Resident Perspectives on Rewards and Challenges of Caring for Ambulatory Patients with Chronic Illness

BY

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THESIS

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This thesis is dedicated to my partner, Peter, for supporting me completely during the time I needed to complete this degree and thesis. And to our beautiful daughter, Lucia, who was born in the middle of my MHPE studies and for whom I now do everything.
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I would like to thank my thesis committee, Ilene Harris, H. Barrett Fromme, and Alan Schwartz. They all provided steady and insightful guidance and mentorship I needed to accomplish this thesis.

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I would also like to thank my family, both Thomas and Marchese, who have done more things, both big and small, over the many years to support my goals.

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CCM</td>
<td>Chronic Care Model</td>
</tr>
<tr>
<td>ACP</td>
<td>American College of Physicians</td>
</tr>
<tr>
<td>SGIM</td>
<td>Society of General Internal Medicine</td>
</tr>
<tr>
<td>IM</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>PGY</td>
<td>Post-Graduate Year</td>
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<td>AHC</td>
<td>Academic Health Center</td>
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SUMMARY

Purpose

To elicit residents’ perspectives on rewards and challenges of caring for ambulatory patients with chronic illness and ways to improve their education in caring for these patients.

Method

The authors conducted a prospective qualitative study at three Academic Health Centers from October 2011 through February 2012. Focus groups were conducted with Internal Medicine residents during their ambulatory block rotation. Qualitative analysis was used to identify themes.

Results

Discussions produced 224 comments, which were categorized in 5 domains and 36 themes. Twelve (12) themes related to perceptions of challenges in providing care and 3 themes related to perceptions of rewards in providing care. Eight (8) themes focused on strategies to improve the patient experience. Strengths of the residency program were identified in 7 themes. Six (6) themes related to ways for improving learning about caring for patients with chronic disease in the ambulatory setting.

Conclusion

Residents perceive both challenges and rewards in caring for patients with chronic illness in the ambulatory setting. Residents identified a number of barriers in caring for patients with chronic illness, from both the provider and from the patients’ perspectives. Nevertheless, they have
developed strategies to provide effective care for their patients. Residents also identified best practices within their residency for resident education and patient care as well as making suggestions for improvement. These results have implications for curriculum development and practice redesign in the 21st century for care of patients with chronic illness.
Introduction

At present, many residents care for patients in a traditional environment, with episodic and acute interventions and suboptimal ambulatory continuity of care. The complexity of caring for patients with chronic illness in a short ambulatory care visit can be challenging for any provider. It may also not provide the appropriate time for the patient to interact with the provider about the longitudinal care for their chronic diseases. As a result, both patient and provider may become frustrated with the complexity of assessing and managing these chronic illnesses in the ambulatory care setting.

Many organizations call for an increased focus on care of patients with chronic illness in health care and health care systems. However, little is known about the best ways to educate trainees for care of patients with chronic illness in the ambulatory setting and trainees’ perceptions about caring for patients with chronic illness in the ambulatory care setting.\(^1\)

The purpose of this study was to elicit residents’ perspectives about rewards and challenges they experience in caring for patients with chronic illness in the ambulatory setting. Also we explored the strategies used by residents to care for these patients as well as opportunities to improve learning about this care during their residency.

The Chronic Care Model (CCM) will serve as the conceptual framework to understand the perceptions of Internal Medicine residents about the rewards and challenges of caring for
patients with chronic illness as well as how best to enhance residents education in caring for patients with chronic illness. We first review pertinent literature, then describe the study methods and results, and then discuss the results in the context of training Internal Medicine residents in the care of ambulatory patients with chronic illness

Background

Many organizations are calling for a re-thinking of how medical and health care is delivered in light of changing population demographics. The population is aging and many people are living with chronic illnesses. The American College of Physicians (ACP), the Society of General Internal Medicine (SGIM) and other professional organizations have called for systems and practice changes to deliver improved care to these patients. The education of residents and other trainees to care for patients living with chronic illness has only minimally been addressed. Ideally, residents would be trained in ways that enhance their education in ambulatory care and the care of patients with chronic illness. However, their education remains focused in an acute care and episodic model.

The CCM identifies the components of a health care system that encourages and facilitates efficient, effective and quality driven care for patients with chronic illness. The CCM was initially developed from a review of interventions to improve the care of those with chronic illness. Multi-component interventions were outlined in four categories: 1) increasing providers' expertise and skill, 2) educating and supporting patients, 3) making care delivery more team-based and planned and 4) making better use of registry information systems. These
interventions ultimately formed the basis of the CCM. The essential elements of the CCM are: 1) Self-Management Support, 2) Delivery System Design, 3) Decision Support, 4) Clinical Information Systems, 5) Community Resources and 6) Health Care Organizations. The ultimate goal is to achieve positive interactions between informed patients and pro-active providers\textsuperscript{7,8}.

A qualitative study with directors of grant funded residency-based chronic care projects explored the challenges in providing chronic illness care and training in these clinics\textsuperscript{12}. The challenges identified from program directors' perspectives were related to limited faculty and resident time and institutional barriers related to authority, competing priorities, and resource limitations. Another study focused on the impact of implementing the CCM on asthma outcomes and found an effect on residents' education of the CCM primarily with increased knowledge of asthma guidelines and patients receiving them, access to community information as well as a decrease in asthma related emergency room visits\textsuperscript{13}.

Given the changing demographics of the United States, it will be important for physicians and all health care providers to be able to care for patients with chronic illnesses in the ambulatory care setting. It is essential, as the population ages and is living longer with chronic illness, for providers to learn these skills. Complicating the issue is the increasing focus on treating patients with chronic illnesses in the ambulatory care setting\textsuperscript{14,15}. Patients are now experiencing shorter acute hospital stays and being discharged with increased needs for care of their complex chronic illness by the physician in the ambulatory care setting. At present the health care work force is not adequately prepared or trained for this approach to providing healthcare\textsuperscript{16}. 
Goals of Study

The goals of this study are to explore what Internal Medicine (IM) trainees, in three large academic practices, perceive as: 1) the rewards of caring for patients with chronic illness in the ambulatory care setting; 2) the challenges of caring for patients with chronic illness in the ambulatory care setting and 3) how best to enhance residents' education in caring for patients with chronic illness.

Methods

We used a qualitative design, with focus groups of Post-Graduate Year (PGY) 2 and 3 Internal Medicine residents. Interviews and focus groups were conducted with residents during their ambulatory care rotations at three Academic Health Centers (AHCs). The three residency programs were chosen to represent geographic diversity and program size variation: the University of Illinois at Chicago College of Medicine (C.K., I.H., A.S.), the University of Michigan Hospital and Health Systems (N.S.) and Mount Sinai School of Medicine (D.C.T.). We obtained Institutional Review Board approval at all three institutions. We conducted the study from October 2011 through February 2012.

We purposefully sampled all IM residents during their ambulatory care rotation. The focus group at each program was conducted during the regularly scheduled ambulatory care morning report; all PGY 2 and 3 housestaff on their ambulatory care rotation were included and residents were given the option to decline participation in the group, without consequence. One or two focus
groups were held at each site in order to have 8-12 residents per site participating in focus groups.

Questions to guide the focus group discussion were developed based on the published literature of the CCM. The questions were designed to stimulate and direct conversation to the topic of caring for patients in the ambulatory care setting, from the perspective of an Internal Medicine resident. The questions used during the focus groups were (diabetes was used as an example of a chronic disease for each question):

1. What do you find most rewarding about caring for patients with chronic illnesses (like diabetes) in the ambulatory setting?
2. What do you find most challenging about caring for patients with chronic illnesses (like diabetes) in the ambulatory setting?
3. What are the strengths of your residency program in helping you learn to care for patients with chronic problems in the ambulatory setting?
4. What could your residency program do to improve your learning to care for patients with chronic disease, especially in the ambulatory setting?
5. What else do you want to add about taking care of patients with chronic diseases in the ambulatory setting?

Each site investigator conducted the focus groups independently but, in order to improve the consistency of the focus group experience across all these sites, the investigators first discussed
in conference calls and e-mail how to conduct a focus group. A detailed faculty guide was
developed for use based on these conference calls and e-mails.

The one-hour focus groups were audio taped and transcribed. Data were analyzed for themes
using an iterative constant comparative method, associated with the grounded theory approach.

The units of analysis were words and phrases. The recordings were de-identified when
transcribed and then the recordings were destroyed. Two coders (C.K. and D.C.T) identified
themes independently for two focus groups. After initial independent review of these two focus
groups, the two coders estimated inter-coder reliability (75%) and reached consensus on themes
through discussion. After discussion the coders achieved 100% coder agreement.

The analysis of themes was distributed to all members who participated in the focus groups and
comments were elicited from them as a form of member check. Focus group data were evaluated
for trustworthiness, using member checking, where residents were asked to review transcripts for
accuracy for effectiveness of capturing their perspectives. After coding, themes were triangulated
using available published literature on the CCM to evaluate for similarities and differences
between our study findings and other available data and perspectives.

Results

The five focus groups, conducted at the 3 AHCs, included 28 IM residents; 14 were PGY 2, 13
were PGY3 and 1 was a PGY 4. There were 14 females and 14 males. Sixteen (16) planned to
work in ambulatory care, 5 as hospitalists and 7 had other career plans. Twenty-three (23)
planned to apply for a fellowship. The focus groups ranged in length from 21 minutes to 49 minutes; each was conducted using the 5 probing questions.

Qualitative Analysis

The identification of themes was done by two authors (CK and DCT). The themes were refined and reworked in order to provide a clear presentation, e.g., grammatical and spelling errors where corrected. There were five domains identified related to caring for patients with chronic illness in the ambulatory care setting, related to the questions framing the focus group discussions: 1) Challenges in Caring for Patients (32%, n=72), 2) Rewards in Caring for Patients (25%, n=55), 3) Strategies to Improve the Patient Experience (16%, n=35), 4) Strengths of Residency Program in Educating How to Provide Care (14%, n=32), and 5) Ways Your Residency Could Improve Learning on How to Provide Care (13%, n=30) (Table I).
**TABLE I: DOMAINS AND THEMES OF PERSPECTIVES OF INTERNAL MEDICINE RESIDENTS ON CARING FOR AMBULATORY PATIENTS WITH CHRONIC ILLNESS**

<table>
<thead>
<tr>
<th>Domains and Themes</th>
<th>Number of Comments in Domain (%) of Comments in Domain</th>
<th>Total Number of Comments (%) of Overall Comments</th>
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</thead>
<tbody>
<tr>
<td>Perceptions of Challenges in Providing Care</td>
<td></td>
<td>72 (32)</td>
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<tr>
<td>Competing Responsibilities and Time Limitations</td>
<td>17 (24)</td>
<td></td>
</tr>
<tr>
<td>Patient’s Lack of Resources</td>
<td>10 (15)</td>
<td></td>
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<tr>
<td>Feelings of Failure by Provider</td>
<td>9 (12)</td>
<td></td>
</tr>
<tr>
<td>Provider Frustrations with Patient Non-Adherence</td>
<td>9 (12)</td>
<td></td>
</tr>
<tr>
<td>Lack of Continuity between Patient and Provider</td>
<td>5 (7)</td>
<td></td>
</tr>
<tr>
<td>Patient Cultural Issues</td>
<td>4(5)</td>
<td></td>
</tr>
<tr>
<td>Patients Don’t Feel Symptoms of Underlying Disease</td>
<td>3(4)</td>
<td></td>
</tr>
<tr>
<td>Getting Buy-in from Patients for Recommended Treatment</td>
<td>3(4)</td>
<td></td>
</tr>
<tr>
<td>Difficult for Patients to make Needed Frequent Visits</td>
<td>3(4)</td>
<td></td>
</tr>
<tr>
<td>Co-morbidities in Patients</td>
<td>3(4)</td>
<td></td>
</tr>
<tr>
<td>Provider Frustration with Staff in Clinic</td>
<td>3(4)</td>
<td></td>
</tr>
<tr>
<td>Medication Misconceptions</td>
<td>3(4)</td>
<td></td>
</tr>
<tr>
<td>Domains and Themes</td>
<td>Number of Comments in Domain (% of Comments in Domain)</td>
<td>Total Number of Comments (% of Overall Comments)</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Perceptions of Rewards in Providing Care</td>
<td></td>
<td>55 (25)</td>
</tr>
<tr>
<td>Seeing Patients Empowered, Educated and Succeeding in Partnership with Physician</td>
<td>31 (57)</td>
<td></td>
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<tr>
<td>Long Term Relationships with Patients</td>
<td>20 (36)</td>
<td></td>
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<tr>
<td>Working in Teams</td>
<td>4 (7)</td>
<td></td>
</tr>
<tr>
<td>Strategies to Improve Patient Experience</td>
<td></td>
<td>35 (16)</td>
</tr>
<tr>
<td>Education of Patient</td>
<td>8 (23)</td>
<td></td>
</tr>
<tr>
<td>More Time in the Ambulatory Care Setting to Improve Resident Education</td>
<td>5 (14)</td>
<td></td>
</tr>
<tr>
<td>Time Management by Provider</td>
<td>5 (14)</td>
<td></td>
</tr>
<tr>
<td>Manage Own Appointment Calendar</td>
<td>4 (11)</td>
<td></td>
</tr>
<tr>
<td>Improve Clinic Scheduling Process</td>
<td>4 (11)</td>
<td></td>
</tr>
<tr>
<td>Review Labs and Write “To-Do” Prior to Visit</td>
<td>3 (9)</td>
<td></td>
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<tr>
<td>Simplify Information Technology Systems</td>
<td>3 (9)</td>
<td></td>
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<tr>
<td>Use of Questioning</td>
<td>3 (9)</td>
<td></td>
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<tr>
<td>Strengths of Residency Program in Educating How to Provide Care</td>
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<td>32 (14)</td>
</tr>
<tr>
<td>Patients with Many Chronic Diseases</td>
<td>10 (32)</td>
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</tbody>
</table>
TABLE 1: DOMAINS AND THEMES OF PERSPECTIVES OF INTERNAL MEDICINE RESIDENTS ON CARING FOR AMBULATORY PATIENTS WITH CHRONIC ILLNESS

<table>
<thead>
<tr>
<th>Domains and Themes</th>
<th>Number of Comments in Domain (% of Comments in Domain)</th>
<th>Total Number of Comments (% of Overall Comments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume of Patients</td>
<td>5 (16)</td>
<td></td>
</tr>
<tr>
<td>Specialty Clinic Rotations</td>
<td>5 (16)</td>
<td></td>
</tr>
<tr>
<td>Urban Setting</td>
<td>3 (9)</td>
<td></td>
</tr>
<tr>
<td>Time in Ambulatory Clinics</td>
<td>3 (9)</td>
<td></td>
</tr>
<tr>
<td>Ownership of Patients</td>
<td>3 (9)</td>
<td></td>
</tr>
<tr>
<td>Consistent Ambulatory Care Preceptors</td>
<td>3 (9)</td>
<td></td>
</tr>
<tr>
<td><strong>Ways your Residency could Improve Learning on How to Provide Care</strong></td>
<td></td>
<td>30 (13)</td>
</tr>
<tr>
<td>Use of More Team Members in Clinic</td>
<td>7 (23)</td>
<td></td>
</tr>
<tr>
<td>Improve Continuity Scheduling with Provider and Patient</td>
<td>7 (23)</td>
<td></td>
</tr>
<tr>
<td>Education about Community Resources</td>
<td>5 (17)</td>
<td></td>
</tr>
<tr>
<td>Orientation of Staff and Team Members in Clinic</td>
<td>5 (17)</td>
<td></td>
</tr>
<tr>
<td>Facilitation of Chronic Disease Measurements in Clinic</td>
<td>4 (13)</td>
<td></td>
</tr>
<tr>
<td>Education on How to Counsel patients</td>
<td>2 (7)</td>
<td></td>
</tr>
<tr>
<td><strong>Total number of comments</strong></td>
<td></td>
<td>224 (100)</td>
</tr>
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</table>
Challenges in Caring for Patients

