the intervention

##### Current Phase:

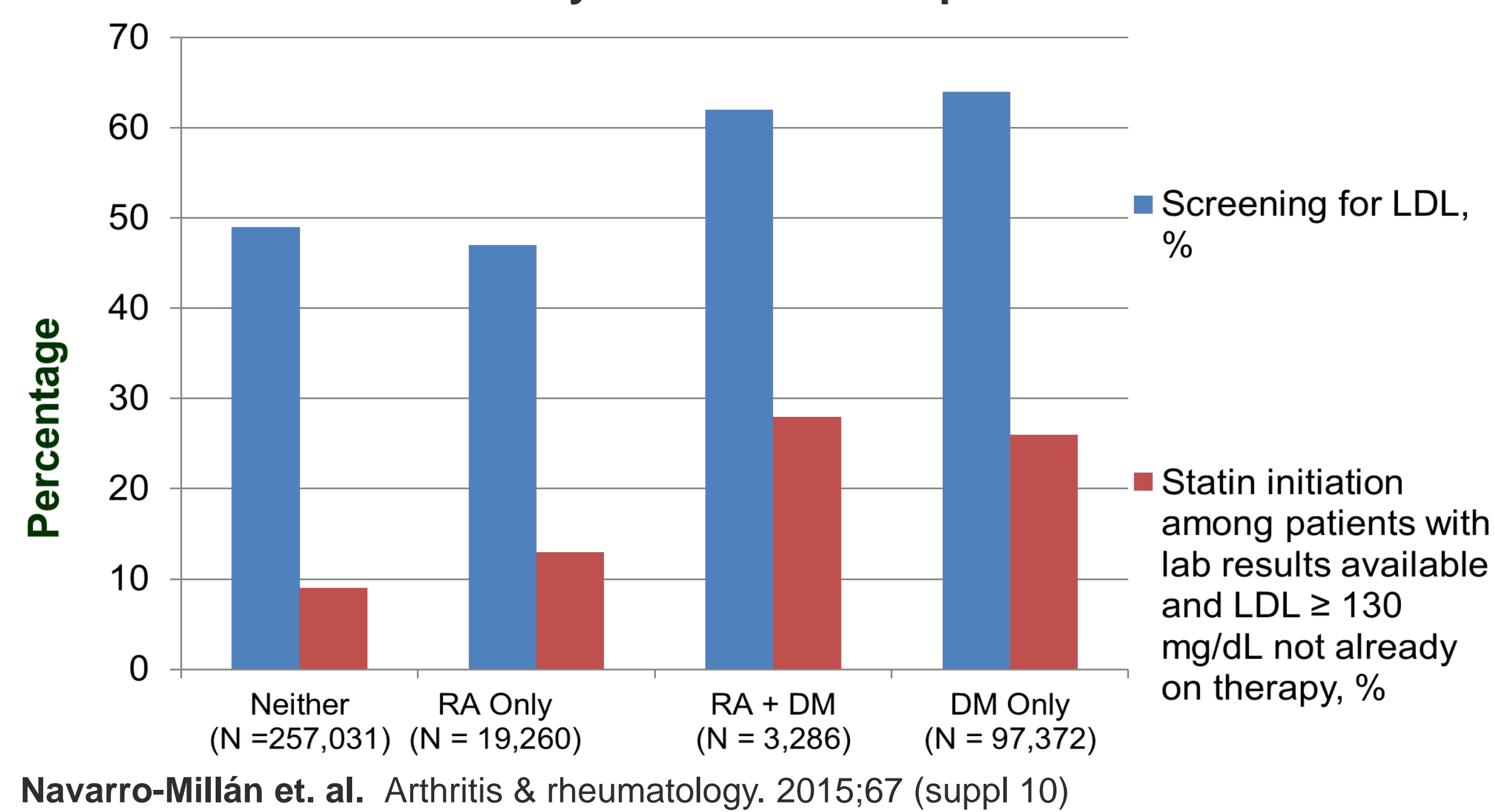
**Aim 1:** Conducted nominal groups with physicians and focus groups with patients

- Abstract accepted to and presented at 2017 Weill Cornell Primary Care Innovations Symposium

**Aim 2:** Initiated development of the patient-centered intervention

**Funding Source:** National Institute of Arthritis Musculoskeletal and Skin Diseases (NIAMS – K23) from the National Institutes of Health

#### Frequency of Lipid Testing and Treatment among Patients with Rheumatoid Arthritis, Diabetes, Both or Neither Condition During 2 years of Follow Up



This graph was generated using data from a mix of private and public insurance claims data. It shows the gap that exists in screening and management of hyperlipidemia among patients with RA compared to patients with diabetes and the general population. This gap is the one that we will be addressing as part of the intervention to reduce cardiovascular risk in patients with RA

#### Patient Reported Outcomes in Rheumatoid Arthritis: electronic data collection tool

##### Research Objectives

- Elicit perspectives of patients with RA regarding perceived barriers and facilitators to collecting data electronically to monitor RA disease activity
- Determine which Patient Reported Outcome (PRO) domains rheumatologists commonly use to assess RA disease activity
- Develop an electronic data collection tool for PRO

**Current Phase:** Data collection, analysis and manuscript preparation.

- Abstracts presented at 2017 ACR/AHRP Annual Meeting, San Diego, US and 2016 European League Against Rheumatism, London, UK

**Funding Source:** Rheumatology Research Foundation

**Next Step:** Expand the utilization of ArthritisPower (an online PRO data collection tool developed as part of this project) to clinical settings (rheumatology, orthopedic and GIM clinics).

#### Quality of Care and Characteristics of Middle-Aged Hispanics Disabled with Arthritis

##### Research Objectives

- Describe the characteristics of individuals younger than 65 years of age with arthritis who receive Medicare due to disability and compare Hispanics to African Americans, Whites, and Native American/Pacific Islanders
- Determine the patterns of health services utilization among Hispanics, African Americans, Whites, and Native American/Pacific Islanders with arthritis who receive Medicare due to disability before age 65
- Determine the factors associated with differences in quality of care between Hispanics, African Americans, Whites, and Native American/Pacific Islanders with arthritis who receive Medicare due to disability before age 65

**Current Phase:** Data Analysis

**Funding Source:** Weill Cornell Primary Care Innovations Seed Grant

### ClinvestiGator is a Web-Based System for Data Collection

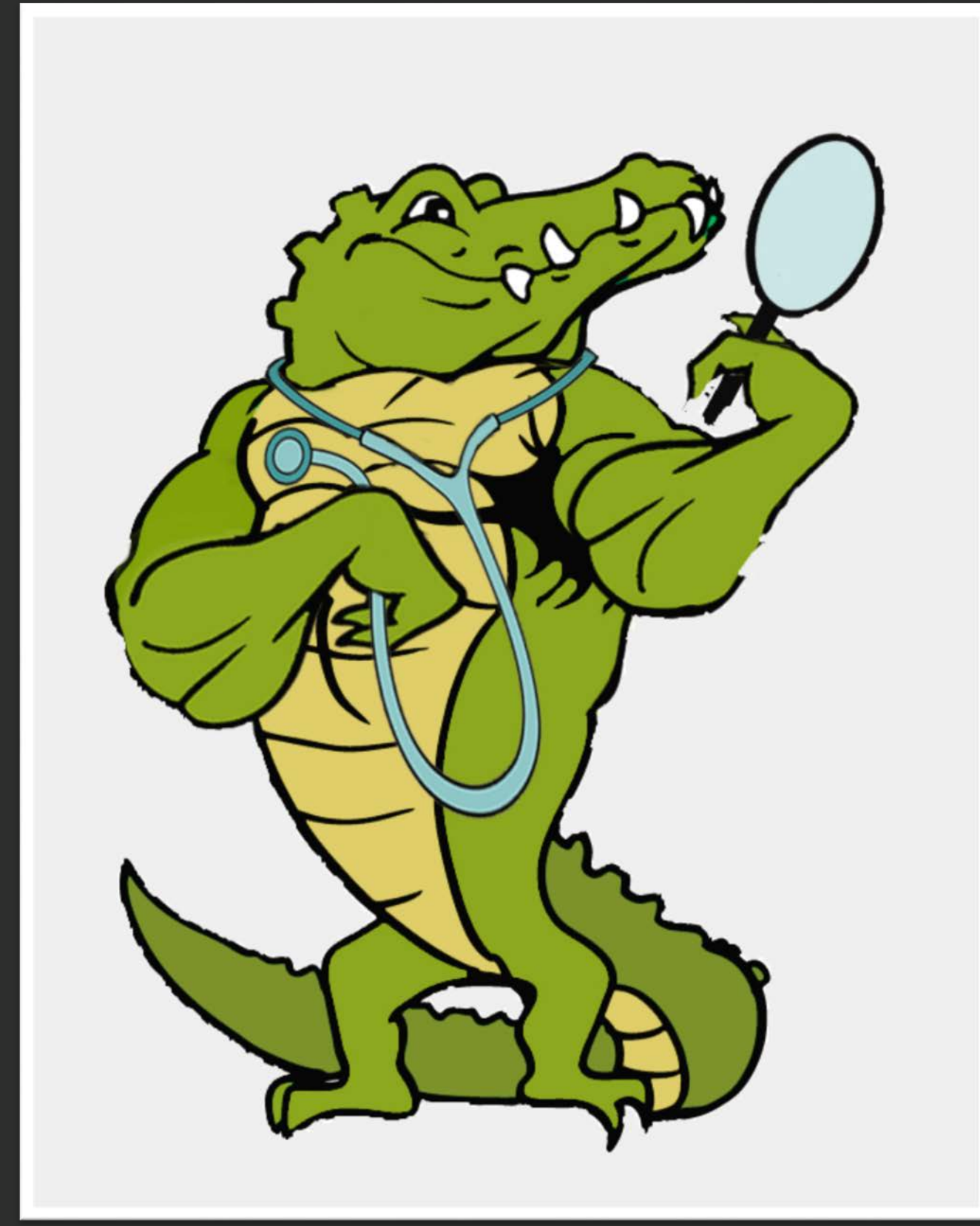
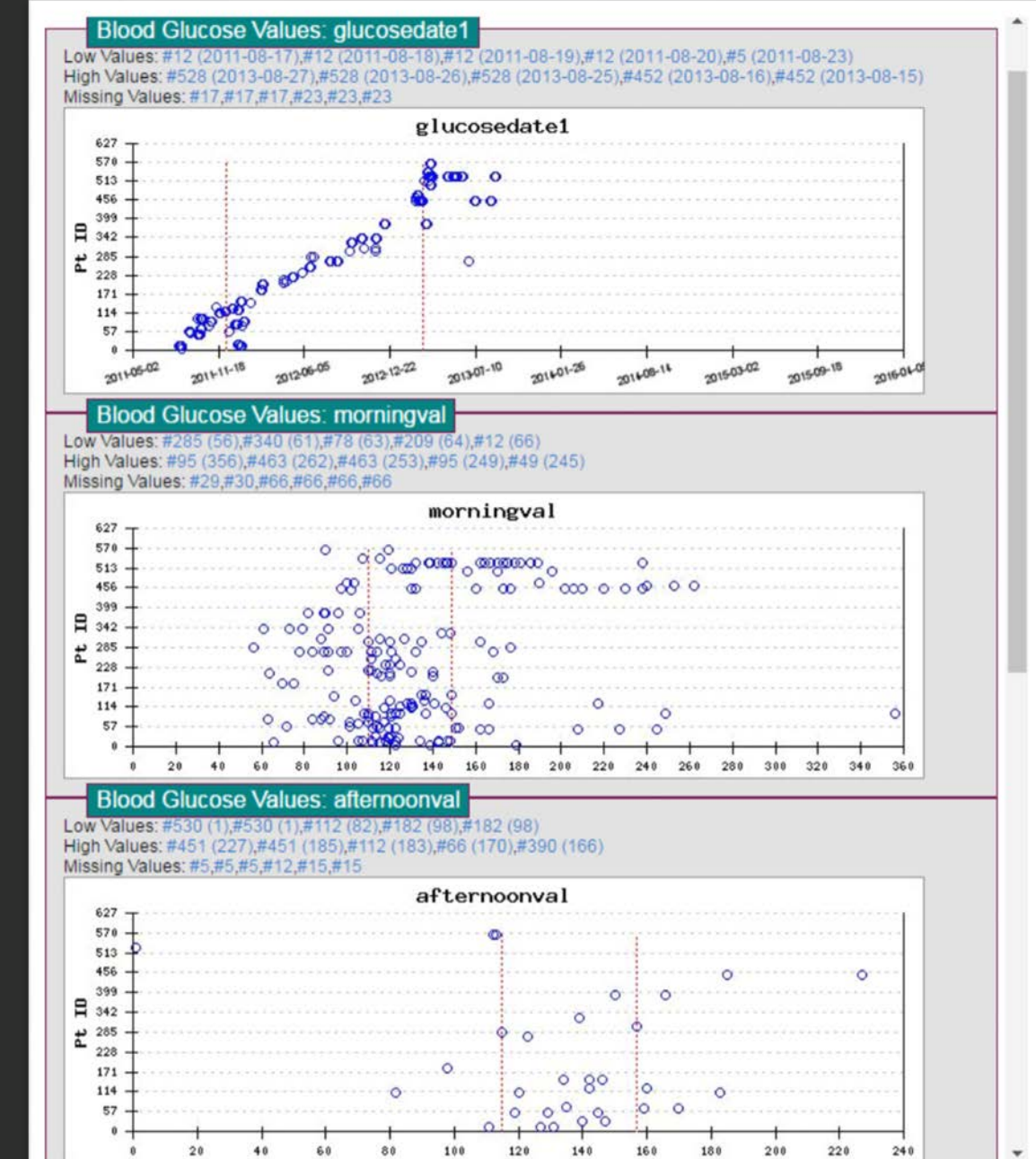
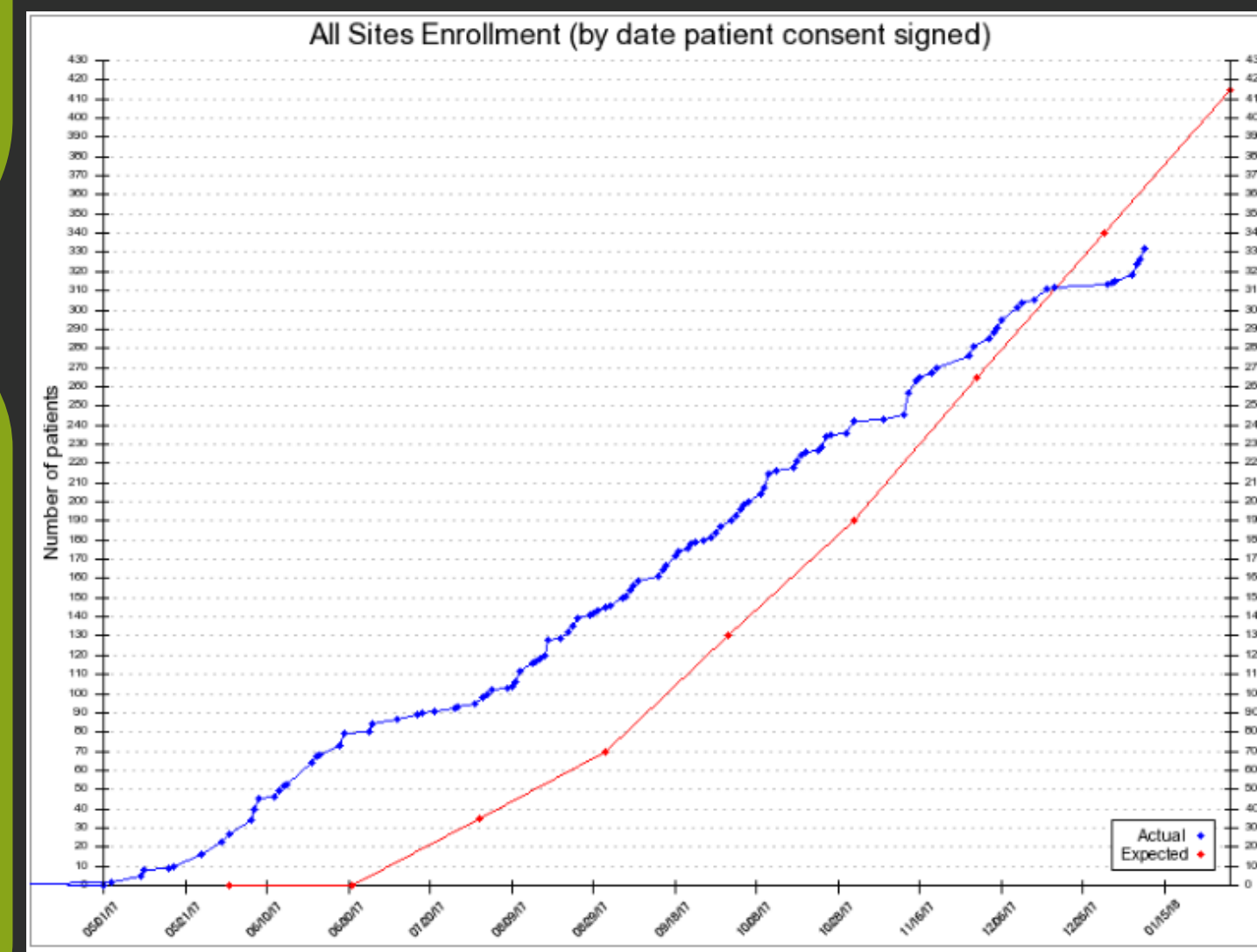
- The researcher defines the data, fields and forms that need to be included
- The ClinvestiGator team creates the web-based version of these forms as part of the database
- Data can be entered by diverse users including research staff and study participants
- Data from other sources can be imported into ClinvestiGator