Challenges in caring for patients with chronic illnesses were identified in 12 themes (Table II). The challenge identified most frequently was Competing Responsibilities and Time Limitations (n=17). For example, a resident commented, “I think it’s really hard for all of us with only one half day a week, maybe it’s not every week when you’re on a busier inpatient month to really be able to consistently follow a large number of people since you just don’t have much availability in terms of time.” The next most frequent challenge identified was Patients’ Lack of Resources (n=10). A resident commented, “Also lack of coverage for some of the ancillary kind of services, nutrition for example, eventually things like that might not be covered or exercise programs may not be covered, like gym memberships. So those kind of things are sometimes frustrating when those are part of the core of the treatment of some of these illnesses.” The next most frequent challenge identified was Feelings of Failure by the Provider (n=9). For example, a resident commented, “[I told him] but there’s not much else that I can really do for you. And I felt really bad. I had to keep apologizing to this guy because I couldn’t help with his complications”. Another challenge identified was: Provider Frustration with Patient Non-Adherence (n=9). One resident commented, “And they’ll always have a reason [not to take medicines] and there’s nothing you can do after a while.” Lack of Continuity between Patient and Provider (n=5) was another challenge identified. A resident commented, “So I can understand why they are pretty frustrated. Why should they have to change their doctor every single time, who is going to change their strategy? Again, it’s a failure of the system, but it’s just one more barrier.” Another challenge identified was Patient Cultural Issues (n=4). One resident commented, “I find the cultural issues much more challenging than the linguistics.” Patients Don’t Feel Symptoms of Underlying Disease (n=3) was another challenge identified. A resident
commented, "Hypertension [is an example] where they don’t have symptoms." Another challenge related to Getting Buy-in from Patients for Recommended Treatment (n=3). A resident commented, "[It’s hard] getting patients to buy-in that they actually need treatment." Another challenge was that it is Difficult for Patients to make Needed Frequent Visits (n=3). One resident commented, "[It’s] hard for them to make an appointment with job and family and other responsibilities to come in that frequently." Co-morbidities in Patients (n=3) was identified as another challenge. A resident said, "I ended up having a lot of female patients when I was an intern, is the underlying domestic stress whether that’s abuse, or previous abuse or violence or even when my patients aren’t getting it, when they’re not getting why high blood pressure is going to lead to a stroke. I delve deeper for depression, anxiety, other stressors and it’s remarkable what comes up." Another challenge was Provider Frustration with Staff in Clinic (n=3). A resident commented, "I don’t know like half of their names [front desk staff], never spoken to half of them. I try to. I go to them, 'Hey, I need you. Can you help me with this? Can we look at this?' But you have to make a big time effort. This does not run like any other clinic I’ve ever seen that there’s absolutely no...there’s like this giant wall between the back and the front." The challenge of Medication Misconceptions (n=3) was commented on by a resident, "[The patient needs] to realize that medications are...should be an adjunct of therapy; they shouldn’t be the only therapy for a lot of chronic diseases." Overall, the residents focused more on the challenges than the rewards and would return to discuss challenges, even in the context of discussing the other topics, such as the rewards of caring for patients with chronic illnesses in the ambulatory setting.
<table>
<thead>
<tr>
<th>Domain and Theme</th>
<th>Representative Comments</th>
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<tbody>
<tr>
<td><strong>Perceptions of Challenges in</strong></td>
<td></td>
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<tr>
<td><strong>Providing Care (n=72)</strong></td>
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<tr>
<td>Competing Responsibilities</td>
<td>• “Yeah. One of the big things I find frustrating is that there's not enough time at appointments. Because if I have 20 minutes and they come in with a new problem, and they have all these chronic problems like hypertension, and high cholesterol, diabetes, then how much time out of that 20 minutes really gets allotted to those chronic illnesses.”</td>
</tr>
<tr>
<td>and Time Limitations (n=17)</td>
<td>• “I think it's hard for all of us with only one half day a week, maybe it's not every week when you're on a busier inpatient month to really be able to consistently follow a large number of people since you just don't have that much availability in terms of time.”</td>
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<td></td>
<td>• “I think ultimately taking care of patients and trying to educate chronic disease in a residency program in general is difficult because it is [a] very limited time of three years or four years. We're trying to learn everything else...inpatient medicine and trying to learn how to become a doctor basically.”</td>
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<tr>
<td>Patient’s Lack of Resources</td>
<td></td>
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<tr>
<td>(n=10)</td>
<td>• “There's a lot of external factors, a lot of social factors. Medical care for people who are on a very limited budget or for when a family member gets sick. And in this patient population everything else needs to...and for their own reasons, everything has to come before their medical care.”</td>
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<td></td>
<td>• “I think another limiting factor is our insurance system. There are a lot of things for people with chronic illnesses that we’d all love to do for them. My clinics, especially people have minimal insurance, that gets them some doctor visits within the system, but you can’t necessarily get all the support that you would ideally like.”</td>
</tr>
<tr>
<td></td>
<td>• “Also lack of coverage for some of the ancillary kind of services, nutrition for example, eventually things like that might not be covered or exercise programs may not be covered, like gym memberships. So those kind of things are sometimes frustrating when those are part of the core of the treatment of some of these illnesses.”</td>
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</table>
### TABLE II: PERCEPTIONS OF CHALLENGES AND REWARDS IN PROVIDING CARE

<table>
<thead>
<tr>
<th>Domain and Theme</th>
<th>Representative Comments</th>
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| Feelings of Failure by Provider (n=9)     | • "[I told him] but there’s not much else that I can really do for you. And I felt really bad. I had to keep apologizing to this guy because I couldn’t help him with his complications."
• "You noticed that you are so far away from anything, just like a little spec [in their life]. They just come to you once every three months and they have a whole lot of....but you hope that, that 15 minutes you spend with them, like changes their next three months, but I think it’s a lot of.....pressure."
• "But in the ambulatory setting, it’s not as easy to problem solve and try another intervention if this doesn’t work because you don’t know if it works or not until the next time you see that patient, which might not be until months later."

| Provider Frustration with Patient Non-Adherence (n=9) | • "[I is] most frustrating for me are the blatant non-compliant"
• "And they’ll always have a reason [not to take medicines] and there’s just nothing you can do after a while."
• "Sometimes they really just maybe don’t want to [take their medicines or follow-up on tests]."

| Lack of Continuity between Patient and Provider (n=5) | • "But we’re still not there in terms of seeing our own patients. There are times that I will be in clinic and I will be next to...[other resident] will be seeing my patient and I will be seeing her patient and we’re like, ‘This doesn’t make sense. We just switch it back.’"
• "So when I saw her after eight months [and her seeing other residents in between], it was just a mess. It felt like a setback for not just her, but also me. We can’t do anything about our Q3 months, so I think continuity for the chronic, it’s easier for other residents, but it’s also really important when you establish that relationship with that patient, to see that patient."
• "So I can understand why they are pretty frustrated. Why should they have to change their doctor every single time, who is going to change their strategy? Again, it’s a failure of the system, but it’s just one more barrier."

| Patient Cultural Issues (n=4) | • "[The patients have] ingrained cultural things that patients have and you kind of have to work around them and sometimes it’s absolutely contrary to what is the best treatment for the disease."
• "I find the cultural aspects much more challenging than the linguistics."
• "I feel it’s a disadvantage of them to see me, translator phone or no translator phone. There’s something lost with me and I think the translator phone does a great job and I also am just like, ‘Okay. Great. Grab the translator phone and let’s go,” but I don’t feel like I would be their best doctor.”
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<th>Domain and Theme</th>
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| Patients Don’t Feel Symptoms of Underlying Disease (n=3) | - “Hypertension [is an example] where they don’t have any symptoms.”  
- “I think the hardest thing is just like the nature of internal medicine being that the benefit, like most patients with hypertension or diabetes, they don’t even feel it, at least over the course of the two years.”  
- “I think one of the hardest parts is especially diabetes, hyperlipidemia, and heart disease. A lot of these things, at least in their early stages, are fairly asymptomatic for the patient. Even if you make the diagnosis and say that your blood sugars are elevated and you start explaining all these long term management things regarding their kidneys, their heart or their eyes, they may not really take it that seriously as most of us don’t when it’s not something that’s sort of tangible for us.” |
| Getting Buy-in from Patients for Recommended Treatment (n=3) | - “[It’s hard] getting patients to buy in that they actually need treatment.”  
- “For a lot of the chronic conditions, sometimes the patients themselves are not as invested in their health problem as you might be. I think that leads to a lot of frustration. You can schedule follow-up visits and have them come back frequently, but they may or may not make any of the changes necessary to sort of facilitate their improvement. I think that also is a frustration.”  
- “It’s challenging in the treatment of chronic illnesses when patients are difficult to adjusting their lifestyles. It takes a long time for the patient’s to adjust their lifestyles, exercise habits and eating habits. And a lot of chronic illnesses, these are very important. So I feel like I repeat myself and I don’t know if they actually are motivated to change.” |
| Difficult for Patients to make Needed Frequent Visits (n=3) | - “[It’s] hard for them to make an appointment with job and family and other responsibilities to come in that frequently.”  
- “And I think that's one thing that's frustrating about it, is it takes multiple visits and it takes a sustained effort. I guess that's one thing that's kind of cool about it too, but it can be kind of frustrating that you're having to spend multiple visits just so you can get a better sense of their medical issues.”  
- “I think sometimes, especially in residency with our lack of regular, frequent outpatient times, we have long stretches, long intervals between follow-up visits which is sometimes frustrating.” |
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<th>Domain and Theme</th>
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<tr>
<td>Co-morbidities in Patients (n=3)</td>
<td>• &quot;[I have a patient] who thinks his hypertension can be solved with a little bit of cayenne pepper. But he's also schizophrenic.&quot;</td>
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<td>• &quot;I ended up having a lot of female patients when I was an intern is the underlying domestic stress whether that's abuse, or previous abuse or violence or even when my patients aren't getting it, when they're not getting why high blood pressure is going to lead to stroke. I delve deeper for depression, anxiety, other stressors and it's remarkable what comes up.&quot;</td>
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<td>• &quot;And I feel like a lot of these patients are just so complicated and they have so many things going on and so many &quot;social issues.&quot; And it's like it takes several visits, I think, before you can get a good bird's eye view of who this person is and what their real issues are,&quot;</td>
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<td>Provider Frustration with Staff in Clinic (n=3)</td>
<td>• &quot;There's really nothing motivating them [the staff to improve the clinic system].&quot;</td>
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<td>• &quot;That's the hardest part is that once you go talk to the attending, they have to go back to recall the translator. I usually don't end up doing it, that's why.&quot;</td>
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<td>• &quot;I don't know like half of their names [front desk staff], never spoken to half of them. I try to. I go to them, &quot;Hey, I need you. Can you help me with this? Can we look at this?&quot; But you have to make a big time effort. This does not run like any other clinic I've ever seen that there's absolutely no...there's like this giant wall between the back and the front.&quot;</td>
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<td>Medication Misconceptions (n=3)</td>
<td>• &quot;Some people I think feel that medications are going to fix everything.&quot;</td>
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<td>• &quot;[The patient needs] to realize that medications are...should be an adjunct of therapy; they shouldn't be the only therapy for a lot of chronic diseases.&quot;</td>
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<td>• &quot;That sort of misconception [about taking medications].&quot;</td>
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<td>Perceptions of Rewards in Providing Care (n=55)</td>
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| Seeing Patients Empowered, Educated and Succeeding in Partnership with Physician (n=31) | • “I think it is empowering for them to understand the disease, understand the treatments, understand why they are doing it, and then if you get to follow them and see them actually pull it off, that is really rewarding.”
• “[It is rewarding] finally, following them and able to educate them and help them actually understand what their disease is and get a handle on it.”
• “I think it’s nice to see that you sort of follow them along and see changes with your interventions and a lot of times, more urgent visits you’ll make an intervention and not see the patient again, but it’s kind of neat with more chronic illnesses that you can kind of watch and see what your interventions are doing and learn from that.” |
| Long Term Relationships with patients (n=20) | • “Yeah. It’s the better part of medicine, or part of the reason I got into medicine is to have that relationship. The patient walks in and they go, “Hey.” I’m like, “I know you. I know what’s going on with you. I know what’s going on in your life besides medicine,” and then, I feel like we can get more done together and that you will bring stuff to me that you might not bring to other people. I think it’s a more rewarding relationship.”
• “Well I think on the inpatient side [as opposed to the outpatient], it’s a lot more one sided. You're essentially [are] forcing compliance and forcing adherence and stuff. And I mean...it’s almost...[too quick, and outpatient is more a partnership].”
• “I think what I find rewarding is that you build trust and so the patients start to believe what you say and they are willing to negotiate with you and actually make changes, which is different from seeing them the first time and maybe not having that trust and no matter how much time you spend with them, they may not be in agreement with what your recommendations are.” |
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<td>Working in Teams (n=4)</td>
<td>• &quot;I had a patient that was always seeing pharmacy, so then I would talk to the pharmacist....I thought that made it easier for me and therefore more rewarding.&quot;</td>
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<td>• &quot;I believe there's a way of linking them into a system from a health literacy standpoint because what I usually do, at least with the hypertensive patients and some of the heart failure patients that had post discharge follow up is to link them up with the nurses that will follow them chronically.&quot;</td>
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<td>• &quot;Along those same lines, I think especially working in an ambulatory setting it works really well when you know the team really well including the nurses the MAs [medical assistants]. It works like a clock in some of the clinics where the physician and the nurse, everyone else, they've been working together for a long time. It works really well.&quot;</td>
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Rewards in Caring for Patients

The residents did perceive rewards for themselves in caring for patients with chronic illness in the ambulatory setting. Three main themes were identified as rewards in caring for patients (Table II). Greater than 50% of the comments focused on Seeing Patients Empowered, Educated and Succeeding in Partnership with the Physician (n=31). For example, one resident responded, “I guess I find it most rewarding when patients kind of come to this realization that they can control or at least have some degree of control and really take an initiative on managing their chronic illnesses on their own.” Development of stronger Long Term Relationships with Patients was a significant reward (n=20). For example one resident commented, “I really like the continuity of care when I have my own patients in my primary care clinic that I’ve followed for a long time.” The other reward identified was Working in Teams (n=4), with comments such as “Along those same lines, I think especially working in an ambulatory setting it works really well when you know the team really well including the nurses, the MAs [medical assistants]. It works like a clock in some of the clinics where the physician and the nurse, everyone else, they’ve been working together for a long time. It works really well.”

Strategies to Improve Patient Experience

Eight (8) themes were identified in discussion of strategies to improve the patient experience (Table III). The theme in this domain with the greatest number of comments (n=8) centered on Education of the Patient. For example, a resident commented, “I like suggesting ideas and making it simple to understand their disease.” A related theme was for residents to have More Time in the Ambulatory Care Setting to Improve Resident Education (n=5). For example, a
resident commented, "I think our educational experiences in the ambulatory care setting with chronic disease are of high value when you're there, but I think we have a fairly inpatient heavy residency. So, more time in the ambulatory setting, especially for people who want to go into primary care or predominately outpatient specialties." The strategy of Time Management by the Provider elicited an equal number of comments (n=5). For example, a resident commented, "Time management is always like...very critical, you always feel like there's never enough time." Other suggestions for improving the patient experience included Managing Own Appointment Calendar (n=4) reflected in the comment, "I'm really compulsive about it [checking my own appointment] because I really think continuity of care is really important." Another strategy for improving patient care was Improve Clinic Scheduling Process (n=4) with one resident commenting, "I've actually called the patient scheduling line and it's been at least half an hour." Review Labs and Write What “To-Do” Prior to Visit (n=3) was a strategy as reflected in the comment, "Like look up their lab results and sometimes I'll write little reminders in my notes." An equal number of comments centered on Simplify Information Technology Systems (n=3). For example, a resident commented, "The ultimate solution is one united medical records system like the VA [system] has. If every hospital facility could get together, figure out...or at least have it so that they're all compatible, that would be very helpful." With the same number of comments, Use of Questioning (n=3) was stated by a resident, "[I ask them] Why did you forget?"
### Table III: STRATEGIES TO IMPROVE PATIENT EXPERIENCE

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<td><strong>Strategies to Improve Patient Experience (n=35)</strong></td>
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| Education of Patient (n=8)                                                      | - “Break down the problems in order to better educate the patient.”  
- “I like suggesting ideas and making it simple to understand their disease.”  
- “Yeah, at first, one of the best things about it is, like you said health literacy is education.”                                                                 |
| More Time in the Ambulatory Care Setting To Improve Resident Education (n=5)     | - “I think our educational experiences in the ambulatory setting with chronic disease are of high value when you’re there, but I think we have a fairly inpatient heavy residency. So, more time in the ambulatory setting, especially for people who want to go into primary care or predominantly outpatient specialties.”  
- “Along the same lines of more time in general, more time in some of the more outpatient-based specialties like rheumatology, endocrinology, and allergy. We just don’t get a lot of exposure to that.”  
- “I think we have way too many inpatient required months and I mean, not everybody wants to be a hospitalist. Not everybody wants to do a sub-specialty in the hospital. Many of us want to work in the ambulatory setting. So I think it’s hard to say that it has to change because there is always patient care need in the hospital and the hospital needs to have staff in the hospital. And many of the acute care occur in the hospital, which we have to learn, but yeah. I think sometimes ten months per year for the interns to be in the inpatient side and it’s required, but that’s one thing that I would change.” |
| Time Management by Provider (n=5)                                               | - “Time management is always like... very critical, you always feel like there’s never enough time.”  
- “Look at your patients ahead of time so you know what the main issue is going to be.”  
- “I’ve become really proactive about going up-front and being like looking through the stack and taking them even before the vitals are drawn.” |
| Manage Own Appointment Calendar (n=4)                                            | - “[I say] this patient usually sees Dr. so-and-so, can you reschedule them into their clinic.”  
- “I’m really compulsive about it [checking my own appointment] because I really think continuity of care is really important.”  
- “That’s what I’ve been focusing on [scheduling my patients to see me], but it’s been great because I always tell the patient “whenever you schedule an appointment, say you only want to see me.” That way, they can overbook you on my schedule.” |
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| Improve Clinic Scheduling Process (n=4)              | • “I’ve actually called the patient scheduling line and it’s been at least half an hour.”  
• “So I think one thing, when they’re calling to make the appointment if they can ask, ‘What is this appointment for?’ And they say, ‘Oh, I was just in the hospital.’ Then they can tell them you have to bring in your paperwork before you come to see the doctor. That would, I think, help in their care a lot.” |
| Review Labs and Write What “To-Do” Prior to Visit (n=3) | • “Like look up their lab results and sometimes I’ll write little reminders in my notes.”  
• “I’ll check [labs] the day before for my VA clinic.”  
• “Usually do it [check labs] the morning of [my clinic session].” |
| Simplify Information Technology Systems (n=3)        | • “You have to log on to like three different places.”  
• “The ultimate solution is one united medical records system like the VA [system] has. If every hospital facility could get together, figure out … or at least have it so that there’re all compatible, that would be very helpful.”  
• “But not having a computerized record makes it very hard to have any sort of continuity. All of the test results that come back to me. So, I get caught up on what’s happened in the past week or two weeks with someone when I show up the next time to clinic.” |
| Use of Questioning (n=3)                             | • “Who told you? And what’s their background [to understand the patient’s perspective of culture]?”  
• “I ask them about their kids.”  
• “[I ask them] Why did you forget?” |
Strengths of Residency Program in Educating How to Provide Care

Seven (7) themes were identified as strengths of the residency program in educating residents to care for patients with chronic illnesses in the ambulatory setting (Table IV). The themes with the greatest number of comments centered on taking care of Patients with Many Chronic Diseases (n=10) as well as the Volume of Patients (n=5) with many chronic diseases. For example, one resident said, “We see lots of people with lots of chronic diseases” and “As a resident where you only have clinic maybe once or twice a week I think you really get that volume a lot faster with chronic illness.” Specialty Clinic Rotations (n=5) was described by a resident who commented “This subspecialty stuff that we now have within [the clinic] I think for the most part is really good...It’s nice that it’s us doing it [rotating in the specialty clinics] also so it doesn’t really get separated from primary care.” An Urban Setting (n=3) was described as a strength by residents. For example, one on, “I’m sure they have those same patient populations [in other urban teaching residencies].” The residents described Time in Ambulatory Clinics (n=3) as a strength, with one commenting, “Sometimes as frustrating as it is, the fact that they do kind of really try to make sure that you go every week, to sort of maximize that. I know that I definitely have my moments on busy inpatient services where that seems really hard. I think probably in terms of having any sort of continuity with patients having that much frequency that I go to clinic as opposed to having an ambulatory block where you make up a bunch of primary care clinics is the space of two weeks or something is probably useful I think.” Another theme was Ownership of Patients in Clinic (n=3) and one resident said, “Building on that, I’d say that they allow you to make decisions within their supervision that...I guess builds ownership. Build that concept of ownership and efficacy so you actually feel confident.” Consistent Ambulatory Care Preceptors
(n=3) was highlighted with the comment, "The faculty who are the continuity clinic preceptors are really involved and want to be doing that. I think you feel that support as a resident."
Table IV: STRENGTHS OF RESIDENCY PROGRAMS AND WAYS TO IMPROVE LEARNING ON HOW TO PROVIDE CARE

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<td><strong>Strengths of Residency Program in Educating How to Provide Care (n=32)</strong></td>
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| Patients with Many Chronic Diseases (n=10)                  | • “We see lots of people with lots of chronic diseases.”  
• “We see so many patients with multiple chronic diseases.”  
• “Because we see so much of these illnesses on the wards, I think we get very good at knowing what we’re trying to do [prevent complications of chronic diseases].” |
| Volume of Patients (n=5)                                   | • “That’s huge [number of days spent seeing patients in ambulatory care] in terms of our exposure to volume.”  
• “While there is a good amount of volume, I don’t think it’s an absurd amount of volume [of patients].”  
• “As a resident where you only have clinic maybe once or twice a week I think you really get that volume a lot faster with chronic illness.” |
| Specialty Clinic Rotations (n=5)                           | • “We do [rotate] like the specialty clinics.”  
• “This subspecialty stuff that we now have within [the clinic] I think for the most part is really good... It’s nice that it’s us doing it [rotating in to the specialty clinics] also so it doesn’t really get separated from primary care.”  
• “The other thing is that, we do have a lot of specialists here. Not compared to some of the other hospitals. So, we also get to see management problems from the specialist point of view, which is somewhat different from the general medicine doctors.” |
| Urban Setting (n=3)                                        | • “It’s pretty underprivileged like you said, inner city.”  
• “I’m sure they have those same patient populations [in other urban teaching residencies].”  
• “[In an urban setting] You’re going to have understanding and you’re going to have flavor and then I think we have great attendings that transition us, like you brought us into East Harlem. Right away you made us see what our patients are like and that gave us a perspective and there are programs in place to kind of help us, like Linda’s program with Transitions of Care and we went out to the community to TCC [the nursing home] perspective, that’s a strength.” |
**Table IV: STRENGTHS OF RESIDENCY PROGRAMS AND WAYS TO IMPROVE LEARNING ON HOW TO PROVIDE CARE**

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| Time in Ambulatory Clinics (n=3)                      | • “We do two half days a week [in ambulatory clinics] when most residencies do one half day a week.”  
• “I think in outpatient, they do a good job of showing intern yearly [about the quality of care provided by provider], like why do we care about anyone to see, who should be screened for X, I think that they do a pretty good job of showing us that data so we don’t just go through a checklist of what they’re doing for no reason.”  
• “Sometimes as frustrating as it is, the fact that they do kind of really try to make sure that you go every week, to sort of maximize that. I know that I definitely have my moments on busy inpatient services where that seems really hard. I think probably in terms of having any sort of continuity with patients having that much frequency that I go to clinic as opposed to having an ambulatory block where you make up a bunch of primary care clinics in the space of two weeks or something is probably useful I think.” |
| Ownership of Patients in Clinic (n=3)                 | • “There’s a very strong emphasis on the patients you see in your continuity clinics are your patients”  
• “Building on that, I’d say that they allow you to make decisions within their supervision that...I guess build ownership. Build that concept of ownership and efficacy so you actually feel confident.”  
• “Yeah. Have your own patients and make your own plan and when there are equivocal therapeutic pathways, you get to pick which one.”  
• “The faculty who are the continuity clinic preceptors are really involved and want to be doing that. I think you feel that support as a resident.”  
• “They [ambulatory care preceptors] are, in most instances, quite experienced with working with residents so they have an understanding of kind of, your needs when you’re on an inpatient service or busy with other things and are pretty helpful. I think for the most part the faculty that are chosen to do those roles I think are very good. I would say that’s a definite strength here.”  
• “Yeah, I feel like my learning about management of chronic illnesses comes from the individual attending that I work with. So I don’t know if this applies to everyone, but we all tend to learn the specific style of that one or two attendings that work with us, so for example, managing heart failure or managing, although they sometimes go to a separate clinic, but managing diabetes, we learned the style of this attending.” |
<p>| Consistent Ambulatory Care Preceptors (n=3)           |                                                                                                                                                                                                                                                                                                                                                        |
| Ways your Residency could Improve Learning on How to Provide Care (n=30) |                                                                                                                                                                                                                                                                                                                                                        |</p>
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| Use of More Team Members in Clinic (n=7)| • "And definitely more services. Our patients have nothing. We need pharmacists in the clinic to take...something that would take less time for me, is I'm always doing med reconciliations with my patients, especially ones that have missed a bunch of appointments. They have no idea...I have no idea what they're on. They have no idea what they're on. And you can save a lot of problems just with the whole medication reconciliation thing."
  • "A big difference is at [hospital], there is a medical assistant who is assigned to me, and a couple of other residents. That is the MA [medical assistant] that I call or send something through CareWeb [electronic health record] or send a message, please send a letter about this or please call this patient and tell him this." |
| Improve Continuity Scheduling with Provider and Patient (n=7) | • "I think I learn the most about taking care of patients from the patients themselves. That's why it's easy to learn about acute presentations rather than chronic illnesses because if you were to learn from the patient about his or her chronic diseases, you would have to follow them for years. And so one thing I think we could do is have it set up where you could invite patients with chronic illnesses to come and speak to the residents about how they were diagnosed, what happened and how they've been doing." |
| Education about Community Resources (n=5)  | • "But incorrectly scheduled into my clinic, patients that I would not normally see, for no specific reason. Like the other resident that usually sees them is there, has open appointments and then they're scheduled in my clinic for some reason."
  • "[It would help to have] a little bit more oversight for that scheduling of patients [to their primary doctor]."
  • "Continuity. I mean, I know I've said this eighteen times now, there needs to be a better system between schedulers and the doctors."
  • "We have [community] resources that we don't know about that we could offer our patients."
  • "Educating attendings so they could tell us [about community resources], then we could provide better care for our chronic illness patients."
  • "Yes. Give me a little sheet or a packet that says, "Okay, patient can't afford heat." Things you can do. You can call this company. You can send a letter of medical need to this place." |
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| Orientation to Staff and Team Members in Clinic (n=5)       | • "You just show up to the clinic our first day and it’s like, ‘what am I doing?’ ‘Where am I going?’ ‘Who is the clerk?’
• "It [orientation] helps you break it down, that’s really helpful and when they help you understand what you’re doing and how to refer, they take that extra step, I think that makes a really big difference."
• "[Orientation] So that could be the location and the organization, structure that you’re working within, just being familiar with that can be a barrier."                                                                                      |
| Facilitation of Chronic Disease Measurements in Clinic (n=4) | • "I think optimizing and maximizing those point of care tests [would improve how to care for patients]."
• "Modalities so that you can closely follow it and show the patient exactly what you’re seeing."
• "For example in [hospital], you can check a hemoglobin A1C on the spot. I would love to do that at The VA, but we can’t do that. There’s a microscope at the [hospital] office, but there is nothing like that at The VA. Little things like that. It makes a big difference I think."
| Education on how to Counsel Patients (n=2)                  | • "I feel like I’ve had very little formal training on how I can better counsel people."
• "And I think that we get a lot of good training on how to deal with the disease that stems from it. But I just think that if I could spend 10 or 15 minutes...I mean it sounds ridiculous, but if I could spend that much time talking about smoking or opioids, or something like that, that would be ideal. And I don’t know how to spend 10 minutes talking about smoking."                                                                                                                                 |

Table IV: STRENGTHS OF RESIDENCY PROGRAMS AND WAYS TO IMPROVE LEARNING ON HOW TO PROVIDE CARE
Ways Your Residency Could Improve Learning on How to Provide Care

In this final domain, six themes were identified as ways the residency program could improve. The two with the greatest number of comments, making up nearly half of the comments were, Use of More Team Members in Clinic (n=7) and Improve Continuity Scheduling with the Provider and Patient (n=7). One resident commented on use of more team members, as follows, “A big difference is at [hospital], there is a medical assistant who is assigned to me, and a couple other residents. That is the MA [medical assistant] that I call or send something through CareWeb [electronic health record] or send a message, please send a letter about this or please call this patient and tell him this.” A resident commented about stated about scheduling, “Continuity, I mean, I know I’ve said this eighteen times now, there needs to be a better system between schedulers and the doctors.” Both of these are necessary components of any practice caring for patients with chronic illnesses. Education about community resources and orientation to staff and team members in clinic accounted for the next largest number of comments. The theme Education about Community Resources (n=5) was commented on as, “We have [community] resources that we don’t know about that we could offer our patients.” Residents wanted Orientation to the Staff and Team Members in Clinic (n=5). For example, one resident commented, “[Orientation] so that could be the location and the organization, structure that you’re working within, just being familiar with that can be a barrier.” Other comments dealt with Facilitation of Chronic Disease Measurements in Clinic (n=4) at the point of care as reflected in a resident comment, “I think optimizing and maximizing those point of care test [would improve how to care for patients]” (Table IV).
Discussion

Internal Medicine residents identified many issues which relate to the care of patients with chronic illness in the ambulatory setting. In only a short time as physicians, the residents are able to identify challenges, but also rewards in caring for patients. Residents across all three institutions have developed strategies to improve the patient experience. In addition, they were able to identify the strengths of their residency program in educating them on how to care for patients with chronic illness. And finally, identifying ways the residency could improve their learning of how to care for these patients is already part of the residents' personal conversations.