### ClinvestiGator Facilitates Study Coordination

- Investigators can easily manage the flow of the study protocol
- Study participants can be followed over time
- Study participant status at any point in time can be easily determined
- Time sensitive "To Do" list is maintained by the system
- Information can be easily communicated among members of the study team
- Staff workload and productivity can easily be tracked

### ClinvestiGator is a Powerful Tool for Real-Time Reporting and Analysis

- Reports can identify populations or outcomes of interest
- Reports can be run in real time to analyze variables of interest
- Reports can be run to determine overall study status
- Reports can be run to export data

## Experience – Customizability – Security – User Support

### Experience

- Long history of research and extensive analytic and methodologic experience
- History of creating interfaces and working with multiple constituencies

### Customizability

- Custom widgets
- Custom reports
- Custom dashboard
- Custom dynamic flow control
- Customize validation

### Flexibility

- Ability to modify study in progress
- Data entry can be done by either staff or directly by subjects.

### Outstanding support

- Guidance and strong personal support
- Impressive responsiveness to user's requests / feedback
- Capability of integrating the researcher's clinical logic

### Security

- HIPAA compliant
- Strong encryption
- Strong password rule
- Data recovery mechanism

### Dynamic system

- Real time capability
- Query capability
- Real time scheduling and communication with patients and rest of study team
- Data cleaning in real time

## Feature List

### Security

- User access control
- Role level security
- Task level security
- Multi-site security
- All data entry fully auditable

### Ease of use

- Predefined standard clinical form library
- Branching logic / dynamic forms
- Ability to share forms and data across studies and registries
- Automatic scoring of forms during data entry
- Online rapid design tools
- Field / form / patient level data validation
- Direct study participant based data entry capabilities.
- Track email response rate
- Remind users and study participants to enter data via scheduling algorithms
- Collect data from multiple predefined time points as well as event driven
- Reuse data collection forms for longitudinal data with optional normalization of data on output
- Dynamically adjust form control

### Reporting

- Fully programmable report capability
- Real time reporting
- Automatic scheduled reporting
- Report library

### Others

- Compatible with all browsers
- Support rich set of datatypes including files such as documents, audio, video, images.
- Complex / programmable flow control
- Import / export data to data analysis packages

## Meet the Team



**Dr. James Hollenberg**  
Jim.Hollenberg@clinvestiGator.com



**Martin Gerard**  
Martin.Gerard@clinvestiGator.com



**Lew Perin**  
Lew.Perin@clinvestiGator.com

Clinical research study data is complex. No two studies have exactly the same needs. **ClinvestiGator** provides each investigator with a custom-tailored, secure and reliable data system. Launch your study with a data management system that works for you!

Sign in to **ClinvestiGator**





Stephanie Tang MD, Sydney Katz MD, Alice Tang MD

## Background

Many sub-internship rotations lack a formal curriculum. Students often acquire clinical care skills through observation; however, clinical teachers are varied in their skills and observation may not be the most effective and time-efficient means of teaching these critical skills. Additionally, students often do not receive sufficient timely, specific, and actionable feedback which is critical for skills advancement.

## Objectives

To create a sub-internship curriculum and structured feedback process that ensures students develop the necessary key skills for internship through deliberate practice.

**Table 1.** Skills Identified as Being Very Important for Internship, According to a Survey of Internal Medicine Resident Respondents to the 2013-2014 Internal Medicine In-Training Examination

Skill	Respondents rating each skill as very important*			
	Total, no. (% of 20,484)	PGY1, no. (% of 6,936)	PGY2, no. (% of 7,162)	PGY3, no. (% of 6,386)
Identifying when to seek additional help and expertise	17,753 (89.1)	5,962 (88.4)	6,233 (89.4)	5,558 (89.7)
Prioritizing clinical tasks and managing time efficiently <sup>a</sup>	17,471 (88.0)	6,019 (89.2)	6,045 (87.0)	5,407 (87.7)
Communicating with other providers around care transitions (admission, discharge, ICU transfer)	16,513 (82.6)	5,557 (81.9)	5,789 (82.7)	5,167 (83.2)
Practicing evidence-based medicine at the point of care <sup>b</sup>	15,680 (79.1)	5,454 (81.3)	5,427 (78.1)	4,799 (78.0)
Reflecting on patient care performance and identifying steps for improvement <sup>b</sup>	15,127 (76.6)	5,230 (78.2)	5,219 (75.4)	4,678 (76.2)
Communicating with consultants <sup>b</sup>	15,212 (76.4)	5,293 (78.4)	5,227 (74.9)	4,692 (76.0)
Providing a prioritized/organized signout <sup>b</sup>	14,066 (71.2)	4,626 (69.3)	4,967 (71.6)	4,473 (72.7)
Communicating with nonphysician members of the health care team <sup>b</sup>	13,506 (68.0)	4,545 (67.6)	4,651 (66.8)	4,310 (69.9)
Recognizing burnout/depression in self and others	12,504 (64.1)	4,201 (63.8)	4,365 (63.9)	3,938 (64.7)
Obtaining informed consent	11,780 (59.5)	4,004 (59.6)	4,078 (58.9)	3,698 (60.1)

\* Periera et al. Important Skills for Internship and the Fourth-Year Medical School Courses to Acquire Them: A National Survey of Internal Medicine Residents. Acad Med. 2016 Jun;91(6):821-6.

**Figure 1.** The Collaborative Feedback Worksheet promotes student self-reflection and goal setting, creates a shared mental model for attending and student, and defines a specific action plan to drive progress and accountability. Students complete the “Areas of Improvement” column prior to meeting with the attending and together student and attending develop a specific “Action Plan” for the most prioritized 3 items discussed.

	Areas for Improvement	Action Plan
<b>Medical Knowledge</b> • demonstrates extensive knowledge • explains pathophysiology and rationale for diagnosis and therapy		
<b>Patient Care</b> • <b>Interviewing:</b> elicits accurate, organized and appropriately focused history, including key discriminating features • <b>Physical Exam:</b> performs organized, accurate, and appropriately focused PE, including key discriminating features, and with correct techniques • <b>Diagnostic Testing:</b> appropriately selects and interprets common tests, incorporating skills of EBM and cost-effective principles • <b>Clinical Reasoning:</b> correctly synthesizes clinical data, generates prioritized DDx; able to explain management plan; promptly recognizes changes in patient condition that require urgent/emergent evaluation and management • <b>Execution of Management Plan:</b> accurately enters orders and prescriptions to execute care plan, appropriately communicates urgency to members of care team		
<b>Interpersonal &amp; Communication Skills</b> <b>Patients/Families:</b> • communicates exceptionally well with patients/families; builds excellent rapport, addresses all concerns <b>Health care team:</b> • oral & written communication is highly organized, synthesizes and highlights all pertinent findings; explains clinical reasoning • provides sign out that is effective and efficient, concisely encapsulates patient condition and contingency plans; clarifies crucial points when receiving patient sign out		
<b>Practice-based Learning &amp; Improvement</b> • outstanding initiative to self-reflect and seek and apply feedback • consistently applies EBM to patient care and shares proactively		
<b>Professionalism</b> • Member of health team (integrity, reliability); takes full responsibility for patients; takes initiative and functions as both team member and leader • Patient care: demonstrates exceptional respect and compassion		

## Curriculum

- **Foundations Series** – Interactive workshops to explicitly teach important clinical care skills
- **Collaborative Feedback Worksheet** – A structured tool to maximize the effectiveness of weekly feedback sessions
- **On the Fly Feedback** – Team structure of 1 attending and 1 PA with 1 student maximizes opportunities for specific actionable feedback, mentorship and coaching

WEEK	Monday	Tuesday	Wednesday	Thursday	Friday	Weekend
1	Review Goals & Expectations	<b>Foundations 1: Time Mgt &amp; Prioritization</b>		<b>Foundations 2: Sign-Out</b>	Chairman's Rounds	Weekly Feedback Session
2		<b>Foundations 3: Transitions of Care</b>		<b>Foundations 4: Calling Consults</b>	Chairman's Rounds	Weekly Feedback Session
3		<b>Foundations 5: Resiliency</b>			Chairman's Rounds	Weekly Feedback Session
4			<b>Foundations 6: EBM Presentation</b>		Chairman's Rounds	Weekly Feedback Session

## Results

This rotation hosted 2 students per month during July & Aug 2017. On average each student performed 10 new admissions and cared for 20 patients, with an average daily census of 3-4.