As one might expect, competing responsibilities and limited time were perceived as the most significant challenges in providing care to patients with chronic illness. The residents were very cognizant of the challenges facing patients with chronic illness, including the financial and insurance issues that challenge patients who are trying to care for their chronic illness and the associated need for multiple ambulatory care visits. Compounding the issue is the perception that the patient does not understand how the resident clinic practice functions. The patients' social issues were the subject of frequent comments about challenges in caring for patients with chronic problems which may reflect a predominantly urban population more than relating specifically to patients with chronic illness. All of the challenges highlighted by the residents suggest the need for health system changes as well as a role for advocacy for change as part of their curriculum.

Substantial rewards in caring for patients with chronic illness were identified. There were only three themes identified in this domain, but taken together these comments are enlightening on
what drives residents. The improvements and progress of patients' health and health outcomes over time were perceived as a reward for the residents when caring for patients. The residents understood the importance of developing stronger relationships with patients as an important component in caring for patients with chronic illness as well as working in teams.

There were many themes identified in residents' suggestions of strategies to improve the patient care experience. Many of these ideas are currently being discussed by opinion leaders as ways to enhance the ambulatory care experience for patients. Educating the patient was identified as a major strategy to improve the patient clinic experience. Interestingly, the residents did see the value of having more time in the ambulatory care setting for their overall education which matches current trends in where patients are being treated. Other strategies revolved around ways to improve the process and efficiency of the actual ambulatory care visit. Some of these strategies would benefit from the increased use of team members in the ambulatory setting.

The volume of patients seen seems to have a dual meaning for the residents. On the one hand, it was a source of frustration during a clinic visit because of time limitations for patient care, but was also viewed as a strength of the residency training program because of the extent of experiences provided with chronic care. Other comments which focused on the residency training program highlighted the benefits of working in the ambulatory setting overall. The residents indicated that they enjoy working as a team to care for patients and enjoyed taking ownership of their patient. The use of more team members in clinic, emphasized by the current changes in primary care, was highlighted as a way to improve teaching on how to care for
patients with chronic illness. Improving continuity and understanding the community, as well as information about chronic disease management tools, were deemed important. All of these points are critical to caring for the changing population demographics and the CCM, and already identified as important from the perspective of the residents, only after a few years as physicians in training.

The CCM served as the conceptual framework for this study and many of the residents' comments generally map, at least partially, to the 6 elements (Table V). The residents' approach is practical and provides specific examples of what one could use to develop a curriculum in the CCM as well as how to re-design a practice that would facilitate resident learning about how to care for these patients. The implications resulting from this study and the specific themes, in light of the CCM, on health systems and training programs are crucial for patients.
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<tr>
<th>CCM Element</th>
<th>Description</th>
<th>Themes from this Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Management Support</td>
<td>Educate, empower and prepare patients in a patient-centered approach about managing their health and health care</td>
<td>• Seeing patients empowered, educated and succeeding in partnership with physician</td>
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<tr>
<td></td>
<td></td>
<td>• Education of patient</td>
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<td></td>
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<td>• Use of questioning</td>
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<tr>
<td>Delivery System Design</td>
<td>Assure the delivery of effective and efficient clinical care and self-management support</td>
<td>• Long term relationships with patients</td>
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<td>• Working in teams</td>
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<td>• Time management by provider</td>
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<td>• Manage own appointment calendar</td>
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<td>• Improve clinic scheduling process</td>
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<td>• Review labs and write “to-do” prior to visit</td>
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<td>• Consistent ambulatory care preceptors</td>
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<td>• Improve continuity scheduling with provider and patient</td>
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<td>• Facilitation of chronic disease measurements in clinic</td>
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<td>• Education on how to counsel patients</td>
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Table V: THEMES FROM THIS STUDY MAPPED TO ELEMENTS OF THE CHRONIC CARE MODEL

<table>
<thead>
<tr>
<th>CCM Element</th>
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<th>Themes from this Study</th>
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| Decision Support             | Promote clinical care that is consistent with current scientific evidence and patient preferences (EBM Translation to patients/designing a system) | • More time in the ambulatory care setting to improve resident education  
• Specialty clinic rotations |
| Clinical Information System  | Organize patient and population data to facilitate efficient and effective care | • Simplify information technology systems  
• Patients with many chronic diseases  
• Volume of patients |
| Community Resources          | Mobilize community resources to meet needs of patients                       | • Education about community resources  
• Urban setting |
| Health Care Organization     | Create a culture, organization and mechanisms that promote safe, high-quality care | • Orientation of staff and team members in clinic |
Within Self-Management Support the residents highlighted the need for educating the patient and ultimately succeeding in their care as partners. Many themes relate to Delivery System Design and focus on ways to better enhance the specific process of how the clinic operates and how the residents work within the practice especially with teams. Time specifically dedicated to ambulatory care education would benefit Decision Support by engaging in an evidence-based approach to caring for these patients. The volume of patients especially those with chronic illness along with Information Technology would focus on the Clinical Information System element allowing for the development of registries. The benefit of Community Resources was simply stated as necessary by the residents. Health Care Organization was not a large component of the comments offered by the residents, but changing the culture of the clinic by developing the team was acknowledged.

There are several limitations in this study. This study was conducted at large ACHs and may not be generalizable to other IM training programs. Another limitation is that this study used a convenience sample of residents during their ambulatory care rotation. Since the residents were more focused on the outpatient setting, it may skew their perceptions. In addition, this study was limited to IM residents. Expanding to include other specialties may add an interesting perspective on how best to care for patients with chronic illness and how to train future physicians for this important health care mission. Lastly, each focus group at each institution was conducted by a different facilitator. There may have been differences among groups’ responses even though every effort was made to standardize the facilitators’ approach to running the focus groups.
Conclusion

Based on the results of IM residents' focus groups, it appears that the residents do perceive both rewards and challenges when caring for patients with chronic illness. The residents are also keenly aware of barriers that may be present for the patient in caring for their own chronic illness. Residents do focus on the education, both for themselves and of the patient, which is necessary to care for patients with chronic illness in the ambulatory care setting. Identifying best practices and giving suggestions for ways to improve the care of these patients was already being discussed at the resident level. Residents do recognize the plethora of barriers present, from both the provider and from the patients’ perspective in caring for patients with chronic illnesses, but they have developed strategies to best care for their patients.

The implications for curriculum development and practice re-design for the care of patients with chronic illness in the ambulatory care setting are evident. The residents provided comments representing a majority of the elements of the CCM. Those developing curriculum or re-designing practices may want to consider the CCM and themes identified in this article when doing so. Internal Medicine residents are at the center of caring for, and being educated about, patients with chronic illness and offer a unique perspective that would be important to include during curriculum design and practice re-design. The care of patients with chronic illness in the 21st century depends on both.
CITED LITERATURE


APPENDIX

Appendix 1: Perceptions of Challenges in Providing Care (n=72)¹

- **Provider Competing Responsibilities and Time Limitations (n=17)**
  - “See them at least every three months [when I don’t have time in my clinic schedule].” (1, 5)
  - “I really don’t feel that I have enough time to educate my patients with chronic diseases.” (1, 36)
  - “I think in a three-year, really two-year time period, because by the time you really establish a patient load, versus when you’re already starting to leave [residency], it’s hard to see that much of a change and that’s why it’s chronic illness [and hard to see any rewards during residency]. The benefits you see are really over the course of a year, or over like a decade, rather than like a year or two.” (2, 1)
  - “It [improved control] doesn’t happen with all our patients, clearly, but I think that [it] can happen in the two years. Then, of course, you say goodbye and then, they meet someone new and you kind of take a step back.” (2, 2)
  - “It’s just like you’re not in that mode of thinking about it [ambulatory care] and you order these labs and then, you check next week when you’re back in the EPIC [computer system] system. So yeah, but again, that’s not continuity. Like during a month [of ambulatory block rotation], you have a ton of continuity, but it’s just part of residency.” (2, 23)
  - “I remember getting an e-mail about you haven’t checked your labs on these patients and I was like, honestly, I’m lucky I’m checking the labs on my interns, like I’m lucky I’m on top of my interns. That was when I really felt like a failure and I was like I’m set up to fail.” (2, 24)
  - “[It’s difficult] To follow up with my outpatients [when I’m on the wards]. I’m probably useless when I’m there [in the clinic]. I’m trying to do the bare minimum. I feel bad saying that.” (2, 24)
  - “All you want to do is just get back [to the wards] because you’ve got like admissions waiting.” (2, 25)
  - “Yeah. One of the big things I find frustrating is that there’s not enough time at appointments. Because if I have 20 minutes and they come in with a new problem, and they have all these chronic problems like hypertension, and high cholesterol, diabetes, then how much time out of that 20 minutes really gets allotted to those chronic illnesses.” (3, 8)
  - “Sometimes if it’s like really...something if they’re very focused on something else, then I’ll try to make another close followup to deal with other chronic issues, or I’ll just have to go over time to deal with it.” (3, 9)
  - “It would be nice if we had time set...it’s a time issue at the moment. It would be nice if we had...we have protected time for clinic, we have protected time for conferences, we have protected time...we have inpatient obligations. But nobody gives us time to sit down and just do all the clerical crap. That would make everything flow a lot more. It’d be nice instead of trying to do it from my house with my phone blocked at 6:00 at night.” (3, 22)
  - “I think it’s hard for all of us with only one half day a week, maybe it’s not every week when you’re on a busier inpatient month to really be able to consistently follow a large number of people since you just don’t have that much availability in terms of time.” (4, 3)
  - “It’s getting them to be able to remember and manage taking all of the medications that you want or making it to the test that you need them to make it to. Especially with getting to tests, we don’t have as much time to follow-up and make sure that things were done.” (4, 4)
  - “But for us [residents], that’s not as typical because we only get...well, for my clinic I get there once a week and sometimes I’m not there for over a month or two because of inpatient work or because of scheduling. So, I think that’s one of the challenges.” (4, 4)
I think ultimately taking care of patients and trying to educate chronic disease in a residency program in general is difficult because it is [a] very limited time of three years or four years. We're trying to learn everything else...inpatient medicine and trying to learn how to become a doctor basically.”

(4, 12)

“I agree with that statement [about resources] since often in primary care clinic as the Primary Care Provider don't have very much time to speak to these patients about dietary changes or exercise or if they have a new diagnosis of diabetes and what all of that means, there's not a whole lot of time for education.” (5, 4)

“So I see people fairly frequently actually in my clinic. And then some of these other chronic diseases that they also have, it's also nice to be able to have those followed because in a three-year residency, if you're seeing somebody every six months and you miss a couple of those because you were on night float or something, you're only seeing them two or three times.”

(5, 4)

Patient’s Lack of Resources (n=10)

- “[The patients are] coming in from low resource settings” (1, 5)
- “[The patients have] low education levels and that just makes it that much harder to do the education.” (1, 5)
- “I tried to talk to him about different organs in the body an show him pictures of the liver and things like that, but I don't know that that was connecting for him” (1, 6)
- “The neighborhood's unsafe to walk.” (1, 6)
- “They don't have access to fresh fruits and vegetables.” (1, 6)
- “The university setting where people may or may not have resources or may or may not have access.” (1, 11)
- “There's a lot of external factors, a lot of social factors. Medical care for people who are on a very limited budget or for when a family member gets sick. And in this patient population everything else needs to...and for their own reasons, everything has to come before their medical care.” (3, 4)
- “Trying to get them hooked up with social work, we don't have any...at the clinic; we don't have any social workers. We don't have any pharmacists that can help patients with their medicine lists. I mean, it's just...the resources are lacking.” (3, 5)
- “I think another limiting factor is our insurance system. There are a lot of things for people with chronic illnesses that we'd all love to do for them. My clinic, especially people have minimal insurance, that gets them some doctor visits within the system, but you can't necessarily get all the support that you would ideally like.” (4, 5)
- “Also lack of coverage for some of the ancillary kind of services, nutrition for example, eventually things like that might not be covered or exercise programs may not be covered, like gym memberships. So those kind of things are sometimes frustrating when those are part of the core of the treatment of some of these illnesses.” (5, 2)

Feelings of Failure by Provider (n=9)

- “[I told him] but there's not much else that I can really do for you. And I felt really bad. I had to keep apologizing to this guy because I couldn't help him with his complications.” (1, 8)
- “[It is very frustrating when I have to say] I can't do anything for you. I'm sorry.” (1, 9)
- “You feel like it's your fault [if the patient was admitted to the hospital] even though you haven't seen them, or maybe because they didn't come or they saw other people, or whatever.” (2, 5)
"You noticed that you are so far away from anything, just like a little spec [in their life]. They just come to you once every three months and they have a whole lot of... but you hope that, that 15 minutes you spend with them, like changes their next three months, but I think it’s a lot of... pressure.” (2, 12)

"A little bit of frustration. But you just feel bad. In the end, it's not going to affect me. I'm going to go home and I'm going to be okay. In the end, it's somebody, who unfortunately, you're not going to really be able to do much for.” (3, 6)

"Yeah. I mean, I definitely kind of agree with that. Having the lack of participation with a patient. You internalize that and feel like that's your failure a little bit because you're frustrated.” (3, 6)

"Then if you see labs that are concerning and then you try to refer them after that, first of all you may be busy so you may not be able to handle that administrative load as well. Second, even if you do inform the right people, they may not be able to be seen quickly.” (4, 4)

"But in the ambulatory setting, it's not as easy to problem solve and try another intervention if this doesn’t work because you don’t know if it works or not until the next time you see that patient, which might not be until months later.” (4, 5)

"And many times I can't provide that within the 50 minutes that I have to see them, examine them, and talk to them and then discuss it with my attending and then come back, so I think education of these patients is something that they miss and it’s hard to achieve, especially when they have four or five chronic illnesses going on.” (5, 3)

**Provider Frustration with Patient Non-Compliance (n=9)**

"[It is] most frustrating for me are the blatant non-compliant” (1, 9)

"This is like the reverse insight; the insight to say ‘hey, I cannot take my meds for three months and I’ll be all right” (1, 9)

"I think it’s more frustrating when they’re dishonest about it [taking medications]” (1, 9)

"And they’ll always have a reason [not to take medicines] and there’s just nothing you can do after a while.” (1, 10)

"And I try to say it not so bluntly, but pretty close to that is ‘help me understand, why are you doing very discordant things.” (1, 11)

"Sometimes they really just maybe don’t want to [take their medicines or follow-up on tests].” (1, 11)

"I felt really good after the first visit, but when I saw her come back, I was like, maybe it wasn’t...... well...... we did it [reviewed all her medications].” (1, 12)

"And he’s not coming in for any of his follow-up because he’s got a legal thing going on.” (3, 5)

"Yeah. They’ll buy into kind of the medical interaction the medications, but if there are any lifestyle modifications that are required or if there is any diligence required with regard to diet or exercise or something, something different than just a pill or an injection.” (4, 4)

**Lack of Continuity between Patient and Provider (n=5)**

"I think the biggest problem with this clinic and probably most resident clinics is continuity. So I feel like the hardest patients I see are... is not even walk ins for pain refills, it’s like that primary care appointment for resident Xs patient that I don’t know and they’re coming in for a refill of Percocet.” (2, 8)