**Table 2.** Student perceptions as reported on Exit Interview Surveys

Rate your level of confidence in starting internship: (1- no confidence, 5- very confident)	Average
Before your sub-internship	2.5
After your sub-internship	4.63

Rate your experience in the following areas: (1- poor, 5 excellent)	Average
Autonomy	5
Supportive coaching & mentorship	5
Observation & feedback	5
Culturally-sensitive patient care	5
Collaboration with outpatient providers	4.5

Rate the following activities in its utility towards your professional growth: (1- least useful, 5- most useful)	Average
Foundations Lectures	
• Time Management & Prioritization	4.25
• Transitions of Care	4.5
• Sign-Out	4.75
• Calling Consults	5
Post-discharge Phone Calls	4
Chair of Medicine Rounds	5
EBM Presentation	4.75
Collaborative feedback form	5

*“On some rotations students feel like an afterthought. But this rotation really felt like it was designed specifically for medical students. Every student should do this rotation, even if they’re not going into medicine.”*

*“It was really great working one-on-one with attendings here and to be able to learn some of the more mature decision-making that sometimes we don’t get to see with the residents.”*

*“Good frequency of feedback and direct teaching from attendings. Great team structure – PA’s are nice and helpful! Great interaction with nurses, social workers, and interpreters! Everything is so great! I’ll miss it here!”*

## Future Directions

- Expand Foundations Curriculum to all Medicine Sub-Internship sites
- Expand the use of the Feedback form to other clerkships
- Increasing the number of students who rotate on the LMH medicine sub-internship rotation

Alice Tang MD, Sydney Katz MD, Rachel Aubuchon PA-C, Gene Liaw PA-C, Vanessa Oliveira PA-C, MPH, Stephanie Tang MD

## Introduction

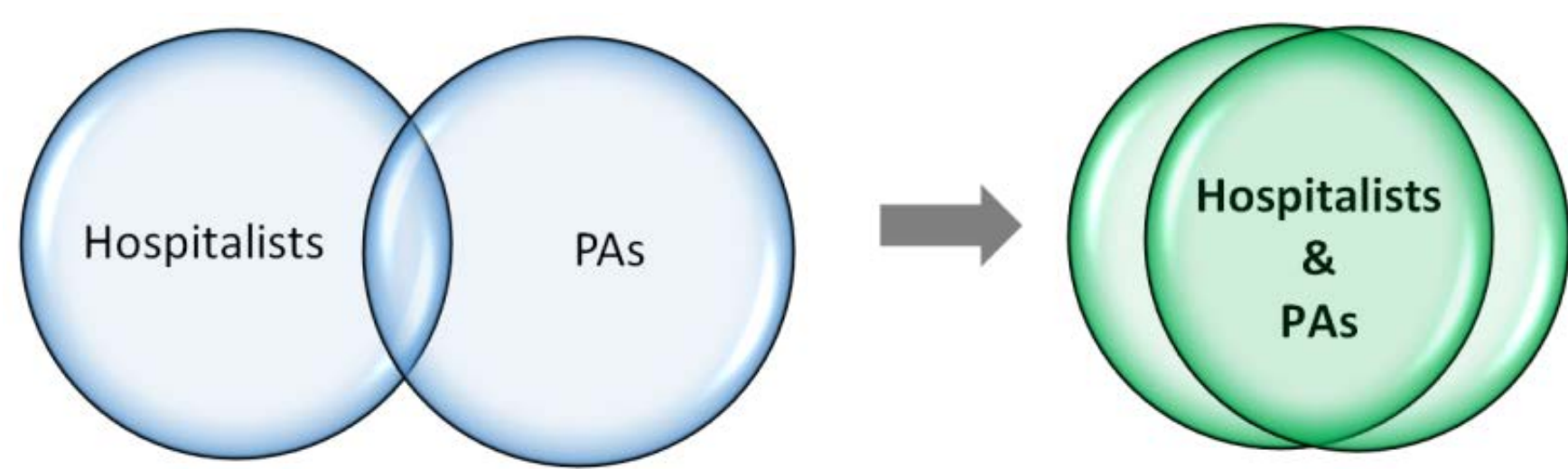
Burnout is a pervasive problem amongst healthcare professionals. Instead of focusing on fixing individual problems which perpetuates negative emotion, our group used an appreciative inquiry (AI) approach to improve job satisfaction and professional development. A PA-Hospitalist Task Force was created to identify strengths in our PA's and hospitalists, recognize potential opportunities for improvement, and harness the group's assets to propose group-wide changes in best practices.

## Objectives

This collaborative working group seeks to enhance the Hospital Medicine experience for Hospitalist & PAs at LMH by:

1. Developing strategies that can be employed to achieve shared goals
2. Fostering collaboration and creativity
3. Serving as a forum for constructive dialogue & development of ideas

## Vision & Goals



## What is our vision for improving the Hospital Medicine experience for Hospitalists & PAs?



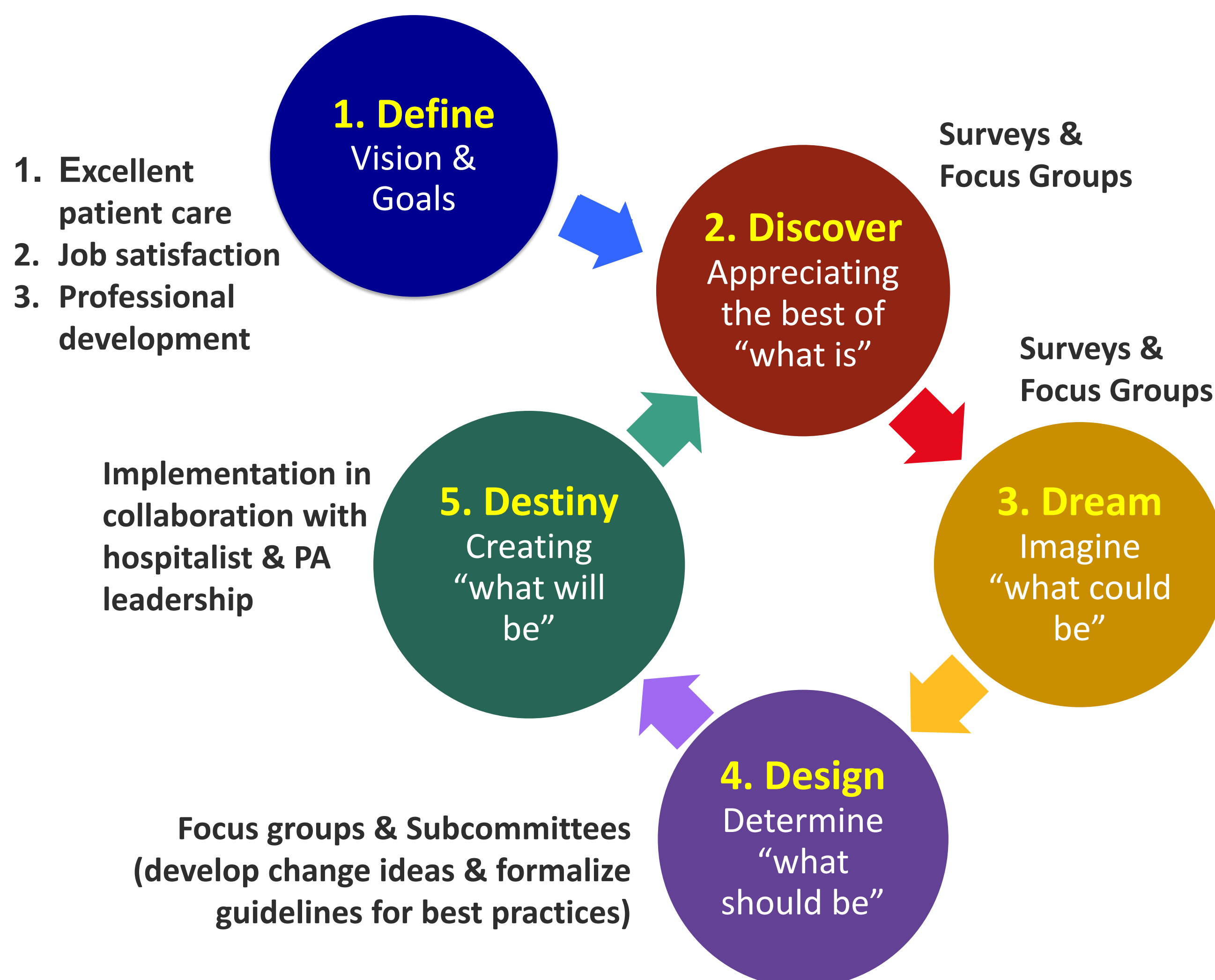
Excellent patient care in an academic setting

Improve hospitalist & PA job satisfaction & retention

- Find meaning in our work
- Feel motivated and inspired

Improve hospitalist & PA professional development

## Appreciative Inquiry 5D Cycle



<https://appreciativeinquiry.champlain.edu>

## Future Directions

- Hold a series of focus groups to provide a forum for members to discuss existing strengths and formulate a set of group-wide "best practices."
- Development of subcommittees to help enact change and track the impact of these changes on our goals.
- Dissemination of process and results to serve as a model for other institutions.

## Survey Results

1. Without being humble, describe what you feel is your greatest strength in your job? How did you develop that skill? How could others learn from what you do to improve their practice?



1. Empathy and Compassion
2. Relationships with patients
3. Communication
4. Positive attitude
5. Organizational skills
6. Efficiency
7. Role model
8. Teaching
9. Team-building

2. Think of one peer PA and one peer hospitalist at LMH that you see as a role model. Describe a time when you felt their behavior was exemplary. How has this impacted your own practice or how could this impact your practice?

"One busy night, he completed 5 or 6 discharge summaries in order to make less work for the day PA.... His teamwork is contagious and motivates me to assist my peers whenever I have a free moment."  
- PA about PA

"She pushed my boundaries. She also gave real time feedback, which was really appreciated. I felt more confident and motivated to do better each time."  
- PA about Hospitalist

"I really admire how (hospitalist) is so curious and does so much self-learning and reading."  
- Hospitalist about Hospitalist

"She has incredible dedication to her patients- she takes true ownership, works diligently to ensure they receive the care they need, and thinks critically about patients which allows for true partnership in determining the management plan."  
- Hospitalist about PA

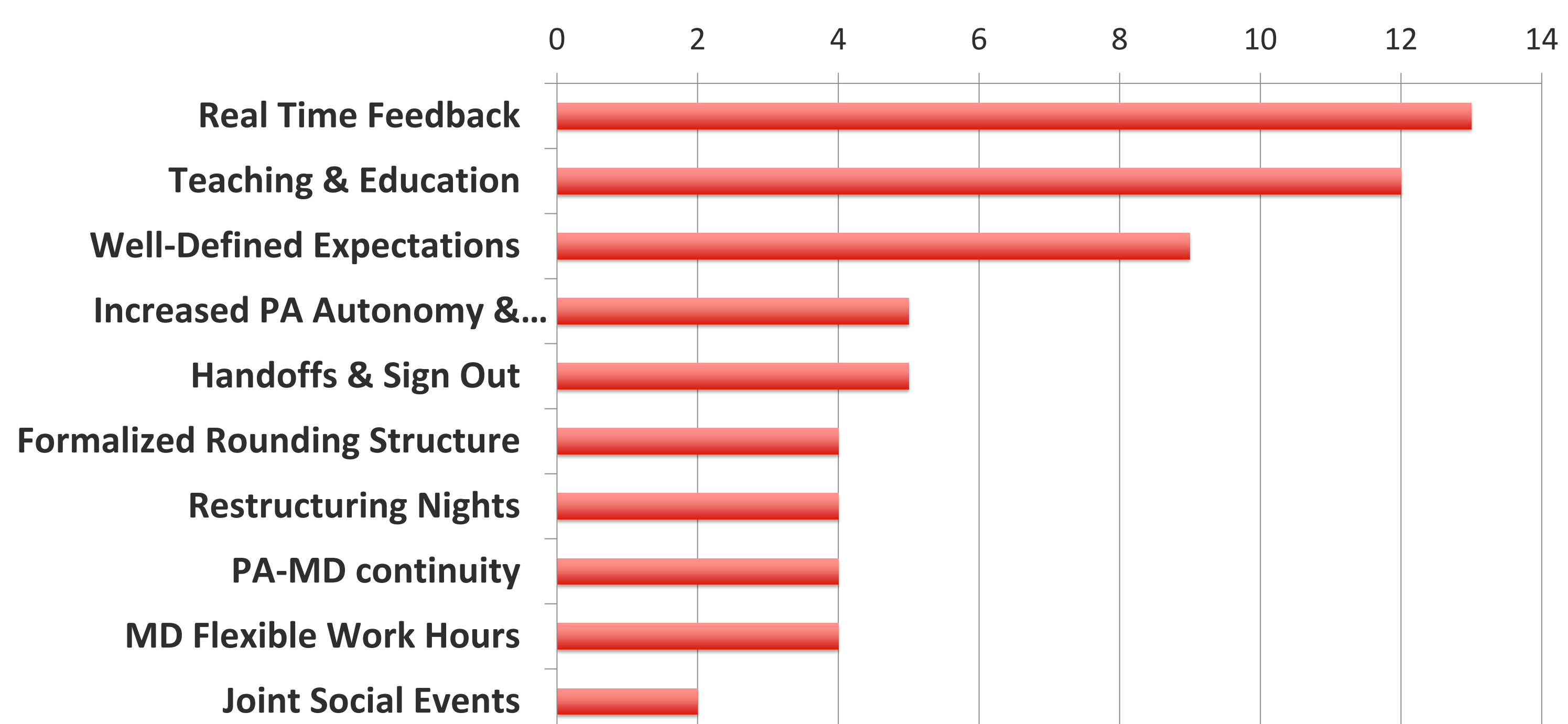
3. Describe the best relationship you've experienced between a PA and a hospitalist. What made this type of collaboration possible?

"The best relationship I've had is when I feel comfortable enough to ask questions [as] an equal partner in the process of providing quality care to our patients. I enjoy when we collaborate, brainstorm, and create a plan that both of us worked together to bring for our patients."  
- PA

"A PA who actively comes up with a plan and leads the interview during every patient encounter is the most rewarding colleague to have as a hospitalist. This is one way in which the rounding experience can be more stimulating, and patient care will certainly improve."  
- Hospitalist

"One of the best relationships I've experienced was where I was given independence. I've rounded with attendings where I could lead conversations. We would discuss our initial plan prior or after seeing the patient. Afterwards we split the work to complete and then we would be able to discuss any topics that were interesting."  
- PA

4. What 3 specific changes to the workflow would have the greatest impact on improving fulfillment, education, and professional development? (MD respondents = 17, PA respondents = 12)



## Acknowledgements:

- ◆ Arthur Evans
- ◆ Cecily Gallup
- ◆ Deanna Joa
- ◆ Vishwas Anand Singh
- ◆ Judy Tung
- ◆ Phyllis Vitale

## Introduction

Transitioning patients efficiently and safely from the emergency department to the inpatient setting can be challenging. ED volumes are increasing, which are resulting in increased Medicine and ICU admissions.

To combat the increased pressures all departments feel, open communication and collaboration among specialties is necessary. In order to provide the highest level of care, and overcome conflicts between the groups, it is important for each group to know the pressures each department faces. This allows for solutions to be devised and improvements in care to occur.

## Objective

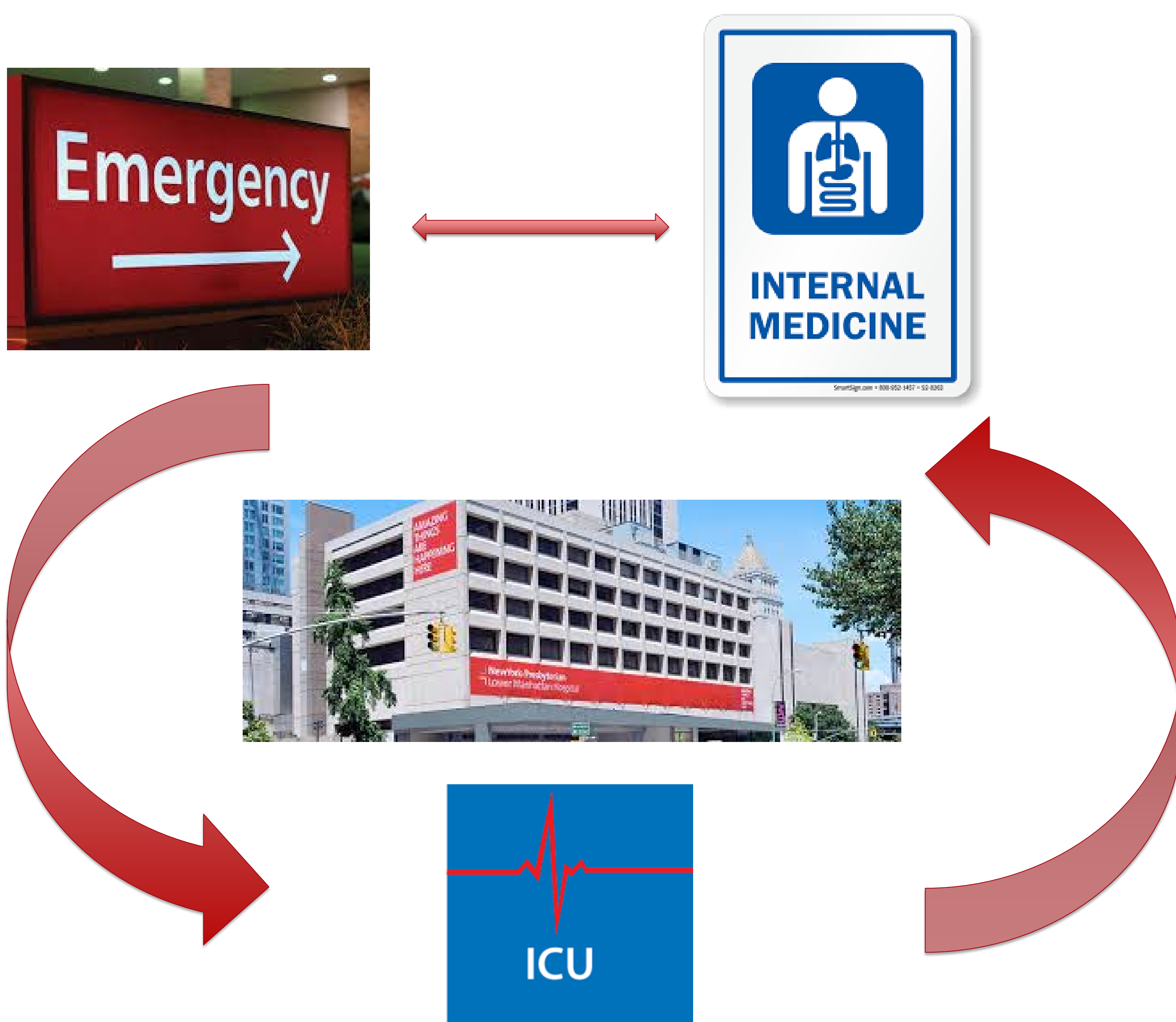
- Increase work-flow productivity
- Safer care for patients with improved transitions of care
- Understand and clarify roles
- Address systems issues
- Improve communication across various departments
- Increase collegiality and satisfaction among providers

## Program Details

ED, IM and ICU meet monthly to review cases brought up by each specialty

### Based on discussions:

1. Individual providers receive feedback if needed
2. Systems issues that caused problem are identified and solutions sought
3. Discrepancies between specialties are addressed quicker than previously
4. Protocols and guidelines are implemented



## Results from work-to-date:

### Eliminating duplicate/inefficient work

Medicine consults are now utilized in cases where ED has the opportunity to discharge the patient directly

- Medicine can give recommendations without having to admit and subsequently discharge the patient (which can be a 2 hour unnecessary process)

Admitting medicine attendings now triage own patients directly with ED attending

- Previously, medicine triage hospitalist called ED for signout on every admission and would subsequently tell the admitting attending the case, creating duplicate work

Encouraging Mobile Heartbeat utilization between ED and Medicine attendings

- Mechanism for attendings to talk quickly to each other for signout. Previously all calls went through main ED line if no extension line was provided, creating delays in care

### Clarifying Roles

Ownership of patients during high risk times for adverse events (like signout times) defined

- Even if patient accepted from ED to Medicine, ED attending will be responsible for patient until Medicine officially changes the Attending of Record in Allscripts
- ED attendings will give brief signout to colleagues even on these "Admit Aware" patients
- Prevents gap in care, especially around signout/high risk times for adverse outcomes until oncoming service can take over care safely

### Improving triage guidelines for transparency among departments

New Ortho admission guidelines created to clearly demarcate for ED how to triage Ortho patients

- Done in collaboration with ED, Medicine, and Ortho services to clarify when patient will be admitted to Medicine vs Ortho

### Currently working on DKA guidelines

Pulmonary assisting with guidelines for Iclot

- To see which patients with a pulmonary embolus should be referred to Iclot. It has been unclear thus far when appropriate to consult

### Collaboration with other specialty services

- GI now better equipped to come in during middle of night/weekends for emergent procedures
- Inviting specialists to meetings to share their input (Surgery, Ortho)

### Acknowledgements:

Judy Tung, MD  
Vishwas Anand Singh, MD  
Cecily Gallup, MD  
Anthony Dajer, MD  
Jeffrey Mayer, MD  
Robert Tanyouye, MD

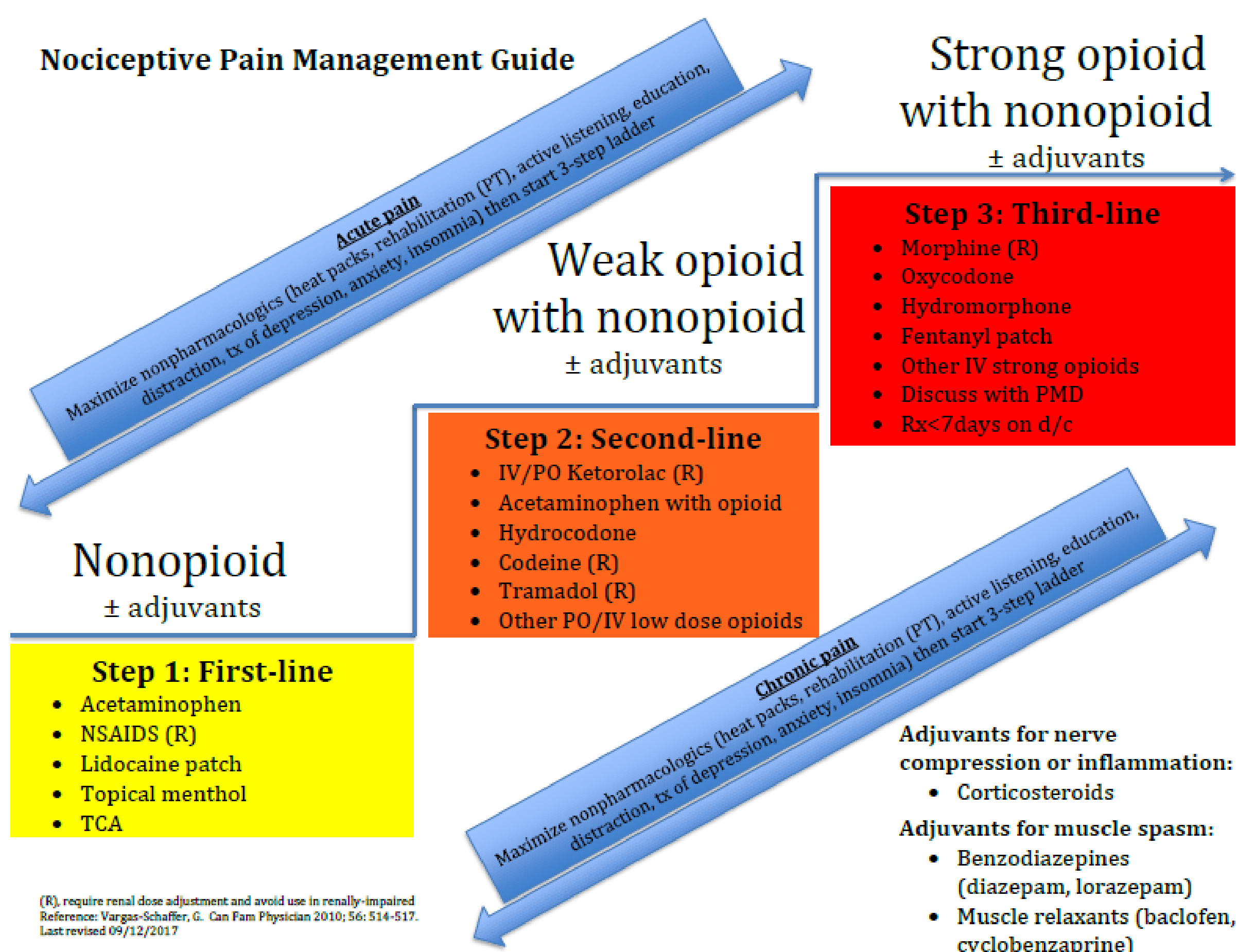
## Introduction

Prescription opioids are at the center of the opioid epidemic as nearly half of all U.S. opioid overdose deaths involve a prescription opioid(1). Part of the Health and Human Services initiative to address the epidemic involves improving opioid prescribing practices(2). Hospitalization is now known to contribute to opioid initiation in millions of adults each year(3,4), thus the in-patient setting has an important role in the opioid epidemic. Current pain management guidelines regarding opioid use can be used to support in-patient providers in improving opioid prescribing(5-10).

The focus of this project is to improve opioid prescribing practices during in-patient admission, specifically to decrease the use of IV high potency opioids as initial and exclusive pain treatment and to reduce overall opioid use in the hospital. We propose to do this through an opioid stewardship program comprised of education regarding hospital specific guidelines and best practices in pain management, PharmD stewardship rounds using a systematic 'Time-out', and patient education materials.