"But we're still not there in terms of seeing our own patients. There are times that I will be in clinic and I will be next to... [other resident] will be seeing my patient and I will be seeing her patient and we’re like, “This doesn’t make sense. We just switch it back.” (2, 8)
"So when I saw her after eight months [and her seeing other residents in between], it was just a mess. It felt like a setback for not just her, but also me. We can’t do anything about our Q3 months, so I think continuity for the chronic, it’s easier for other residents, but it’s also really important when you establish that relationship with that patient, to see that patient." (2, 9)

"But if that patient has that trust with you and is only going to bring you that finger stick log, they lose motivation when they can’t see you and I saw that in two of my patients." (2, 10)

"So I can understand why they are pretty frustrated. Why should they have to change their doctor every single time, who is going to change their strategy? Again, it’s a failure of the system, but it’s just one more barrier." (3, 8)

- **Patient Cultural Issues (n=4)**
  - "The patients have ingrained cultural things that patients have and you kind of have to work around them and sometimes it’s absolutely contrary to what is the best treatment for the disease." (1, 6)
  - "One other challenge I think, it’s probably obvious and doesn’t need to be said, but it is language." (2, 14)
  - "I find the cultural aspects much more challenging than the linguistics." (2, 15)
  - "I feel it’s a disadvantage of them to see me, translator phone or no translator phone. There’s something lost with me and I think the translator phone does a great job and I also am just like, “Okay. Great. Grab the translator phone and let’s go,” but I don’t feel like I would be their best doctor." (2, 16)

- **Patients Don’t Feel Symptoms of Underlying Disease (n=3)**
  - "Hypertension is an example where they don’t have any symptoms;" (1, 5)
  - "I think the hardest thing is just like the nature of internal medicine being that the benefit, like most patients with hypertension or diabetes, they don’t even feel it, at least over the course of the two years." (2, 10)
  - "I think one of the hardest parts is especially diabetes, hyperlipidemia, and heart disease. A lot of these things, at least in their early stages, are fairly asymptomatic for the patient. Even if you make the diagnosis and say that your blood sugars are elevated and you start explaining all these long term management things regarding their kidneys, their heart or their eyes, they may not really take it that seriously as most of us don’t when it’s not something that’s sort of tangible for us." (5, 2)

- **Getting Buy-in from Patients (n=3)**
  - "It’s hard getting patients to buy in that they actually need treatment." (1, 5)
  - "For a lot of the chronic conditions, sometimes the patients themselves are not as invested in their health problem as you might be. I think that leads to a lot of frustration. You can schedule follow-up visits and have them come back frequently, but they may or may not make any of the changes necessary to sort of facilitate their improvement. I think that also is a frustration." (4, 4)
  - "It’s challenging in the treatment of chronic illnesses when patients are difficult to adjusting their lifestyles. It takes a long time for the patient’s to adjust their lifestyles, exercise habits and eating habits. And a lot of chronic illnesses, these are very important. So I feel like I repeat myself and I don’t know if they actually are motivated to change their lifestyles." (5, 2)

- **Difficult for Patients to make Needed Frequent Visits (n=3)**
• Co-morbidities in Patients (n=3)
  o "[I have a patient] who thinks his hypertension can be solved with a little bit of cayenne pepper. But he’s also schizophrenic." (1, 9)
  o "I ended up having a lot of female patients when I was an intern is the underlying domestic stress whether that’s abuse, or previous abuse or violence or even when my patients aren’t getting it, when they’re not getting why high blood pressure is going to lead to stroke. I delve deeper for depression, anxiety, other stressors and it’s remarkable what comes up." (2, 13)
  o "And I feel like a lot of these patients are just so complicated and they have so many things going on and so many "social issues." And it’s like it takes several visits, I think, before you can get a good bird’s eye view of who this person is and what their real issues are." (3, 7)

• Provider Frustration with Staff in Clinic (n=3)
  o "There’s really nothing motivating them [the staff to improve the clinic system].” (1, 30)
  o "That’s the hardest part is that once you go talk to the attending, they have to go back to recall the translator. I usually don’t end up doing it, that’s why.” (2, 16)
  o "I don’t know like half of their names [front desk staff], never spoken to half of them. I try to. I go to them, “Hey, I need you. Can you help me with this? Can we look at this?” But you have to make a big time effort. This does not run like any other clinic I’ve ever seen that there’s absolutely no...there’s like this giant wall between the back and the front.” (2, 21)

Medication Misconceptions (n=3)
  o "Some people I think feel that medications are going to fix everything.” (1, 5)
  o "[The patient needs] to realize that medications are...should be an adjunct of therapy; they shouldn’t be the only therapy for a lot of chronic diseases.” (1, 5)
  o "That sort of misconception [about taking medications].” (1, 7)
Appendix 2: Perceptions of Rewards in Providing Care (n=55)

- Seeing Patients Empowered, Educated and Succeeding in Partnership with Physician (n=31)
  - “You do get a chance sometimes to see your interventions work.” (1, 1)
  - “[I like seeing what I do works and] just seeing a benefit from it [taking the medications].” (1, 2)
  - “I think it is empowering for them to understand the disease, understand the treatments, understand why they are doing it, and then if you get to follow them and see them actually pull it off, that is really rewarding.” (1, 2)
  - “[It is rewarding] finally, following them and able to educate them and help them actually understand what their disease is and get a handle on it.” (1, 2)
  - “It is [rewarding] seeing the patients that have a good insight into their disease.” (1, 3)
  - “What is most rewarding for me is when a patient has the insight into their disease and the motivation to stay on board with the script and the plan that you have got for them.” (1, 3)
  - “Sometimes you can see the light go on, and you see people follow up, and you see people get to those goals.” (1, 3)
  - “I find that extremely rewarding when you can literally drop medicines from chronic people and take them off.” (1, 3)
  - “He had lost 30 pounds…...Just the fact that I had the power to change just by telling him something to do, being a physician that mattered to him, and he listened to that and did what I told him to do. It was kind of cool. Pretty awesome.” (1, 3)
  - “And then next time you do some like step-wise stuff and the patient slowly improves [and you see them do well].” (1, 14)
  - “I have a lot of patients with diabetes and hypertension and you take somebody who had really high blood pressure or really high A1C, you start them on treatment and you explain it to them and they can follow up with you regularly and they can see their improvement, that’s rewarding.” (1, 1)
  - “I think I’ve had one patient where I’ve actually seen a significant improvement from someone that was very poorly controlled on their diabetes. I specifically remember one because it was just with Metformin. She went from 14 to 6 on her A1C, but it’s like the only patient I can remember that got that kind of improvement…and I love seeing her.” (2, 1)
  - “I think the thing that you can see in that two-year time that has kind of built up as [the other resident] was saying is basically the change in health literacy about the idea, so they may not be fully controlled, but they understand they’re not fully controlled. They understand a little better, at least.” (2, 1)
  - “When you can bring the understanding to them and then, have them feel good about the fact that they’re getting better.” (2, 1)
  - “[After a year or two the patients] have a grasp as to why they’re doing what they’re doing and they’ll be more amenable to changing of the regimens and they’ll be more interactive [with their chronic disease].” (2, 2)
  - “I don’t really know if you can put a word on it, but somehow I feel as if it’s a certain sense of accomplishment you feel by keeping that person out of the hospital.” (2, 4)
  - “I will say weight loss from some of my patients. I have one patient in particular to give this example, she came in, she’s only lost like six or seven pounds in the last two or three months, but it’s been like a very concerted effort for her to do it and you can tell she has a lot of pride in having done it and that was very rewarding.” (2, 7)
  - “One of the things that I enjoy especially when I have patients that I see repeatedly in the ambulatory setting is to see them become more educated about their illness. Because a lot of times they’ll come in and they don’t really know what their goals should be or what they
should be watching out for. And then, hopefully, when you get to see them over and over, you get to really get information to them.” (3, 1)

- And then secondary to that, getting to see them improve their compliance. Because I feel lots of times if they know what they're supposed to be looking for, they're more likely to be compliant with their medications because they know that's the purpose that it's serving. And then seeing them meet their health goals after that.” (3, 1)

- “I like it when the participation means that there are no bad outcomes. For example, with diabetes, when they're not having renal disease, when they're not having peripheral neuropathy. When they come in after six months and you can say, "Yes, you're still doing well. You're still not sick. Great." I like that. When they don't have to see me as much.” (3, 2)

- “When they don't have complaints. It's a good thing. That's what I like most. When I get to tell them, "Yes. You're doing everything great, keep going." That's what I like.” (3, 2)

- “Just seeing those positive outcomes. I think one of the major things in my clinic is obesity. And so people that actually try to actively lose weight, either on their own or through a program, and they're actually seeing results. And as a result, they consequently feel better, their other medical conditions improve and I think that...it's nice to see them take charge of their health too.” (3, 3)

- “I think that one thing that's cool about chronic...or managing chronic diseases is seeing things improve over a span of many months, as opposed to being on the wards and seeing it improve overnight. Because I think that there's something unique about seeing it improve over time. Because that shows that there's kind of a partnership going on. The patient is now invested in it and you're invested in it. And I think that's something that's kind of unique to outpatient ambulatory chronic.” (3, 3)

- “When they actually reach the goals that you have set for them, in terms of actual numbers because diabetes is very much a numbers game, trying to meet the hemoglobin A1C goal, trying to meet the blood pressure goal. So, after months and months of trying, they finally reach 6.9, something like that. It's pretty rewarding when they actually work with you and they reach that goal.” (4, 1)

- “I think like she was just saying, I guess ones with goals, where you can sort of achieve a goal...makes you feel better and I think it makes the patient feel better.” (4, 1)

- “So, seeing people who, when you first saw them might have been in a pretty bad state get better over time, it's pretty rewarding.” (4, 1)

- “I think another thing too is, is that with certain chronic illnesses you have a long time to achieve symptom control, like asthma or CHF. When you finally get people to more of a steady state where they feel like they can manage their disease and they don't have flares or exacerbations as frequently, I think that can be pretty rewarding too. Especially when they're sort of new to you and you see them in a state of illness and you can get them into more of a steady state.” (4, 2)

- “I think it's nice to see that you sort of follow them along and see changes with your interventions and a lot of times, more urgent visits you'll make an intervention and not see the patient again, but it's kind of neat with more chronic illnesses that you can kind of watch and see what your interventions are doing and learn from that.” (4, 1)

- “I guess I find it most rewarding when patients kind of come to this realization that they can control or at least have some degree of control and really take an initiative on managing their chronic illnesses on their own.” (5, 1)

- “Well I guess for me as a physician I find rewarding as time goes by how I see them get more educated about their diseases and as he was saying, gaining more control over what they have. You know, if they have diabetes they sort of learn how to, not all of them, but it's rewarding when some of them get to learn what exactly to eat and what not to eat and it gets
better as you see them within the years and so, I guess to me that is rewarding. You are giving them the tools to gain control of their chronic disease.” (5, 1)

- Long Term Relationships with Patients (n=20)
  - “Seeing the same people for two years now.” (1, 1)
  - “I will see the same people every three months.” (1, 1)
  - “If you are carrying them for a long period of time, you can see different patients and the natural development of the disease if they comply with the treatment versus if they are noncompliant.” (1, 2)
  - “More so than just seeing like a snapshot but actually seeing long-term” (1, 2)
  - “I think that outside of his primary care setting, he just would not have had the continuity and the trust in his caretakers to finally get to that point where he was like ‘ok, I am going to try it [take insulin].’” (1, 3)
  - “Getting that continuity and you build that rapport with your patients so that you can start to ask tougher questions or make more bold suggestions.” (1, 18)
  - “I think the thing that you can see in that two-year time that has kind of built up as [the other resident] was saying is basically the change in health literacy about the idea, so they may not be fully controlled, but they understand they’re not fully controlled. They understand a little better, at least.” (2, 1)
  - “It’s all how you approach it...as interns, if you know to assign everyone to yourself that you see, essentially then, knowing that third year, you’ll be like, ‘Oh, I know almost my whole patient census.’ I think that makes it more rewarding.” (2, 2)
  - “Again, I think being able to keep track of having all these patients coming to you for their healthcare, you’re the person and they’re not seeing a whole bunch of other people, it’s more satisfying for them and you. I think patients are also happier when they see one person too.” (2, 2)
  - “Again, I guess it comes down to relationships and I think that’s probably the unifying feature.” (2, 3)
  - “Yeah. It’s the better part of medicine, or part of the reason I got into medicine is to have that relationship. The patient walks in and they go, ‘Hey.’ I’m like, ‘I know you. I know what’s going on with you. I know what’s going on in your life besides medicine,’ and then, I feel like we can get more done together and that you will bring stuff to me that you might not bring to other people. I think it’s a more rewarding relationship.” (2, 3)
  - “I felt so confident that I knew him so well and so many other people had seen him in between, but didn’t know the piece that I knew and that goes down to the relationship and that trust that you build, if you can build it.” (2, 3)
  - “Well I think on the inpatient side [as opposed to the outpatient], it’s a lot more one sided. You’re essentially [are] forcing compliance and forcing adherence and stuff. And I mean...it’s almost...[too quick, and outpatient is more a partnership].” (3, 4)
  - “And then I really appreciate how I see all the same patients in the continuity clinic and I get to develop the longevity [with them].” (3, 14)
  - “I think developing a kind of a relationship and being able to see the same person in their progression through things is one of the most rewarding.” (4, 1)
  - “I think you also get to see those patients more often so you develop more of a relationship with them. You might see them every three or four months as opposed to a lot of your patients you see once a year or twice a year. You get to know them a little better.” (4, 1)
  - “One other thing I was thinking about on the flipside of saying that, in some instances, it’s nice because you see the results of your intervention because you follow these people over time.” (4, 5)
"That is probably the closest I felt to being my patient’s doctor as well. You are the one who knows the entire story better than anyone. I found in those situations, my preceptors deferred the most.” (4, 7)

"I really like the continuity of care when I have my own patient’s in my primary care clinic that I’ve followed for a long time.” (5, 1)

"I think what I find rewarding is that you build trust and so the patients start to believe what you say and they are willing to negotiate with you and actually make changes, which is different from seeing them the first time and maybe not having that trust and no matter how much time you spend with them, they may not be in agreement with what your recommendations are.” (5, 2)

- Working in Teams (n=4)
  - "I had a patient that was always seeing pharmacy, so then I would talk to the pharmacist…..I thought that made it easier for me and therefore more rewarding.” (1, 3)
  - "I believe there’s a way of linking them into a system from a health literacy standpoint because what I usually do, at least with the hypertensive patients and some of the heart failure patients that had post discharge follow up is to link them up with the nurses that will follow them chronically.” (2, 4)
  - "I feel that we have a lot of resources here, as well as in the clinic, like linking them up to this hypertension program, CHF [congestive heart failure] programs and things that they have, really, it makes it part of their everyday life and then, you sort of get better continuity for treating their chronic illness.” (2, 13)
  - "Along those same lines, I think especially working in an ambulatory setting it works really well when you know the team really well including the nurses the MAs [medical assistants]. It works like a clock in some of the clinics where the physician and the nurse, everyone else, they’ve been working together for a long time. It works really well.” (4, 3)
Appendix 3: Strategies to Improve Patient Experience (n=35)¹