## Research Question

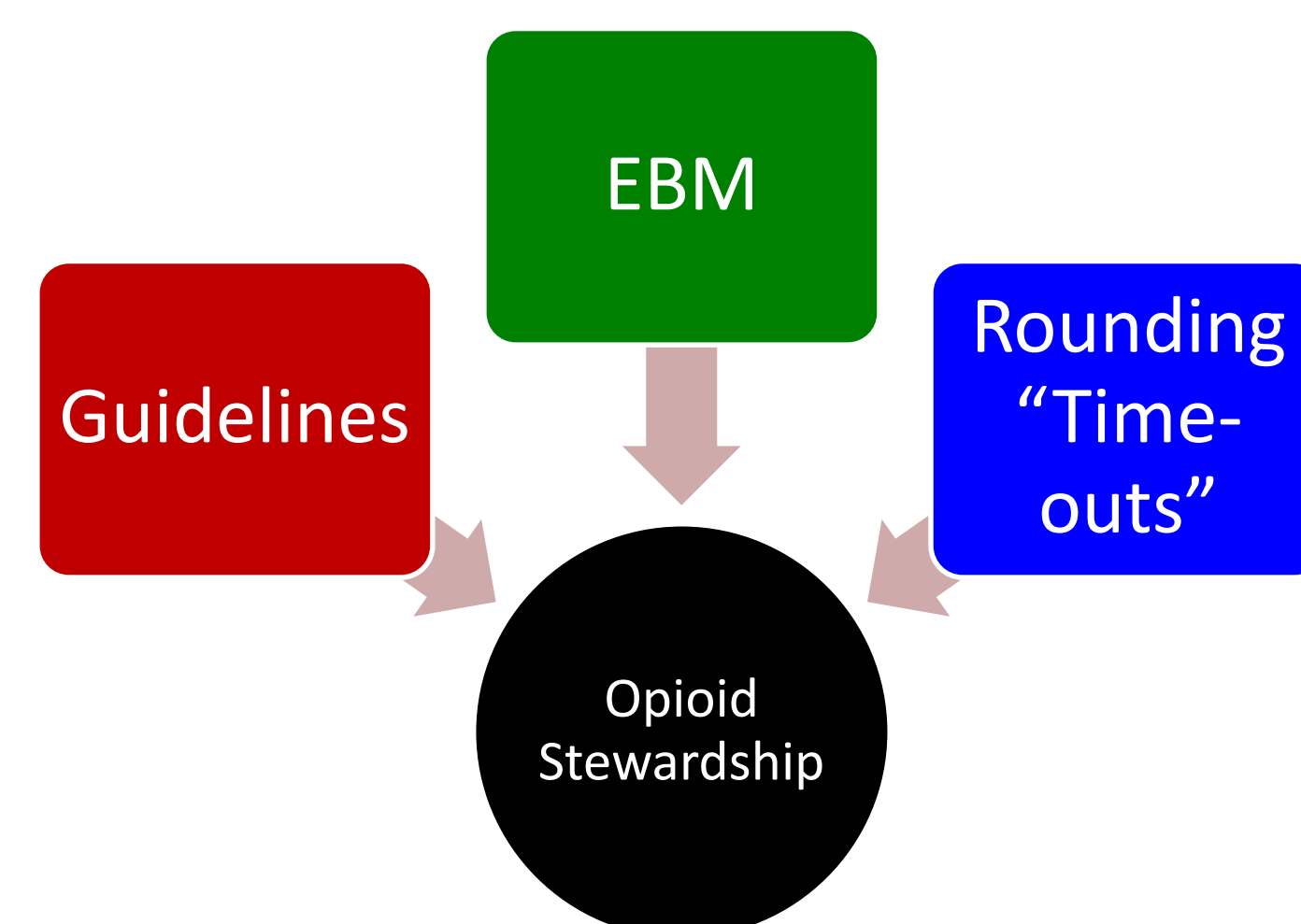
Can the implementation of an opioid stewardship program comprised of education and support tools decrease inappropriate opioid prescribing in the hospital.



## Program Details

The focus of this project is to improve opioid prescribing practices on a hospitalist service through an opioid stewardship program comprised of:

- Formulation of Best Practice opioid management guidelines for LMH using evidence based guidelines, pain management specialist, hospitalist, ED, and PharmD input.
- Education (monthly noon conferences, bi-weekly re-fresher huddles) and increased availability of clinical resources (pain cards, patient education hand-outs) promoting Best Practices in opioid management.
- Systemic 'Time-outs' with PharmD regarding opioid management at daily AM rounds.



## Opportunities for Students & Residents

- Creation of patient and nursing education materials pertaining to opioids and pain management.
- Data collection.

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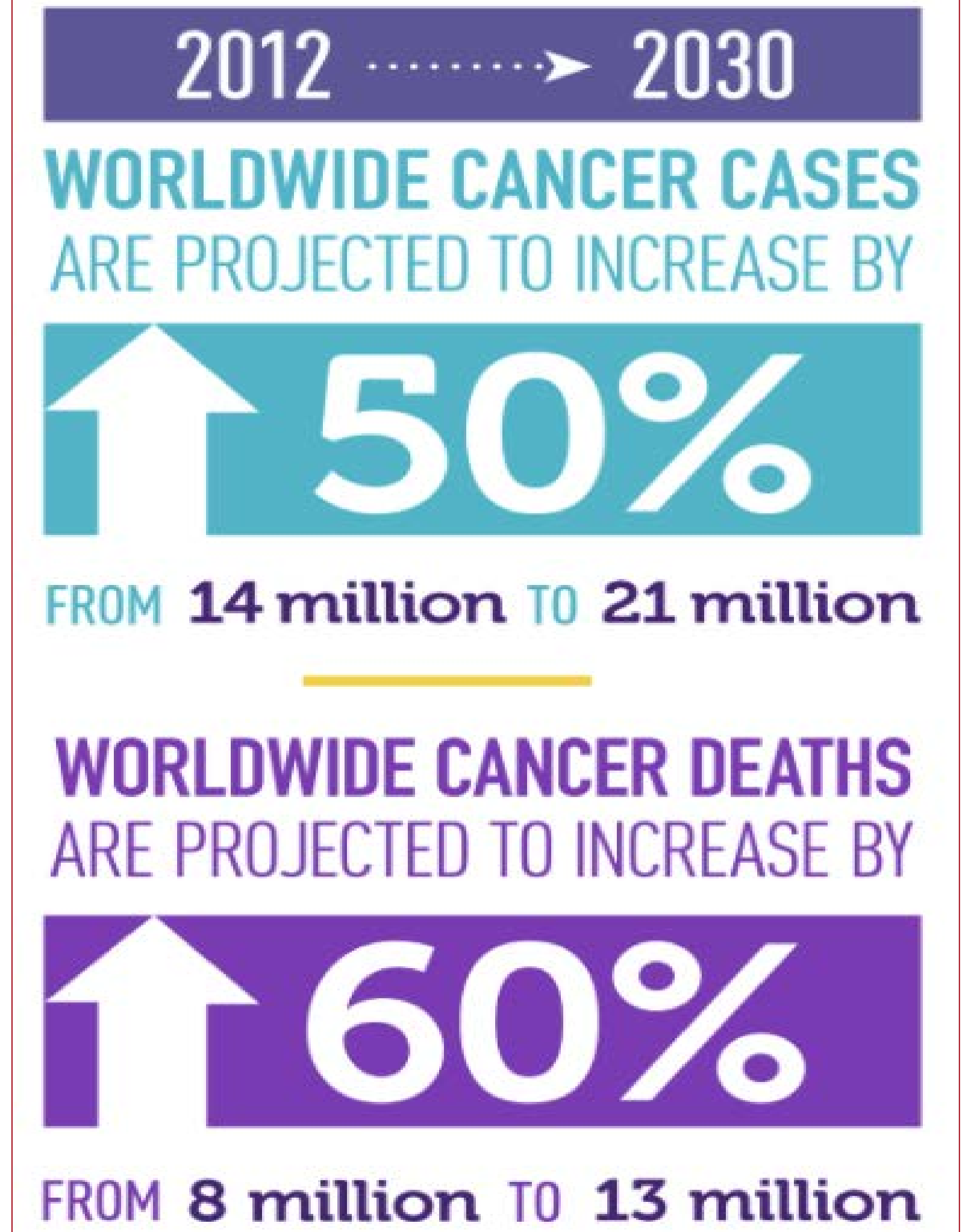
Conflicts of Interest: None

Acknowledgements: Grace Shyh PharmD, Ajay Suman MD, Ara Lee MD, Deanna Jannat-Khah Dr PH

## Defining Health Disparities

Agency	Term used	Definition
U.S. Department Health and Human Services <sup>a,b</sup>	Health disparities	<i>Healthy People 2010</i> : differences in the incidence, prevalence, mortality and burden of diseases, and other adverse health conditions that exist among specific population groups in the United States
	Health disparity	<i>Healthy People 2020</i> : a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage
	Health equity	<i>Health People 2020</i> : attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities
U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) <sup>c</sup>	Health care disparities	Differences or gaps in care experienced by one population compared with another ... within the scope of health care delivery, these disparities may be due to differences in access to care, provider biases, poor provider-patient communication, poor health literacy, or other factors
Institute of Medicine (IOM) <sup>d</sup>	Disparities	Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention
U.S. National Institutes of Health National Cancer Institute (NCI) <sup>e</sup>	Cancer health disparities	Differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States
World Health Organization (WHO) <sup>f</sup>	Health inequities	Avoidable inequalities in health between groups of people within countries and between countries that arise from inequalities within and between societies

## Burden of Cancer



## Examples of Cancer Health Disparities



### BREAST CANCER

African American women are nearly twice as likely as white women to be diagnosed with triple-negative breast cancer and are much more likely than white women to die from breast cancer.



### KIDNEY CANCER

The highest rates of kidney cancer cases and death in the United States occur among American Indians/Alaska Natives.



### LIVER CANCER

Rates of liver cancer are higher among American Indians/Alaska Natives and Asian and Pacific Islanders than other racial/ethnic groups.



### PROSTATE CANCER

African American men are more than twice as likely as white men to die from prostate cancer.



### CERVICAL CANCER

Women in rural areas are twice as likely to die from cervical cancer as women in more urban areas.



### MULTIPLE MYELOMA

African Americans are twice as likely as whites to be diagnosed with and die from multiple myeloma.

## Documented Risk Factors



Genetic and Biological Factors



Health Care Access



Socioeconomic Factors



Chemical and Physical Exposures



Diet



Physical Inactivity

## Implications for Primary Care

- 16 million cancer survivors in the United States
- Cardiovascular disease is the leading cause of death among cancer survivors
- >70% of cancer patients have co-occurring chronic conditions such as diabetes and hypertension
- >30% of cancer survivors are obese, which increases risk of cancer recurrence and mortality

## GIM Faculty Working in This Area

- Laura Pinheiro, PhD, MPH
- Erica Phillips Caesar, MD, MS

## Opportunities for Collaboration

### Center for Health Equity

- Community Engagement Core

### Sandra and Edward Meyer Cancer Center

- New York Presbyterian Brooklyn Methodist
- New York Presbyterian Queens

### New York Department of Health

- Breast Cancer Screening Initiative (2017-2020)
  - Ongoing at WCIMA
  - Patient navigation services
  - Increasing mammography uptake among vulnerable women in New York

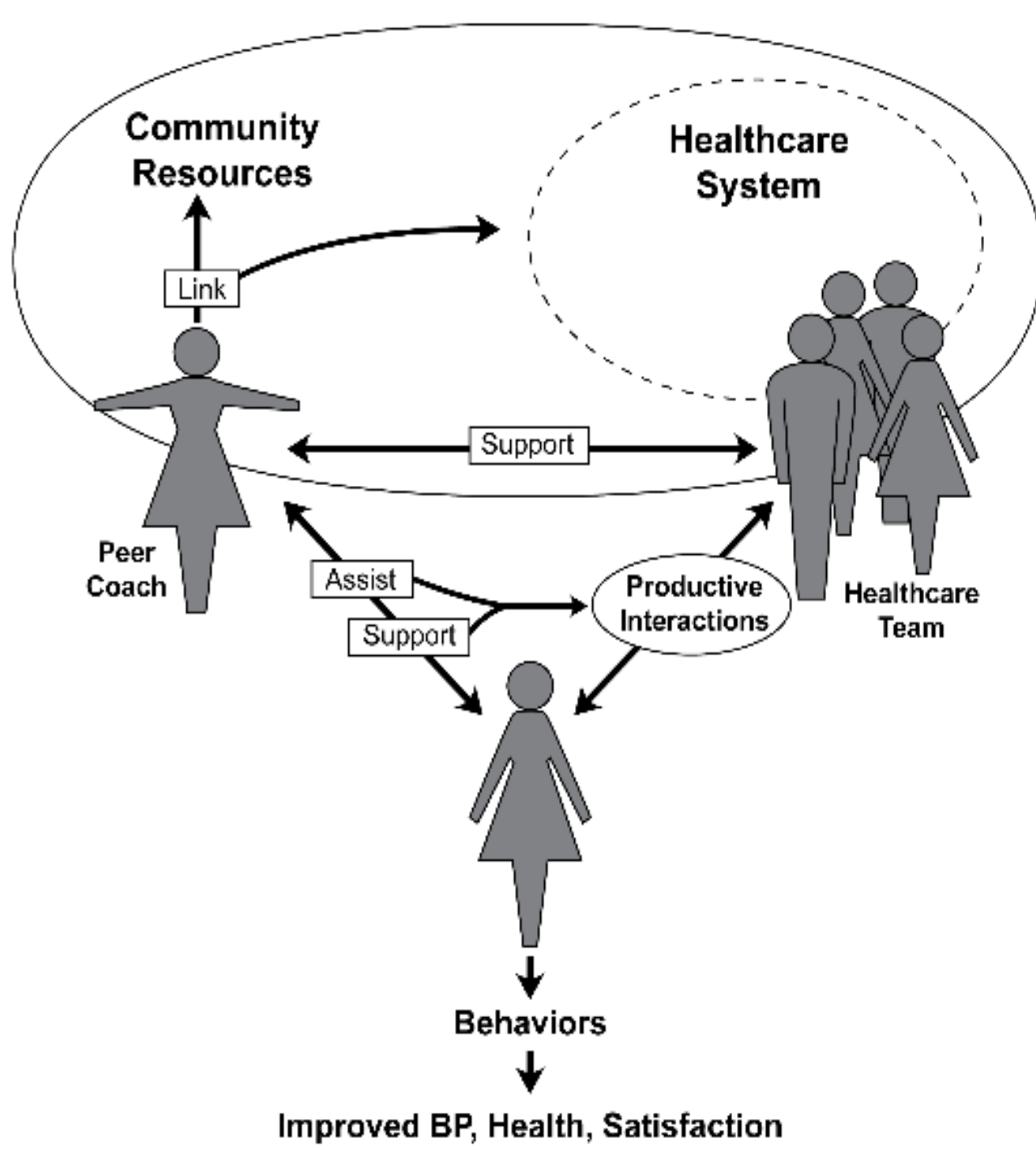
## Introduction

The Southeast is home to rural-dwelling African Americans who live in some of the poorest counties in the US.

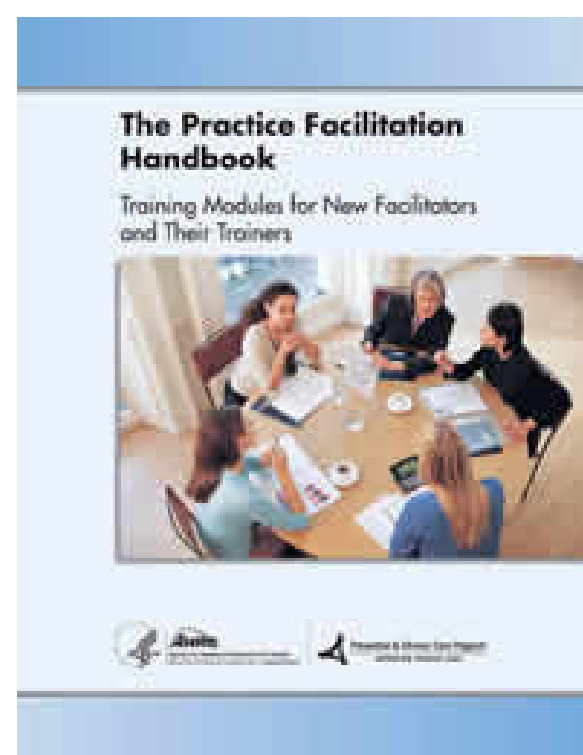


The burden of chronic disease in these counties is enormous, while the availability of healthcare resources is scant.

Community members can overcome some of these resources constraints. We have conducted a series of trials engaging community members as change agents in the form of “peer coaches”. In our work, peer coaches themselves have a chronic medical condition that requires self-management. They receive training and work with clients over the phone to improve self-management practices, including taking medications, reporting side effects or cost issues, and self-monitoring.



In addition, many primary care practices in this region lack training in quality improvement. Practice facilitation is an intervention wherein trained individuals work with a practice to teach quality improvement and help the practice use its data to track progress.



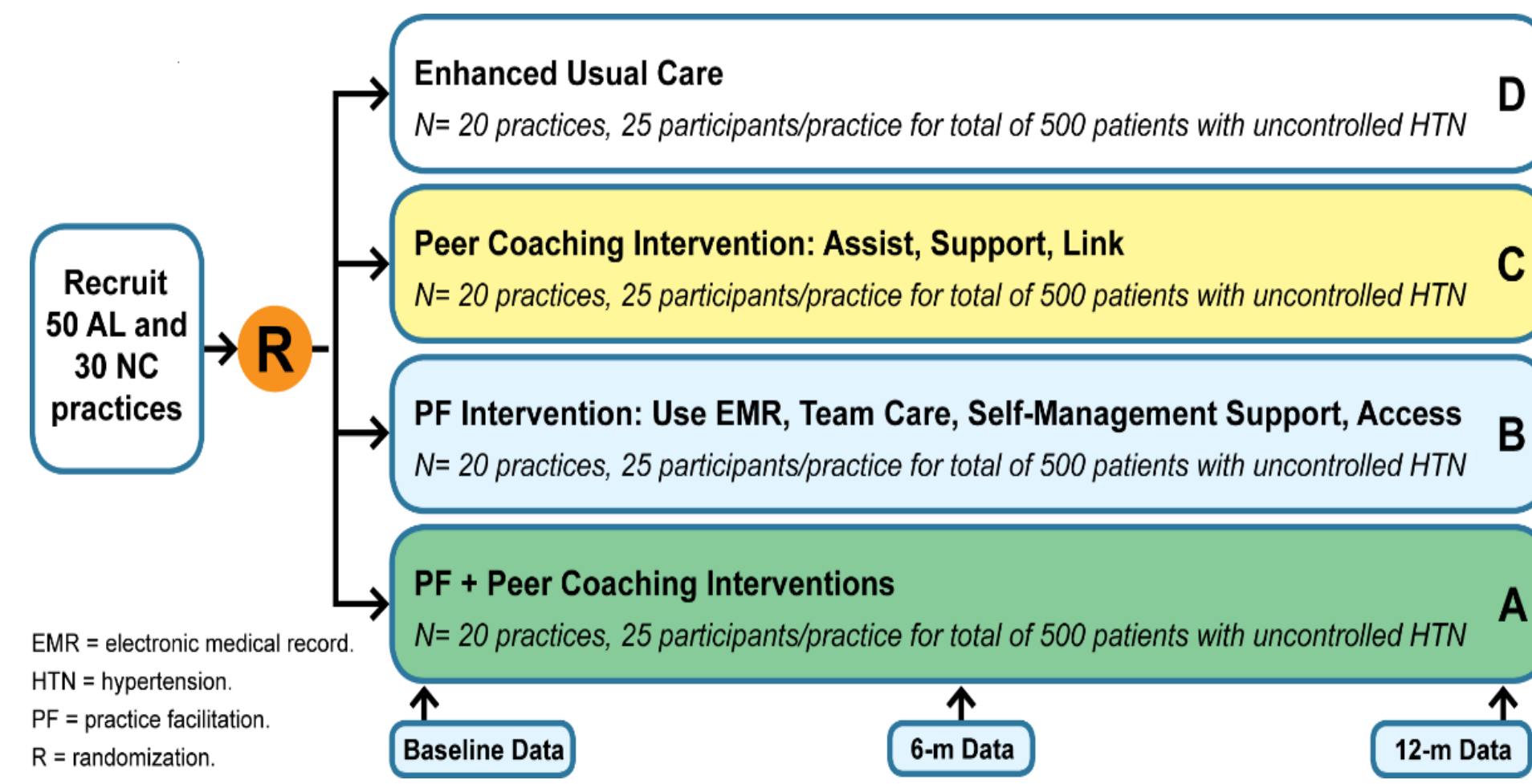
Neither peer coaching, an inherently *relationship-focused* intervention, nor practice facilitation, a *structural process improvement* intervention, have been tested in the Black Belt region of the US Southeast.

## Hypothesis

This trial tests the hypothesis that peer coaching or practice facilitation, or both, will improve blood pressure control more than enhanced usual care.

## Program Details

**Study design:** 4-arm, randomized, controlled pragmatic trial.

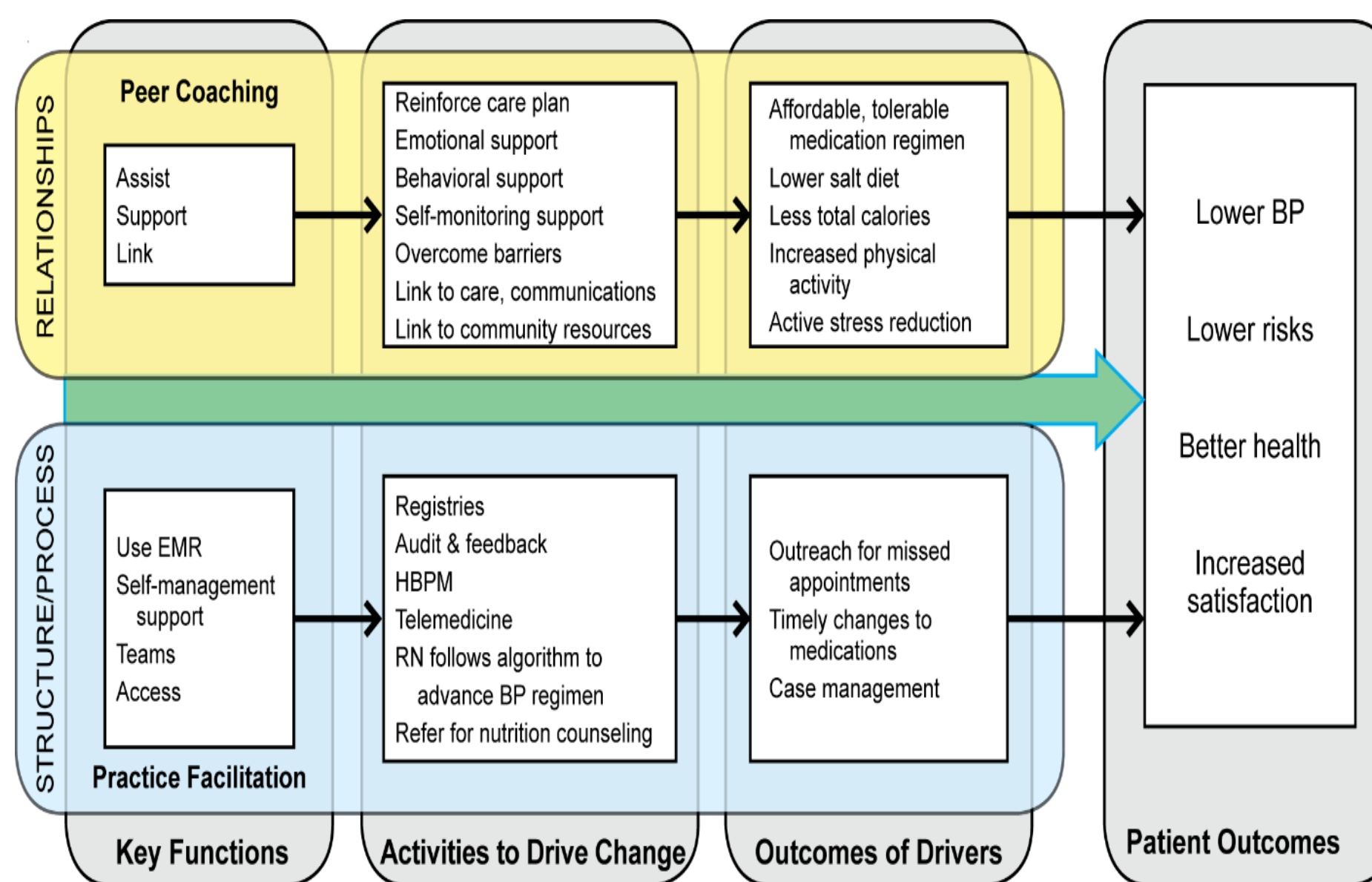


We are engaging 80 primary care practices in rural Alabama and North Carolina.

At each practice, we are enrolling 25 African Americans with persistently uncontrolled hypertension (systolic BP >140 over the previous year plus BP ≥140/90 on enrollment day). We will eventually enroll 2000 participants.

Each practice is randomized to peer coaching, practice facilitation, both, or enhanced usual care.

### Conceptual framework for the study



### Enhanced usual care

All practices receive enhanced usual care: 25 BP monitors, a laptop computer, the Patient Activated Learning System as a patient education tool.



### Peer coaching intervention

Weekly sessions for 8 weeks covering hypertension, medications, healthy eating, physical activity, stress, social support, and the doctor’s visit.

Thereafter monthly contact with boosters if needed

### Practice facilitation intervention

Monthly in-person visits and in-between phone conferences to implement a QI activity in 4 key areas: clinical information systems, team management, standardized care processes, and self-management support.

## Opportunities for Students and Residents

### Community-based trial research assistant

**Anthony Finch, WCM Class of 2019**

Anthony traveled to Alabama to work as a research assistant with the AL-based Team. He traveled to the Black Belt and interacted with trial participants and community-based research team members.