- **Education of Patient** (n=8)
  - “And I talked to him about three different visits about it before finally mentioning; well we better get your blood pressure and diabetes [under control].” (1, 10)
  - “I’ll ask people if they know someone who’s on dialysis.” (1, 11)
  - “Break down the problems in order to better educate the patient.” (1, 11)
  - “I like suggesting ideas and making it simple to understand their disease.” (1, 12)
  - “I’ll ask how do you take your pills... bring your bag to the next appointment.” (1,12)
  - “So I do it again... go over the patient’s medication. It was very helpful.” (1, 13)
  - “This is what you can expect to happen to you in your life with this chronic disease.” (1, 27)
  - “Yeah, at first, one of the best things about it is, like you said health literacy is education.” (2, 2)

- **More Time in the Ambulatory Care Setting To Improve Resident Education** (n=5)
  - “I think our educational experiences in the ambulatory setting with chronic disease are of high value when you’re there, but I think we have a fairly impatient heavy residency. So, more time in the ambulatory setting, especially for people who want to go into primary care or predominantly outpatient specialties.” (4, 10)
  - “Along the same lines of more time in general, more time in some of the more outpatient-based specialties like rheumatology, endocrinology, and allergy. We just don’t get a lot of exposure to that.” (4, 11)
  - “I think that everyone knows for the sub-speciality that you can do consult months in the hospital, but a lot of these specialties will let you do outpatients rotations. I don’t think that that’s well publicized at all. I definitely didn’t know that a lot of them existed until I ran into some scheduling problems.” (4, 11)
  - “So maybe make us rotate through those specific clinics at least during out ambulatory months, a week would be something that we could potentially do. Because I don’t see the system de-specializing those clinics and letting us touch those patients in terms of changing their meds and working with them. So that would be one thing to do to help us.” (5, 5)
  - “I think we have way too many inpatient required months and I mean, not everybody wants to be a hospitalist. Not everybody wants to do a sub-specialty in the hospital. Many of us want to work in the ambulatory setting. So I think it’s hard to say that it has to change because there is always patient care need in the hospital and the hospital needs to have staff in the hospital. And many of the acute care occur in the hospital, which we have to learn, but yeah. I think sometimes ten months per year for the interns to be in the inpatient side and it’s required, but that’s one thing that I would change.” (5, 7)

- **Time Management by Provider** (n=5)
  - “Time management is always like... very critical, you always feel like there’s never enough time.” (1, 24)
  - “Look at your patients ahead of time so you know what the main issue is going to be.” (1, 24)
  - “I’ve become really proactive about going up-front and being like looking through the stack and taking them even before the vitals are drawn.” (1, 29)
  - “The ones [patients] I know well... the ones who know me and know how controlling I am, they come in. They say, “How are you doing?” And they get about two or three minutes to talk about what they want. And I’m like okay. Now let’s go over some of these things.” And I kind of [move right into their medical issues.]” (3, 10)
  - “You hand out their prescriptions before... if you know they’re going to need refills you have these out so those are ready for them.” (3, 11)
• **Manage Own Appointment Calendar (n=4)**
  - “[I say] this patient usually sees Dr. so-and-so, can you reschedule them into their clinic.” (1, 20)
  - “I look at my schedule.” (1, 25)
  - “I’m really compulsive about it [checking my own appointment] because I really think continuity of care is really important.” (1, 26)
  - “That’s what I’ve been focusing on [scheduling my patients to see me], but it’s been great because I always tell the patient ‘whenever you schedule an appointment, say you only want to see me.’ That way, they can overbook you on my schedule.” (2, 4)

• **Improve Clinic Scheduling Process (n=4)**
  - “I’ve actually called the patient scheduling line and it’s been at least half an hour.” (1, 28)
  - “They will come in and they will land on my door like 45 minutes or an hour later and I get burned… where I was sitting there doing nothing.” (1, 29)
  - “So I think one thing, when they’re calling to make the appointment if they can ask, ‘What is this appointment for?’ And they say, ‘Oh, I was just in the hospital.’ Then they can tell them you have to bring in your paperwork before you come to see the doctor. That would, I think, help in their care a lot.” (3, 20)
  - “Patients are just seen in whatever order they show up. They never make an appointment with a particular attending. I feel like, if I were a patient with a chronic illness, I would be very frustrated to have to rehash my story every month or however often they follow-up. Not only a different resident, but a different supervising attending.” (4, 7)

• **Review Labs and Write What “To-Do” Prior to Visit (n=3)**
  - “Like look up their lab results and sometimes I’ll write little reminders in my notes.” (1, 24)
  - “I’ll check [labs] the day before for my VA clinic.” (1, 25)
  - “Usually do it [check labs] the morning of [my clinic session].” (3, 12)

• **Simplify Information Technology Systems (n=3)**
  - “You have to log on to like three different places.” (1, 25)
  - “The ultimate solution is one united medical records system like the VA [system] has. If every hospital facility could get together, figure out … or at least have it so that there’re all compatible, that would be very helpful.” (3, 21)
  - “But not having a computerized record makes it very hard to have any sort of continuity. All of the test results that come back to me. So, I get caught up on what’s happened in the past week or two weeks with someone when I show up the next time to clinic.” (4, 10)

• **Use of Questioning (n=3)**
  - “Who told you? And what’s their background [to understand the patient’s perspective of culture]?” (1, 8)
  - “I ask them about their kids.” (1, 10)
  - “[I ask them] Why did you forget?” (1, 12)
Appendix 4: Strengths of Residency Program in Educating How to Provide Care (n=32)

- Patients with Many Chronic Diseases (n=10)
  - "We see lots of people with lots of chronic diseases." (1, 15)
  - "You see the complications of the things [from chronic diseases]." (1, 15)
  - "Then you can say, 'I've seen these personally, I've seen these complications; you don't want any of these, trust me.'" (1, 15)
  - "Like you know, the university based setting and teaching hospital kind of by its whole nature...kind of attracts a sicker population." (1, 15)
  - "We see so many patients with multiple chronic diseases." (1, 17)
  - "I think the one thing that's kind of unique for us, I mean, is especially at the VA [hospital] and I guess at the [University hospital], as well, is seeing the chronic diseases with all the complications. Be they've been noncompliant or they haven't had follow-up. And to see what it's like when diabetes has gone untreated for years and years." (3, 13)
  - "We definitely have the patient population to see a lot of different chronic problems. And we definitely get a lot of exposure and a lot of times are very protected." (3, 14)
  - "We definitely have the patient population to see a lot of different chronic problems. And we definitely get a lot of exposure and a lot of times are very protected." (3, 14)
  - "Because we see so much of these illnesses on the wards, I think we get very good at knowing what we're trying to do [prevent complications of chronic diseases]." (4, 9)
  - "I was just going to say that I think overall, I don't know how exactly we compare to other programs, but we have a fairly overall sick population of patients, especially in the university affiliated clinic that I work in, so I actually have a number of patients that have renal transplants and other things that are in some way, other forms of chronic illnesses and you do see these people back in a little more rapid cessation only because they get mild illnesses that concern them and they come back in for like a rash which may not concern everybody, but because of the their transplants do." (5, 4)

- Volume of Patients (n=5)
  - "The volume just from the type of hospital, the type of patients we have." (1, 15)
  - "That's huge [number of days spent seeing patients in ambulatory care] in terms of our exposure to volume." (1, 16)
  - "While there is a good amount of volume, I don't think it's an absurd amount of volume [of patients]." (1, 18)
  - "We're essentially protected in that we're limited on the maximum number of patients we can see in a clinic and we have at least ideally on paper a structured time limit for each patient that's very adequate." (1, 18)
  - "As a resident where you only have clinic maybe once or twice a week I think you really get that volume a lot faster with chronic illness." (4, 3)

- Specialty Clinic Rotations (n=5)
  - "We do [rotate] like the specialty clinics." (1, 15)
  - "Well we have twice as many clinics as a lot of residencies." (1, 16)
  - "This subspecialty stuff that we now have within [the clinic] I think for the most part is really good... It's nice that it's us doing it [rotating in to the specialty clinics] also so it doesn't really get separated from primary care." (2, 18)
  - "The other thing is that, we do have a lot of specialists here. Not compared to some of the other hospitals. So, we also get to see management problems from the specialist point of view, which is somewhat different from the general medicine doctors." (4, 9)
"I said it [resources] was one of the challenges, but also we do have resources available. Like for example the metabolic program, the metabolic syndrome program, so that patients can get exactly things like education, exercise training, diet training and those kinds of things." (5, 3)

- **Urban Setting (n=3)**
  - "It’s pretty underprivileged like you said, inner city." (1, 16)
  - "I’m sure they have those same patient populations [in other urban teaching residencies]." (1, 17)
  - "[In an urban setting] You’re going to have understanding and you’re going to have flavor and then I think we have great attendings that transition us, like you brought us into East Harlem. Right away you made us see what our patients are like and that gave us a perspective and there are programs in place to kind of help us, like Linda’s program with Transitions of Care and we went out to the community to TCC [the nursing home] perspective, that’s a strength." (2, 18)

- **Time in Ambulatory Clinics (n=2)**
  - "We do two half days a week [in ambulatory clinics] when most residencies do one half day a week." (1, 16)
  - "I think in outpatient, they do a good job of showing intern yearly [about the quality of care provided by provider], like why do we care about anyone to see, who should be screened for X, I think that they do a pretty good job of showing us that data so we don’t just go through a checklist of what they’re doing for no reason." (2, 18)
  - "Sometimes as frustrating as it is, the fact that they do kind of really try to make sure that you go every week, to sort of maximize that. I know that I definitely have my moments on busy inpatient services where that seems really hard. I think probably in terms of having any sort of continuity with patients having that much frequency that I go to clinic as opposed to having an ambulatory block where you make up a bunch of primary care clinics in the space of two weeks or something is probably useful I think." (4, 8)

- **Ownership of Patients in Clinic (n=3)**
  - "There’s a very strong emphasis on the patients you see in your continuity clinics are your patients" (1, 18)
  - "Building on that, I’d say that they allow you to make decisions within their supervision that...I guess build ownership. Build that concept of ownership and efficacy so you actually feel confident." (4, 8)
  - "Yeah. Have your own patients and make your own plan and when there are equivocal therapeutic pathways, you get to pick which one." (4, 8)

- **Consistent Ambulatory Care Preceptors (n=3)**
  - "The faculty who are the continuity clinic preceptors are really involved and want to be doing that. I think you feel that support as a resident." (4, 8)
  - "They [ambulatory care preceptors] are, in most instances, quite experienced with working with residents so they have an understanding of kind of, your needs when you’re on an inpatient service or busy with other things and are pretty helpful. I think for the most part the faculty that are chosen to do those roles I think are very good. I would say that’s a definite strength here." (4, 8)
  - "Yeah, I feel like my learning about management of chronic illnesses comes from the individual attending that I work with. So I don’t know if this applies to everyone, but we all tend to learn the specific style of that one or two attendings that work with us, so for example,
managing heart failure or managing, although they sometimes go to a separate clinic, but managing diabetes, we learned the style of this attending.” (5, 4)

(focus group, page)
Appendix 5: Ways your Residency could Improve Learning on How to Provide Care (n=30)

- **Use of More Team Members in Clinic (n=7)**
  - "[I] send the nurse to do a spirometry right before you see the patient." (1, 19)
  - "I wish we had a PharmD clinic like we do at the VA...it would be a lot easier to kind of help manage patients that need like blood pressure checks." (1, 22)
  - "And definitely more services. Our patients have nothing. We need pharmacists in the clinic to take...something that would take less time for me, is I'm always doing med reconciliations with my patients, especially ones that have missed a bunch of appointments. They have no idea...I have no idea what they're on. They have no idea what they're on. And you can save a lot of problems just with the whole medication reconciliation thing." (3, 16)
  - "A big difference is at [hospital], there is a medical assistant who is assigned to me, and a couple of other residents. That is the MA [medical assistant] that I call or send something through CareWeb [electronic health record] or send a message, please send a letter about this or please call this patient and tell him this." (4, 6)
  - "I think that any amount of standard education that we could do for care would be helpful in that I think there are certain things about chronic care that you can actually implement just like a routine level like having their blood pressure checked every week or so, having it e-mailed to the nurse coordinator or maybe something like that." (5, 5)
  - "But then the other thing that I know we have a Pharm D's who is dedicated to helping with diabetes education and medication and I think having people like that, Pharm D's and nutritionists that work in a teamwork model with a certain clinic or certain practitioners would be really helpful to try to allocate some of those resources out away from clinic time, per se, and have them involved actively on a more frequent basis with the patient even if it's via phone." (5, 5)
  - "I think I learn the most about taking care of patients from the patients themselves. That's why it's easy to learn about acute presentations rather than chronic illnesses because if you were to learn from the patient about his or her chronic diseases, you would have to follow them for years. And so one thing I think we could do is have it set up where you could invite patients with chronic illnesses to come and speak to the residents about how they were diagnosed, what happened and how they've been doing." (5, 6)

- **Improve Continuity Scheduling with Provider and Patient (n=7)**
  - "But incorrectly scheduled into my clinic, patients that I would not normally see, for no specific reason. Like the other resident that usually sees them is there, has open appointments and then they're scheduled in my clinic for some reason." (1, 20)
  - "[It would help to have] a little bit more oversight for that scheduling of patients [to their primary doctor]." (1, 20)
  - "Continuity. I mean, I know I've said this eighteen times now, there needs to be a better system between schedulers and the doctors." (2, 21)
  - "I think it's going to change with how they're trying to release our schedule in the next six months I'm hoping because I agree that continuity is just not there but I think once we have a schedule in EPIC [electronic health record] for the next six months, they'll be able to schedule us in IMA [clinic] for the next six months." (2, 22)
  - "And then in that same thing, not having enough time I feel sometimes at appointments, sometimes it's hard to have enough close follow up too in terms of, I want to see you back in two or three weeks. Just because of scheduling, that doesn't happen either. So then sometimes things get lost up and then referring them to other services for like chronic care issues. That always takes forever, as well, which can be frustrating too." (3, 9)
- **Education about Community Resources (n=5)**
  - “We have [community] resources that we don’t know about that we could offer our patients.” (1, 21)
  - “But I had this [community] resource I didn’t know about and I know there’s other stuff like that.” (1, 21)
  - “There’s stuff like that that we don’t know about and if the residency did a better job of educating us.” (1, 21)
  - “Educating attendings so they could tell us [about community resources], then we could provide better care for our chronic illness patients.” (1, 22)
  - “Yes. Give me a little sheet or a packet that says, "Okay, patient can’t afford heat." Things you can do. You can call this company. You can send a letter of medical need to this place.” (3, 16)

- **Orientation to Staff and Team Members in Clinic (n=5)**
  - “You just show up to the clinic our first day and it’s like, ‘what am I doing?’ ‘Where am I going?’ ‘Who is the clerk?’” (1, 22)
  - “The first time I came back, I was doing evening clinic from the VA, I did not know what I was doing because I had never been oriented.” (2, 26)
  - “One of the advantages] of doing two blocks of ambulatory care in first few months of residency] has been just [an early orientation]...because that’s what the interns are doing now and I know I missed most of this, but they really like it because all of them, by the time September rolls around, they’ve all had an outpatient block.” (2, 27)
  - “It [orientation] helps you break it down, that’s really helpful and when they help you understand what you’re doing and how to refer, they take that extra step, I think that makes a really big difference.” (2, 30)
  - “[Orientation] So that could be the location and the organization, structure that you’re working within, just being familiar with that can be a barrier.” (4, 7)