### Opportunities:

The trial will continue through mid-2022.

#### (1) Participate as a research team member

- Learn how large clinical trials are run
- Experience the unexpected twists and turns that characterize pragmatic trials and implementation science
- Screen prospective participants by phone. We need personable, sensitive individuals who can engage residents of this area, who are often shy of academics and doctors.
- Conduct follow-up retention calls.
- Assist the team with preparation of materials for meetings.
- Attend team meetings and participate as a full member of the team.

#### (2) Design and carry out your own research project. Student-led research projects in our past trials include:

- Focus groups of patients to understand their perceptions of generic medications
- A survey of trial participants to assess the prevalence of the beliefs that emerged from the focus groups
- A survey of primary care physicians that assessed primary care physician knowledge of beliefs about generic medications

#### (3) Join an ongoing research project

- Perspectives of practice staff on the peer coaching intervention
- Perspectives of practice facilitators and barriers to successful intervention delivery
- Perspectives of patients enrolled in the trial and their thoughts on working with a peer coach
- Characteristics of primary care practices in the Alabama and North Carolina Black Belt region

**Conflicts of interest:** None

**Funding:** Patient Centered Outcomes Research Institute and National Heart Lung and Blood Institute, Weill Cornell Medicine institutional funds

## Introduction



Dr. Oliver Fein is Professor of Clinical Medicine and Professor of Clinical Healthcare Policy and Research, and Associate Dean for Affiliations at the Weill Cornell Medical College. He is a practicing general internist with experience in health policy and a commitment to access to care for vulnerable populations, health system reform and domestic and global health policy education. He has engaged health policy at the following venues

### Weill Cornell Medical College

- Undergraduate medical education: lectures on the social responsibility of the Academic Health Center.
- Co-Director of the David Rogers Health Policy Colloquium: a weekly forum for the presentation of a wide variety of contemporary health policy issues, where students, faculty, other health professionals and administrators can exchange points of view.
- Faculty advisor to student groups interested in health policy, e.g. SNaHP (Students for a National Health Program); WCCHR (Weill Cornell Center for Human Rights).



## Program Details

### NewYork-Presbyterian Hospital

- Organizer of a course for all first year internal medicine residents entitled: Perspectives on the Changing Health Care System.

### Society for General Internal Medicine (SGIM)

- Member of the Health Policy Committee, clinical practice sub-committee
- Coordinator of the Social Responsibility Interest Group
- Organizer of a Symposium for the 2018 Annual SGIM meeting entitled: "Access for All requires a Single-Payer National Health Plan."
- Member of selection committee: David Calkins Award in Health Policy Advocacy.

### Physicians for a National Health Program (PNHP)

- Chair of the Board of the NY-Metro Chapter of PNHP.
- Member of the national executive committee of PNHP.
- Representative of PNHP to the Board of Healthcare-NOW.

### American Public Health Association (APHA)

- Member and past chair of the Medical Care Section
- Member of the editorial board of the journal: Medical Care
- Founder of the Public Health Congressional Fellows Program



## Opportunities for Students & Residents

- Advisory Board Member of the Rogers Colloquium
- PNHP-NY Metro Chapter and Weill Cornell Student Chapter

**For more information contact:**  
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### Background

- Increasingly, the importance of health equity is gaining awareness throughout every level of the healthcare system.
- As Hospitalists, we bare witness to the most severe downstream effects of health disparities in our community.
- Serving our patients involves taking a close look at the root cause of disease and health disparities long before a patient enters the hospital.

### Educational Goals

- Increase opportunities for Medical Students to explore Health disparities
  - Support Hospitalist engagement in exploring and respecting social determinants of health
- Building connections between inpatient LMH teams and community organizations

### Concept

- As Hospitalist, we witness first hand large disparities in health outcomes for many marginalized and excluded populations**
- Students add significant value to the clinical team as they explore various aspects of the patient experience both in and out of the hospital setting.**
- Team will connect specific patient experiences to relevant evidence in health disparities research and explore active community programs.**

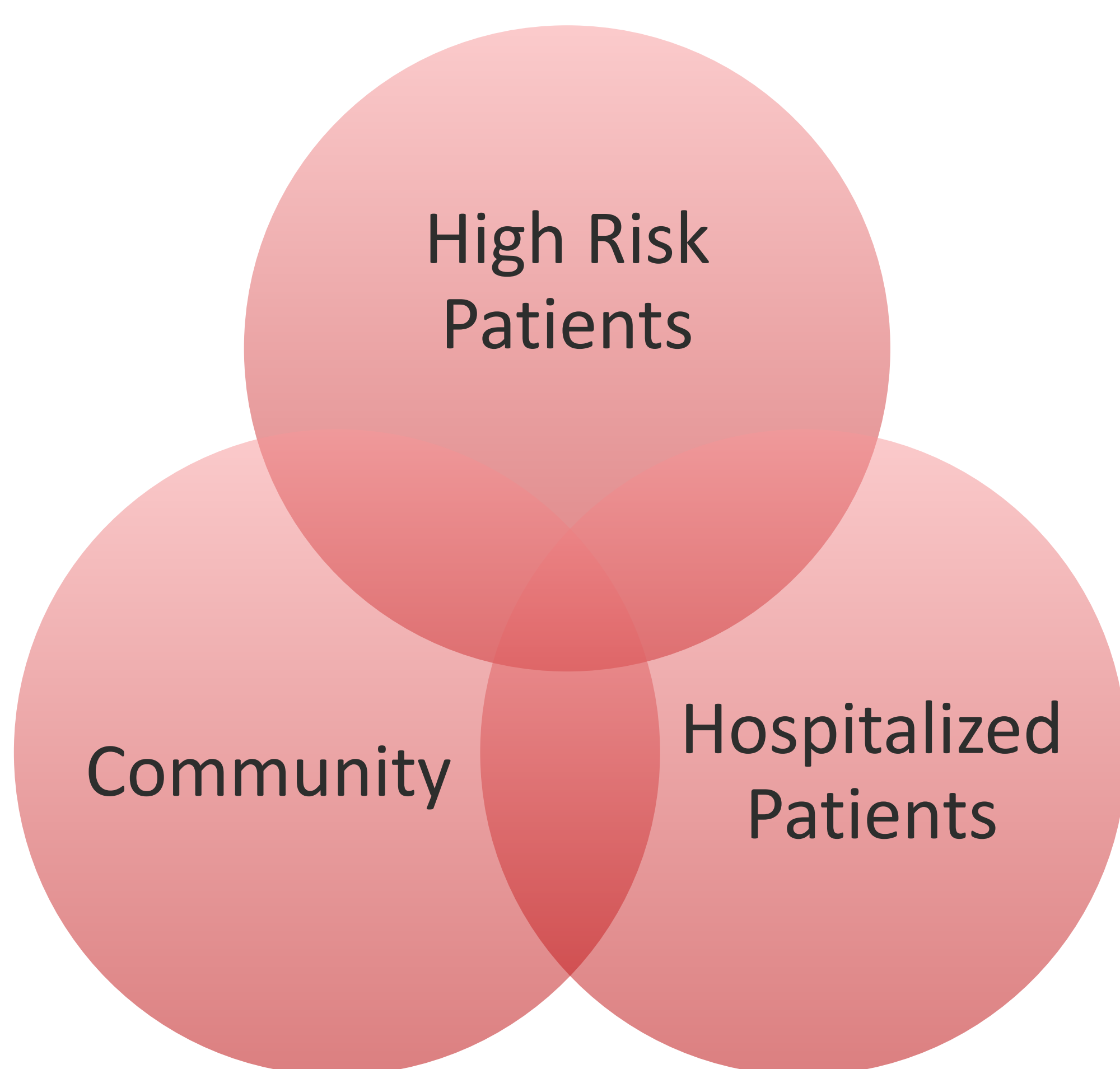
### Student Roles

- Perform in-depth interviews of identified high risk inpatients using the biopsychosocial model
- Deliver information obtained to the Hospitalist team caring for team
- Work with an interdisciplinary team to explore root cause of health events
- Attend various affiliated outpatient programs relevant to your patients
- Delivery community health lectures on high yield topics, working with LMH Community Affairs department
- Engage in Didactic sessions and discussions, lead by multiple dedicated general medicine Attendings, and guest lecturers
- Deliver an evidence-based talk on a topic of health disparities, based on a patient encountered during the rotation with review of current medical literature.
- Explore continued interest with Faculty mentorship for community health projects and research



**Figure 1:**  
Model for Clinical Engagement of Students

Challenges in our work include identifying patterns in barriers to care & wellness. We aim to engage in preventative strategies within the communities we serve.



**Figure 2:**  
Intersection of Populations in New York City

### Building on Current Educational Opportunities

- Growing interest exists at Weill Cornell amongst medical students to engage in areas of study related to underserved communities.
- Current pre-clinical programs include: Community Perspectives in Medicine (MS1) and the Global Health Preceptorship (MS1).
- Our elective serves as a clinical elective for MS3 and MS4 students focusing on these topics, allowing students to actively contribute to a real-time clinical team and applying knowledge gained in the pre-clinical years.

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For more information or interest in collaboration  
contact: Amanda Ramsdell at [akr7003@med.cornell.edu](mailto:akr7003@med.cornell.edu)



## Program Objectives

1. To train the primary care leaders of tomorrow.
2. To allow our residents to develop expertise within the scope of academic general internal medicine, including clinical practice, care delivery, clinical research, medical education, quality improvement, medical ethics, public health, and health policy.
3. To poise graduates of the program for careers as general internists, clinician-educators, clinician-investigators, and patient advocates.

## Program Overview

- 36-month residency providing a focused ambulatory medicine curriculum in addition to intensive inpatient training
- Six-month expanded ambulatory exposure in the PGY2 and PGY3 year
- Comprehensive outpatient subspecialty curriculum consisting of site-visits, procedures, lectures, readings, pre/post-tests, group reviews
- Second continuity-clinic experience during PGY2 and PGY3 year in a clinical area personalized to each resident
- Urban, rural, and international experience
- Longitudinal structured scholarly project
- Wide range of one-on-one mentorship
- Funded travel to academic general medicine conferences
- Evidence based medicine conferences
- Senior leadership and teaching experience as an Assistant Chief Resident

## Subspecialty Clinical Curriculum

<b>Cardiopulmonary</b>	<b>Psychiatry</b>
<b>Women's Health</b>	<b>Dermatology</b>
<b>Endocrine</b>	<b>Musculoskeletal</b>



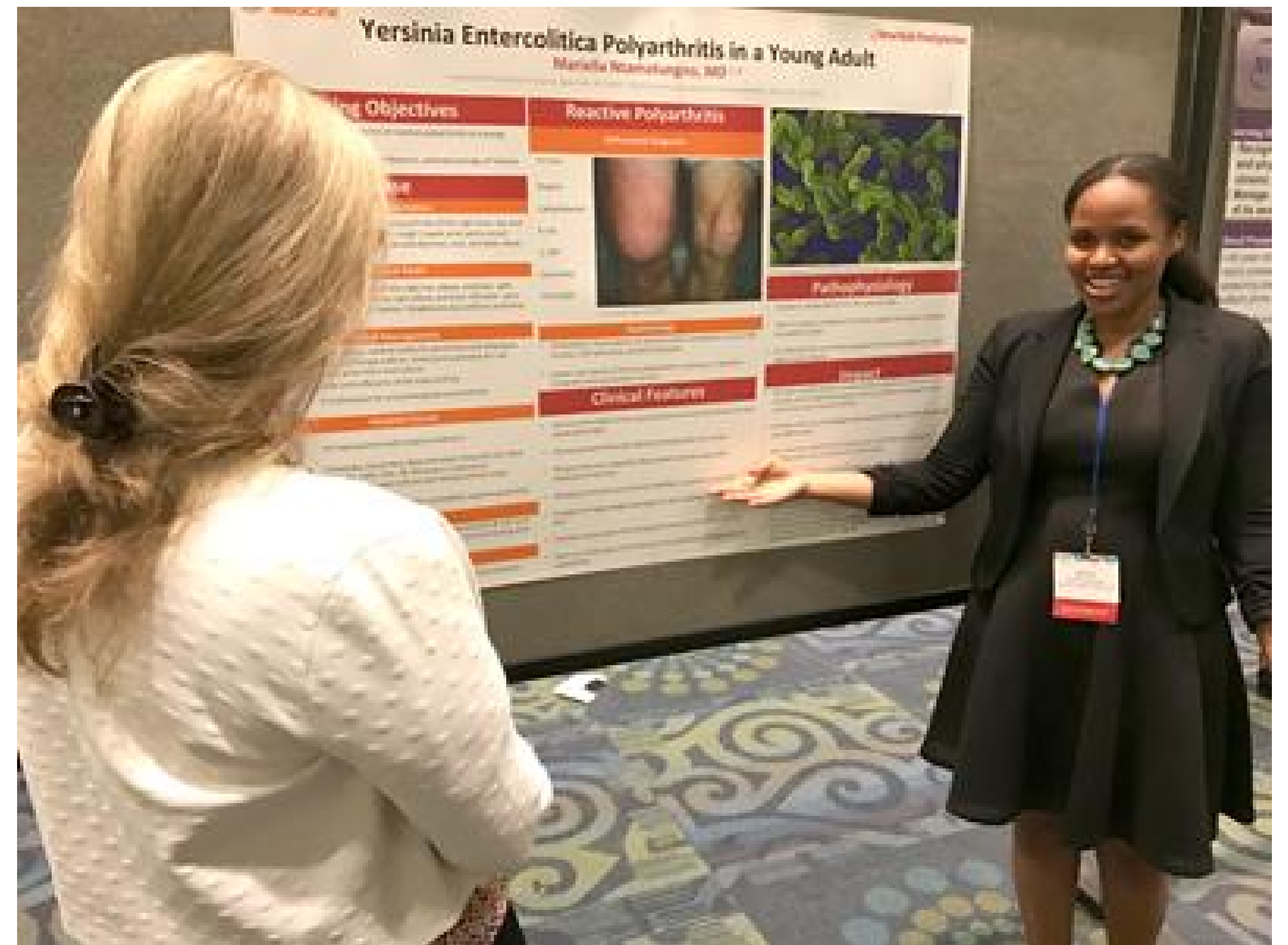
## Program Leadership

Dr. Lee Shearer, Program Director

Dr. Helene Strauss, Associate Program Director

## Scholarly Pursuit

**Dedicated research methodologies course**  
**One-on-one research mentorship**  
**Group Research-in-Progress meetings**  
**Research support from clinical librarians**  
**Funding to present at national conferences**



## Assistant Chief Residency

**PGY3 rotation mirrors the responsibilities of junior academic faculty and teaches trainees about managing an outpatient practice, clinical administration, teaching, and leadership skills**



## Our Graduates

<b>Clinician educator</b>	<b>GIM fellow</b>
<b>IT Innovations</b>	<b>Global health</b>
<b>Policy</b>	<b>Public health</b>
<b>Geriatrics</b>	<b>Hospitalist</b>
<b>QI Chief resident</b>	<b>PC Chief resident</b>
<b>Faculty practice</b>	<b>Residency leadership</b>
<b>Rheumatology</b>	<b>Adolescent medicine</b>
<b>Weight management</b>	<b>Endocrine</b>

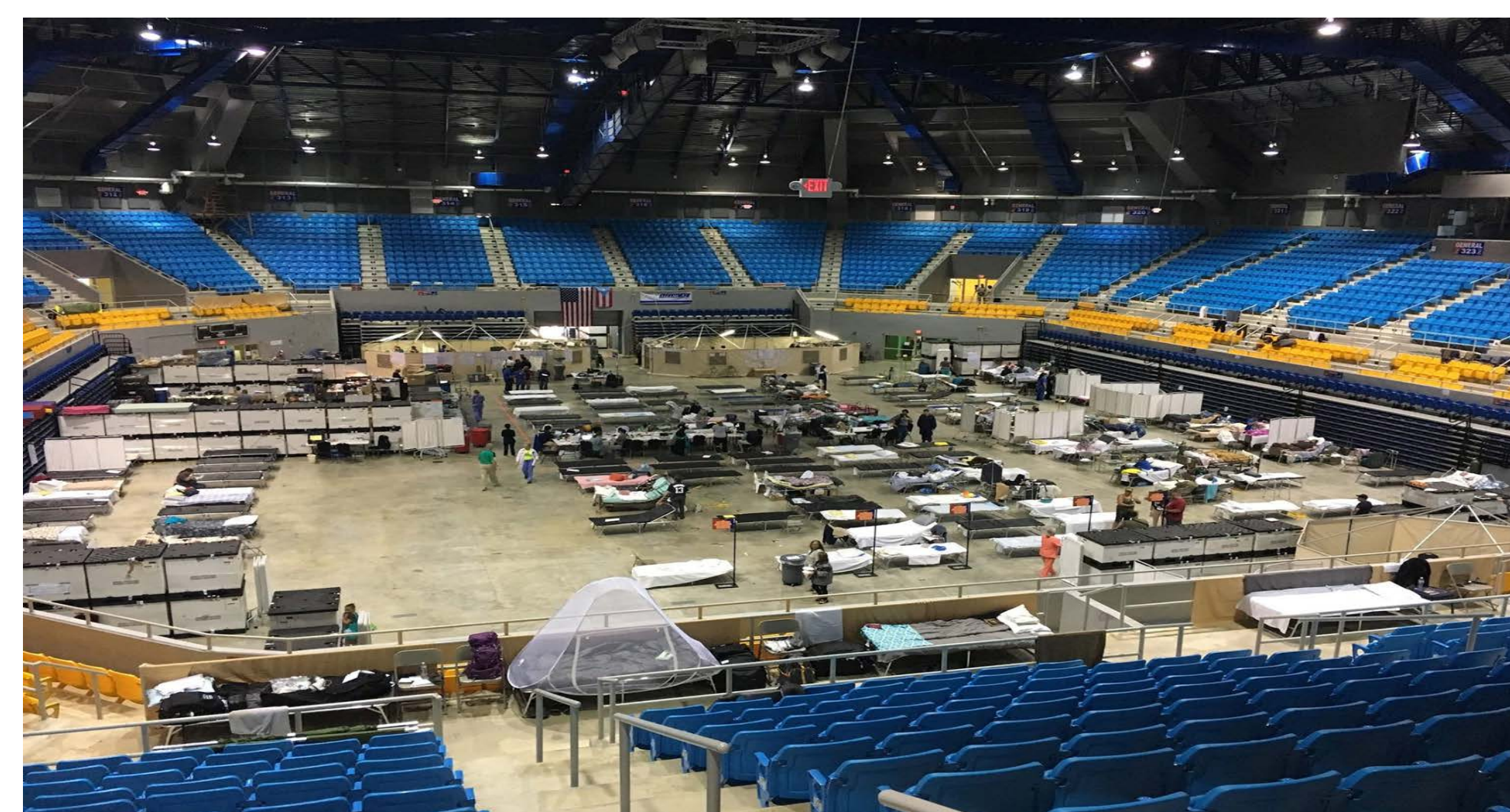
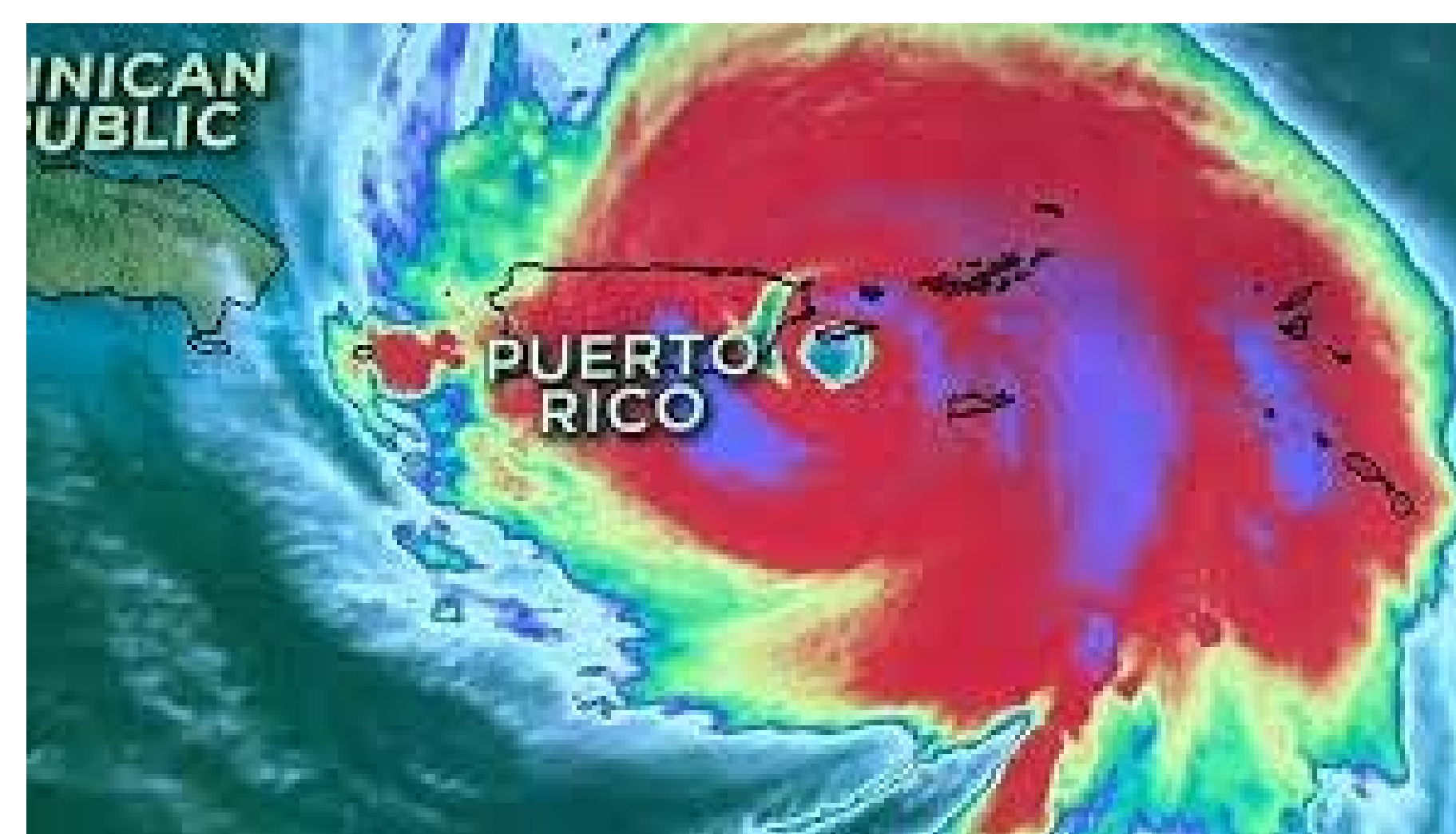
## Learn More

Applications are accepted through the NRMP. To learn more about the program or how to apply, please visit:

<https://medicine.weill.cornell.edu/residency/our-programs/primary-care-track>

### Background

- On September 20<sup>th</sup>, 2017, Category 4 Hurricane Maria swept across the island of Puerto Rico, making landfall near Humacao heading in a northwesterly direction
- The devastation wrought to the island was significant in the weeks after the hurricane
  - 100% blackout from failure of the electrical grid
  - Minimal potable water due to heavy rains and contamination
  - Limited transportation access around island from flooding
  - Major hospital centers in metropolitan areas operated without food, electricity and limited supplies of medication



Federal Medical Shelter at Manatí – Coliseum Bencito

### Mission

- A group of WCMC, CUMC and NYP health professionals gathered under the auspices the Great New York Hospitals Association to provide assistance as members of the National Disaster Medical Service (NDMS) and DMAT teams



- On October 24<sup>th</sup>, 13 team members (consisting of internal medicine and emergency medicine professionals) arrived in the northern city of Manatí
- Working in collaboration with the VA and federal responders, we delivered healthcare to ambulatory patients and inpatients within Federal Medical Shelter created within a basketball stadium
  - Teams saw up to 200 – 220 patients per day (24 hours per day care provided)
  - Inpatients were housed within a 150 bed hospital
- Our team focused on two patient populations
  - Emergency care to individuals of Manatí
  - Elderly and disabled patients whose homes were destroyed, and nursing home patients with electricity requirements (e.g., ventilators, oxygen concentrators, CPAP machines)

### Key statistics about Puerto Rico (before hurricane)

	Puerto Rico	Rest of US (incl. DC)
Population (M)	3.45	317.5
Lives below FPL (%)	46	15
Median household income (USD, K)	20	57.6
Unemployment rate (%)	10.1	4.1
Employer sponsored insurance (%)	35	60
Medicaid insured (%)	49	20
Uninsured	6	9
People with disability (%)	15.4	8.6
Adult diabetes prevalence (%)	15	11
Adult heart disease prevalence (%)	11	7
Infant mortality rate (per 1000 live births)	7.1	6



Members of the team working in the Federal Medical Shelter



Team returning home from Puerto Rico

### Challenges faced working in a disaster setting

- Ongoing power outages affecting ventilators and oxygen concentrators
- Limited oxygen supplies for oxygen-dependent patients
- Limited potable water for patients and staff
- Potential for contagious outbreaks within the shelter (e.g., conjunctivitis, influenza, scabies)
- Diagnosis and management of uncommon conditions without lab or radiological support (e.g., leptospirosis)
- Limited drug supplies, and threat of running out of necessary medications

### Reporting on Puerto Rico in the news

- Reputable news sources<sup>2</sup> report the death toll from the hurricane could exceed 1000 lives, an almost 20 x increase compared to the official toll
- Our team's experience in Manatí supports this

#### References

- Puerto Rico Fast Facts, Accessed 1/5/2018 ([www.kff.org/disparities-policy/fact-sheet/puerto-rico-fast-facts](http://www.kff.org/disparities-policy/fact-sheet/puerto-rico-fast-facts))
- 'Official Toll in Puerto Rico: 64, Actual Deaths May be 1052' NYTimes Dec 8<sup>th</sup> 2017;



#WeAreGIM



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