- **Facilitation of Chronic Disease Measurements in Clinic (n=4)**
  - “In diabetes it’s hemoglobin A1c, in COPD it’s spirometry [that is used to monitor at the point of care in the clinic].” (1, 19)
  - “I think optimizing and maximizing those point of care tests [would improve how to care for patients].” (1, 19)
  - “Modalities so that you can closely follow it and show the patient exactly what you’re seeing.” (1, 20)
  - “For example in [hospital], you can check a hemoglobin A1C on the spot. I would love to do that at The VA, but we can’t do that. There’s a microscope at the [hospital] office, but there is nothing like that at The VA. Little things like that. It makes a big difference I think.” (4, 6)
Education on how to Counsel Patients (n=2)
  o "I feel like I've had very little formal training on how I can better counsel people."
    (3, 17)
  o "And I think that we get a lot of good training on how to deal with the disease that stems from it. But I just think that if I could spend 10 or 15 minutes... I mean it sounds ridiculous, but if I could spend that much time talking about smoking or opioids, or something like that, that would be ideal. And I don't know how to spend 10 minutes talking about smoking."
    (3, 19)

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Mount Sinai School of Medicine
New York, NY

2011 – present

Vice Chair of Academic Affairs
Samuel L. Bronfman Department of Medicine
Mount Sinai School of Medicine
New York, NY

Education:

1985
Boston College
Bachelor of Science, double major in Biology and Philosophy
Chestnut Hill, MA
1986
Tufts University, College of Engineering
Master of Science in Public Health
Medford, MA

1991
Hahnemann University School of Medicine
Doctor of Medicine
Philadelphia, PA

1991 - 1992
St. Vincent's Hospital and Medical Center
Intern, Department of Internal Medicine
New York, NY

1992 - 1995
Mount Sinai Medical Center and Affiliated Hospitals
Resident, Department of Rehabilitation Medicine
New York, NY

1994 - 1995
Mount Sinai Medical Center and Affiliated Hospitals
Chief Resident, Department Rehabilitation Medicine
New York, NY

1995 - 1997
St. Vincent's Hospital and Medical Center
Resident, Department of Internal Medicine
New York, NY
2007 (Matriculated)  University of Illinois at Chicago
College of Medicine
Master of Health Professions Education
Department of Medical Education
Chicago, IL

**Certification:**

1992  National Board of Medical Examiners, Diplomat

1997  American Board of Internal Medicine, Diplomat

1998  American Board of Physical Medicine and Rehabilitation, Diplomat

1998  American Academy of Physical Medicine and Rehabilitation, Fellow

2005  American Board of Physical Medicine and Rehabilitation, Maintenance of Certification (2018), Diplomat

2007  American Board of Internal Medicine, Maintenance of Certification (2017)

2009  American College of Physicians, Fellow

**Licensure:**

1992  New York State, License #191992

**Honors/Awards/Patents:**

Nominated – Physician of the Year Award, 1998.

Solomon Berson Award for Excellence in Teaching, Mount Sinai School of Medicine, Department of Medicine, May 2002.


Brookdale Department of Geriatrics and Adult Development Annual Research Award, June 2002.

Nominated – Faculty Council Award for Academic Excellence by a Junior Faculty, 2003

Nominated – Oath Reader, Mount Sinai Class of 2004 Graduation Ceremony, 2004

Nominated – Institute for Medical Education Teaching Award, 2004

Alpha Omega Alpha, 2005

Top Ten Teachers Award, Department of Medicine, 2005

Presidential Award Finalist (Bush) in recognition of EHHOP, 2006

Edward J. Ronan Mount Sinai Medical Student Distinguished Teacher Award, 2006
Top Ten Teachers Award, Department of Medicine, 2006

President’s Higher Education Community Service Award Finalist for Excellence in General Community Service (MSSM for HHOP), 2007

Nominated, Department of Nursing, Physician of the Year, 2007

Ruth Abramson Idealism in Medicine Award, 2007

Clinician Educator Award, Society of General Internal Medicine, Mid-Atlantic Region, 2008

Physician of the Year, Mount Sinai Medical Center, 2008

Alexander Richman Award for Humanism in Medicine, Mount Sinai School of Medicine, 2008

Gold Humanism Honor Society, Mount Sinai School of Medicine, 2008

Bishop John J. McCort Award for Service to the Poor, West Catholic Alumni Association, 2008

OTTY (Our Town Thanks You) Award for outstanding work on the East Side of New York City, 2009

Marshall, Mount Sinai School of Medicine, 41st Commencement, 2010
Teaching Excellence Award, The Samuel Bronfman Department of Medicine, Mount Sinai School of Medicine, 2010

Master Educator, Institute for Medical Education, Mount Sinai School of Medicine 2010

Master Clinician, Mid-Atlantic Society of General Internal Medicine Regional Meeting, 2011

Leonard Tow Humanism in Medicine Award presented by the Arnold P. Gold Foundation, 2011

Gold Humanism Honor Society, 2011

**OTHER PROFESSIONAL APPOINTMENTS**

1998 – present  
Editorial Advisory Board, Mount Sinai School of Medicine, *Focus on Healthy Aging*

2000 – 2007  
Grant reviewer, The Jacob and Valeria Langeloth Foundation

2001 – 2002  
Panel, Expert Reviewer, Primary Care of People with Disabilities grant, Beth Israel Medical Center

2001 – 2002  
Chair, Mid-Atlantic Regional Meeting of the Society of General Internal Medicine Conference 2002 (New York, NY)

2001 – 2003  
World Rehabilitation Fund Expert Advisory Group

2001 – 2006  
Regional Council, Mid-Atlantic Region of the Society of General Internal Medicine

2002 – 2003  
President-Elect, Mid-Atlantic Region of the Society of General Internal Medicine

2003 – 2004  
President, Mid-Atlantic Region of the Society of General Internal Medicine
<table>
<thead>
<tr>
<th>Year Range</th>
<th>Role/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003 – 2006</td>
<td>External Advisory Panel, A Method to Vertically Integrate Anatomy into the Medical School Curriculum, Lawrence J. Rizzolo, Ph.D., Director, Yale University School of Medicine</td>
</tr>
<tr>
<td>2004 – 2005</td>
<td>Immediate-Past President, Mid-Atlantic Region of the Society of General Internal Medicine</td>
</tr>
<tr>
<td>2004</td>
<td>Reviewer, Innovations in Medical Education, The 27th Annual Society of General Internal Medicine National Meeting</td>
</tr>
<tr>
<td>2004 – present</td>
<td>Reviewer, American Journal of Physical Medicine and Rehabilitation</td>
</tr>
<tr>
<td>2004 – present</td>
<td>Reviewer, Teaching and Learning in Medicine</td>
</tr>
<tr>
<td>2004 – present</td>
<td>Reviewer, Journal of General Internal Medicine</td>
</tr>
<tr>
<td>2004 – present</td>
<td>Reviewer, Archives of Physical Medicine and Rehabilitation</td>
</tr>
<tr>
<td>2005</td>
<td>Reviewer, Innovations in Medical Education, The 28th Annual Society of General Internal Medicine National Meeting</td>
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<tr>
<td>2005 – 2007</td>
<td>Member, Education Committee, Society of General Internal Medicine</td>
</tr>
<tr>
<td>2006</td>
<td>Reviewer, Innovations in Medical Education, The 29th Annual Society of General Internal Medicine National Meeting</td>
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<tr>
<td>2006 – present</td>
<td>Reviewer, Journal of Health Care for the Poor and Underserved</td>
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<tr>
<td>2006</td>
<td>Consultant, Orthopedics for the Primary Care Provider Symposium</td>
</tr>
<tr>
<td>2007</td>
<td>Reviewer, Innovations in Medical Education, The 30th Annual Society of General Internal Medicine</td>
</tr>
<tr>
<td>2008 – 2010</td>
<td>New York City Department of Health Pandemic Influenza Preparedness Project’s Essential Medical Services Work Group</td>
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<tr>
<td>2010</td>
<td>Reviewer, SGIM Scientific Abstract Review, Medical Education Scholarship and Professional Development, The 33rd Annual Society of General Internal Medicine National Meeting</td>
</tr>
<tr>
<td>2010 – present</td>
<td>Reviewer, Association for Medical Education in Europe (AMEE) Scientific Abstracts</td>
</tr>
</tbody>
</table>
2010 Reviewer, Innovations in Medical Education, The 33rd Annual Society of General Internal Medicine National Meeting

2010 Reviewer, Medical Education Scholarship, The 33rd Annual Society of General Internal Medicine National Meeting

2011 Mid-Atlantic Society of General Internal Medicine Clinician-Educator Awards Committee

2011 – present Member, Alliance for Continuing Medical Education (CME)

2011 – present Member, Society of Academic Continuing Medical Education (SACME)

2012 – present Member, Research Committee, Society of Academic Continuing Medical Education (SACME)

**ADMINISTRATIVE LEADERSHIP APPOINTMENTS**

**INTERNAL:**

<table>
<thead>
<tr>
<th>Appointments and Role</th>
<th>Years</th>
<th>Time Commitment</th>
<th>Purpose and/or Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Committee of the Medical Board of The Mount Sinai Hospital</td>
<td>1994 - 1995</td>
<td>Monthly meetings and various sub-committee meetings</td>
<td>Housestaff representation</td>
</tr>
<tr>
<td>The Medical Board of The Mount Sinai Hospital</td>
<td>1994 - 1995</td>
<td>Monthly meetings</td>
<td>Housestaff representation</td>
</tr>
<tr>
<td>Resident Planning Committee, Department of Rehabilitation Medicine</td>
<td>1994 - 1995</td>
<td>Monthly meetings</td>
<td>Housestaff representation</td>
</tr>
<tr>
<td>The Hearings and Appeals Committee of the Medical Board of The Mount Sinai Hospital</td>
<td>1994 - 1995</td>
<td>Bi-monthly meetings</td>
<td>Conduct hearings and appeals from attending physicians</td>
</tr>
<tr>
<td>Committee</td>
<td>Year</td>
<td>Frequency</td>
<td>Description</td>
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<tr>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Combined Internal Medicine and Rehabilitation Medicine Residence Committee, The Mount Sinai Medical Center</td>
<td>1995</td>
<td>Monthly meetings</td>
<td>Planning of combined residency in Internal Medicine and Rehabilitation Medicine</td>
</tr>
<tr>
<td>Research Planning Committee</td>
<td>1997 - 1999</td>
<td>Monthly meetings</td>
<td>Research planning for the Department of Rehabilitation Medicine</td>
</tr>
<tr>
<td>Clinical Affairs Committee</td>
<td>1997 - 1999</td>
<td>Monthly meetings</td>
<td>Management of clinical issues for Department of Rehabilitation Medicine</td>
</tr>
<tr>
<td>Medical Rehabilitation Inpatient Programming Committee</td>
<td>1997 - 1999</td>
<td>Monthly meetings</td>
<td>Implementation and management of inpatient medical rehabilitation unit</td>
</tr>
<tr>
<td>Resident Planning Committee, Department of Rehabilitation Medicine</td>
<td>1997 - 1999</td>
<td>Monthly meetings</td>
<td>Attending representation for Rehabilitation Medicine residency program</td>
</tr>
<tr>
<td>Rehabilitation Medicine Residency Selection Committee</td>
<td>1997 - present</td>
<td>Bi-annual meetings</td>
<td>Interview and selection of resident candidates for Department of Rehabilitation Medicine</td>
</tr>
<tr>
<td>KCC5 South Unit Planning Committee</td>
<td>1997 - 2000</td>
<td>Monthly meetings</td>
<td>Coordination and implementation of daily planning for inpatient Rehabilitation Medicine Unit</td>
</tr>
<tr>
<td>Planning and Operations Committee</td>
<td>1998 - 1999</td>
<td>Monthly meetings</td>
<td>Management of all aspects of inpatient and outpatient issues in Department of Rehabilitation Medicine</td>
</tr>
<tr>
<td>Morbid Obesity Task Force</td>
<td>1998 - 1999</td>
<td>Monthly meetings</td>
<td>Multidisciplinary team examining issues of obesity in hospitalized patients</td>
</tr>
<tr>
<td>Committee</td>
<td>Timeframe</td>
<td>Meeting Frequency</td>
<td>Description</td>
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<tr>
<td>General Medicine Care Center Discharge Planning Committee</td>
<td>1999 - 2000</td>
<td>Monthly meetings</td>
<td>Timely discharge reviews of General Medicine Care Center</td>
</tr>
<tr>
<td>Cancer Center Steering Committee</td>
<td>1999 - 2000</td>
<td>Bi-monthly meetings</td>
<td>Department of Rehabilitation Medicine representation in development of Cancer Center</td>
</tr>
<tr>
<td>Neuroscience and Restorative Care Center's Physician Committee</td>
<td>1999 - 2000</td>
<td>Monthly meetings</td>
<td>Attending representation for Rehabilitation Medicine in regards to care center issues</td>
</tr>
<tr>
<td>Mount Sinai - NYU Outpatient Rehabilitation Strategy Subcommittee</td>
<td>1999</td>
<td>Monthly meetings</td>
<td>Mount Sinai, Department of Rehabilitation Medicine, representation during Health System merger</td>
</tr>
<tr>
<td>Acute Care for the Elderly (ACE) Unit Interdisciplinary Team Committee</td>
<td>1999 - 2003</td>
<td>Monthly meetings</td>
<td>Planning with interdisciplinary team members about daily issues surrounding patient care on 6W</td>
</tr>
<tr>
<td>Acute Care for the Elderly (ACE) Unit Clinical Affairs Committee</td>
<td>1999 - 2003</td>
<td>Monthly meetings</td>
<td>Long term planning issues with Vice-Chairman of Geriatrics and co-director of ACE Unit</td>
</tr>
<tr>
<td>Medicine Intern Selection Committee</td>
<td>2000 - present</td>
<td>Weekly interviews</td>
<td>Interview and selection of intern candidates for Department of Medicine</td>
</tr>
<tr>
<td>THINC Committee</td>
<td>2000 - 2001</td>
<td>Bi-monthly meetings</td>
<td>Integration of third year medicine and geriatrics clerkships</td>
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</tr>
<tr>
<td>ACE Unit (6W) renovations</td>
<td>2000</td>
<td>Bi-monthly meetings</td>
<td>Total coordination/direction of renovations project for 34 bed inpatient geriatric unit</td>
</tr>
<tr>
<td>Art and Science of Medicine (ASM) Advisory Committee</td>
<td>2001 - 2003</td>
<td>Weekly meetings</td>
<td>Development of new 2nd year medical school course</td>
</tr>
<tr>
<td>Art and Science of Medicine (ASM) Advisory Committee</td>
<td>2001 - 2003</td>
<td>Weekly meetings</td>
<td>Development of faculty who teach in ASM course</td>
</tr>
<tr>
<td>Medical School Course Directors Meetings</td>
<td>2001 - 2003</td>
<td>Monthly meetings</td>
<td>Participate as 2nd year medical school course director in planning for medical school curriculum</td>
</tr>
<tr>
<td>Course Director, Art and Science of Medicine (ASM) II</td>
<td>2001 - 2003</td>
<td>Weekly</td>
<td>Develop and coordinate all aspects of this new 2nd year medical school course</td>
</tr>
<tr>
<td>Co-Course Director, Art and Science of Medicine (ASM) II Faculty Seminar</td>
<td>2001 - 2003</td>
<td>Weekly</td>
<td>Develop and coordinate all aspects of faculty development for ASM II</td>
</tr>
<tr>
<td>Sub-Committee on Evaluation of the Executive Curriculum committee</td>
<td>2001 - 2004</td>
<td>Monthly meetings</td>
<td>Develop comprehensive evaluation tool for the end of 2nd year and 4th year of medical school</td>
</tr>
<tr>
<td>9/11, Opportunities to Reflect and Remember</td>
<td>2002</td>
<td>Weekly meetings, summer 2002</td>
<td>Planned Medical Center wide tribute to 1 year anniversary of 9/11</td>
</tr>
<tr>
<td>Third year medical school Intersession Committee</td>
<td>2002 - 2003</td>
<td>Monthly meetings</td>
<td>Participate in development and implementation of intersession for students during 3rd year of medical school</td>
</tr>
<tr>
<td>Role / Committee</td>
<td>Dates</td>
<td>Frequency</td>
<td>Responsibilities</td>
</tr>
<tr>
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</tr>
<tr>
<td>Director, Acute Musculoskeletal Medicine Clinic</td>
<td>2003 - present</td>
<td>Weekly</td>
<td>Develop and coordinate all aspects of this clinic for all housestaff on ambulatory block rotation in general internal medicine.</td>
</tr>
<tr>
<td>Rehabilitation Medicine: The Continuum of Care</td>
<td>2003</td>
<td>Monthly meetings, winter, spring 2003</td>
<td>Planned selective in Rehabilitation Medicine for third year medical students during intersession</td>
</tr>
<tr>
<td>Sex in Gotham City</td>
<td>2003</td>
<td>Monthly meetings, winter, spring 2003</td>
<td>Planned selective in Sexual Health Curriculum for third year medical students during intersession</td>
</tr>
<tr>
<td>Advisory Group Meeting</td>
<td>2003</td>
<td>Meeting, spring 2003</td>
<td>Participate in advisory group on excellence in patient care lead by Dr. Mark R. Chassin</td>
</tr>
<tr>
<td>IMA Retreat</td>
<td>2003</td>
<td>Bimonthly meetings, spring/summer 2003</td>
<td>Developed 1/2 day retreat for all staff in IMA</td>
</tr>
<tr>
<td>Mount Sinai Community Board</td>
<td>2003 - present</td>
<td>Monthly meetings</td>
<td>Participate in all activities of the Mount Sinai Community Board as physician liason</td>
</tr>
<tr>
<td>Interim Director, Internal Medicine Associates Rheumatology Clinic</td>
<td>2003 - 2004</td>
<td>Weekly</td>
<td>Coordinate all aspects of this clinic for PGY3 residents on ambulatory block rotation in general internal medicine</td>
</tr>
<tr>
<td>Mount Sinai Medical Center Community Health Fair</td>
<td>2004 - present</td>
<td>Biweekly meetings, spring 2004</td>
<td>Faculty advisor for medical students organizing community fair held at IMA</td>
</tr>
<tr>
<td>Division of General Internal Medicine Retreat</td>
<td>2004</td>
<td>Weekly meeting winter/spring 2004</td>
<td>Developed and implemented a whole day retreat for all faculty and administration</td>
</tr>
<tr>
<td>Educational Leadership Conference 2004</td>
<td>2004</td>
<td>Faculty development session and retreat</td>
<td>Small group leader for devising a review process for content reform in the medical school</td>
</tr>
<tr>
<td>Committee on Clinical Access</td>
<td>2004 - present</td>
<td>Monthly meetings</td>
<td>Participate in all activities of this committee dealing with access to the medical center and its health care services (financial, physical barriers, etc)</td>
</tr>
<tr>
<td>Role / Position</td>
<td>Time</td>
<td>Frequency</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
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<tr>
<td>Medical Director, East Harlem Health Outreach Project (EHOP)</td>
<td>2004 - present</td>
<td>Weekly</td>
<td>Coordinate and supervise all aspects of this medical student run clinic for uninsured patients in East Harlem</td>
</tr>
<tr>
<td>Mount Sinai IPA Board of Directors</td>
<td>2004 - present</td>
<td>Monthly</td>
<td>Participate in all functions of Board</td>
</tr>
<tr>
<td>Director, Internal Medicine</td>
<td>2004 - 2007</td>
<td>Weekly</td>
<td>Coordinate all aspects of this clinic for PGY3 residents on ambulatory block rotation in general internal medicine</td>
</tr>
<tr>
<td>Co-Course Director, MSTP Clinical Refresher</td>
<td>2004 - 2011</td>
<td>Weekly</td>
<td>Develop and coordinate all aspects of this new 1st year medical school course for MD/PhD students returning to clinical work after completing the PhD phase of medical school</td>
</tr>
<tr>
<td>Clinician Educator Peer Mentoring/Writing Group</td>
<td>2004 - 2007</td>
<td>monthly meetings</td>
<td>Develop and chair monthly peer mentoring/writing group for clinician educators for the Division of General Internal Medicine</td>
</tr>
<tr>
<td>Clinical Initiatives Committee</td>
<td>2004 - 2008</td>
<td>monthly meetings</td>
<td>Participate in all activities at the departmental level concerning interactions of all the divisions of the Department of Medicine</td>
</tr>
<tr>
<td>Executive Committee of the Division of General Internal Medicine</td>
<td>2004 - 2008</td>
<td>weekly meetings</td>
<td>Participate in all the strategic planning for the Division</td>
</tr>
<tr>
<td>Administrators Meeting</td>
<td>2004 - 2008</td>
<td>weekly meetings</td>
<td>Chair and participate in all components of the strategic planning for the Internal Medicine Associates outpatient faculty and resident practices</td>
</tr>
<tr>
<td>Ambulatory Revenue Cycle - Denial Reduction Committee</td>
<td>2005 - 2006</td>
<td>bimonthly meetings</td>
<td>Responsible for decreasing denials for Internal Medicine Associates and Outpatient Medical Specialty Clinics</td>
</tr>
<tr>
<td>Position</td>
<td>Start Year - End Year</td>
<td>Frequency</td>
<td>Responsibilities</td>
</tr>
<tr>
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<tr>
<td>Hospital Based Practice Chiefs</td>
<td>2005 - 2007</td>
<td>Monthly meetings</td>
<td>Participate with the Vice-Chair of Ambulatory Care in the strategic planning of the outpatient practices</td>
</tr>
<tr>
<td>Revenue Enhancement Meeting</td>
<td>2005 - 2008</td>
<td>Bimonthly meetings</td>
<td>Participate in committee responsible for enhancing revenue for all outpatient departments for the medical center</td>
</tr>
<tr>
<td>Electronic Health Record Implementation Committee</td>
<td>2005 - 2009</td>
<td>Monthly meetings</td>
<td>Coordinating and working with Information Technology division to choose and implement the EMR for the medical center starting with the outpatient clinics and practices</td>
</tr>
<tr>
<td>General Medicine Fellows Conference</td>
<td>2005 - present</td>
<td>Bimonthly meetings</td>
<td>Participate with all fellows in developing their educational and research projects</td>
</tr>
<tr>
<td>Advisory Committee of Advancing Idealism in Medicine (AIM)</td>
<td>2005 - present</td>
<td>Biennial meetings</td>
<td>Participate in meetings to review current programs and suggest future directions for resident training</td>
</tr>
<tr>
<td>Clinical Advisory Group for Ambulatory EMR</td>
<td>2005 - present</td>
<td>Monthly meetings</td>
<td>Provide clinical advice and oversight on Epic Ambulatory EMR</td>
</tr>
<tr>
<td>Subject Matter Expert for Ambulatory EMR</td>
<td>2005 - present</td>
<td>Weekly meetings</td>
<td>Content expert for design, build and validation of ambulatory EMR</td>
</tr>
<tr>
<td>Intern Selection Committee</td>
<td>2005 - present</td>
<td>Weekly meetings</td>
<td>Select and recruit new housestaff for the Department of Medicine</td>
</tr>
<tr>
<td>Executive Committee of Intern Selection Committee</td>
<td>2006 - present</td>
<td>Weekly meetings</td>
<td>Participate in setting agenda for recruitment of housestaff for the Department of Medicine</td>
</tr>
<tr>
<td>Curriculum Content Review Taskforce</td>
<td>2006</td>
<td>Monthly meetings</td>
<td>Evaluate and Assess the content and teaching methodologies for medical school curricular change across all 4 years</td>
</tr>
<tr>
<td>Quality Search Committee</td>
<td>2007 - 2008</td>
<td>Monthly meetings</td>
<td>Search committee for chair of the Department of Health Policy</td>
</tr>
<tr>
<td>Role and Committee</td>
<td>Year Range</td>
<td>Frequency</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Co-Chair, Orthopedics for the Primary Care Provider Symposium (CME)</td>
<td>2008 - present</td>
<td></td>
<td>Development and Implementation of 2 day long Continuing Medical Education Course</td>
</tr>
<tr>
<td>Co-Chair, Ambulatory Care Strategic Planning Committee</td>
<td>2008 - present</td>
<td>Weekly meetings</td>
<td>Participate with the Vice-Chair of Ambulatory Care in the strategic planning of the outpatient practices</td>
</tr>
<tr>
<td>Medication Reconciliation Task Force Committee</td>
<td>2008 - 2010</td>
<td>Monthly meetings</td>
<td>Develop and Implement medication reconciliation policy and procedures</td>
</tr>
<tr>
<td>Ambulatory Care &amp; Emergency Department Work Group Committee</td>
<td>2008 - present</td>
<td>Monthly meetings</td>
<td>Coordinate efforts between ED and Ambulatory Care</td>
</tr>
<tr>
<td>Inpatient System Selection Committee</td>
<td>2008 - 2011</td>
<td>Monthly meetings</td>
<td>EPIC Inpatient Electronic Medical Record Project, hospital chart review, nursing documentation, pharmacy.</td>
</tr>
<tr>
<td>Institute for Medical Education Membership Selection Committee</td>
<td>2009 - present</td>
<td>Monthly meetings</td>
<td>Select and recruit new faculty, core educators, clinicians and researchers.</td>
</tr>
<tr>
<td>Institutional Review Board (IRB)</td>
<td>2009 - present</td>
<td>Monthly meetings</td>
<td>To review monthly grants and application contracts submitted to the Board.</td>
</tr>
<tr>
<td>Primary Care Residency Track</td>
<td>2010 - 2011</td>
<td>Bimonthly meetings</td>
<td>Planning and Development of new Primary Care Residency track within the Internal Medicine Program.</td>
</tr>
<tr>
<td>Educational Accountability, Department of Medicine</td>
<td>2010 - 2011</td>
<td>Biweekly meetings</td>
<td>Chair of committee to develop plan to categorized and record the educational efforts for faculty in the Department of Medicine</td>
</tr>
<tr>
<td>Liaison Committee on Medical Education (LCME), Committee III, Medical Students</td>
<td>2010 - 2011</td>
<td>Biweekly meetings</td>
<td>Review member for Mount Sinai School of Medicine LCME preparation</td>
</tr>
<tr>
<td>Role</td>
<td>Time Period</td>
<td>Meetings</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Co-Chair Challenges in Internal Medicine (CME course)</td>
<td>2011-present</td>
<td>Biweekly</td>
<td>Planning, Development and Implementation of a 3 day long CME course for Department of Medicine.</td>
</tr>
<tr>
<td>Chair, CME Re-Accreditation Committee</td>
<td>2011-present</td>
<td>Weekly</td>
<td>Plan and organize the re-accreditation process for MSSM CME</td>
</tr>
<tr>
<td>Curriculum Design Team</td>
<td>2012-present</td>
<td>Biweekly</td>
<td>Review and Implement changes to the MSSM four year curriculum</td>
</tr>
</tbody>
</table>

**EXTERNAL:**

2002 – 2003  
Co-Chair, Mid-Atlantic Regional Meeting of the Society of General Internal Medicine Conference 2003 (Baltimore, MD)

2002 – 2007  
Improving Doctoring for Elder Americans (IDEA) Task Force – Society of General Internal Medicine

2003  
Chair, Clinician-Educator Award Committee, Mid-Atlantic Regional Meeting of the Society of General Internal Medicine Conference

2004  
Regional Coordinator Nominating Committee, Society of General Internal Medicine

2004  
Co-Leader, Regional Leaders Primer for Regional Officers, The 27<sup>th</sup> Annual Society of General Internal Medicine National Meeting

2004  
Co-Director, Regional Leaders Primer, The 27<sup>th</sup> Annual Society of General Internal Medicine National Meeting

2004  
Chair, Aging/Geriatrics Workshop Committee, The 28<sup>th</sup> Annual Society of General Internal Medicine National Meeting

2005  
Chair, Regional Officers Nominating Committee, Mid-Atlantic Region of the Society of General Internal Medicine

2005  
Chair, Mentoring Program, Mid-Atlantic Region of the Society of General Internal Medicine
2005 Co-Developer, SGIM Strategic Planning Retreat: Improving the Care of Older Adults Provided by Practicing Generalist Physicians

2006 Chair, Mentoring Program, Mid-Atlantic Region of the Society of General Internal Medicine

2006 Program Committee, Mid-Atlantic Region of the Society of General Internal Medicine Regional Meeting Development Committee, Society of General Internal Medicine

2006 -- present Health Care Disparities Sub-committee, Society of General Internal Medicine

2007 One-on-One Mentoring Program, Society of General Internal Medicine National Meeting

2008 - 2010 Co-Chair, Development Committee, Society of General Internal Medicine

2009 Awards Committee, Society of General Internal Medicine, Mid-Atlantic Region

2009 -- present Geriatrics Task Force, Society of General Internal Medicine

2010 Awards Committee, Society of General Internal Medicine, Mid-Atlantic Region Clinician-Educator Awards Committee

2010 -- present Chair, Development Committee, Society of General Internal Medicine

2010 -- 2011 Capital Campaign Committee, Society of General Internal Medicine

2010 -- 2011 2011 Society of General Internal Medicine Program Committee, 34th Annual Meeting

2010 -- 2011 Workshop Chair, Society of General Internal Medicine 34th Annual Meeting

2010 Ad Hoc Financial Advisory Committee, Society of General Internal Medicine

2010 -- 2011 Co-Chair, Capital Campaign Committee, Society of General Internal Medicine

2011 Clinician-Educator Committee, Society of General Internal Medicine, Mid-Atlantic Region
2012  | Poster Judge, 2012 Mid-Atlantic Regional Society of General Internal Medicine
---|---
2012  | Mentor, 2012 Mid-Atlantic Regional Society of General Internal Medicine

**Training Record:**

<table>
<thead>
<tr>
<th>Trainee's Name</th>
<th>Level of Trainee</th>
<th>Role in Training &amp; Inclusive Dates of Training</th>
<th>Training Venue</th>
<th>Trainee's Current Status &amp; Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liping Yao, MD</td>
<td>PGY 1 - 3</td>
<td>Career Advisor 1997-2000</td>
<td>N/A</td>
<td>Attending, Abington Memorial Hospital</td>
</tr>
<tr>
<td>Arick Olson, MD</td>
<td>PGY 1 - 3</td>
<td>Career Advisor 1999-2001</td>
<td>N/A</td>
<td>Attending, Mount Sinai School of Medicine, Department of Medicine</td>
</tr>
<tr>
<td>Shane O. LeBeau, MD</td>
<td>PGY 2 - 3</td>
<td>Advisor 2000 - 2002</td>
<td>N/A</td>
<td>Endocrinology Fellow</td>
</tr>
<tr>
<td>Reena Karani, MD</td>
<td>Chief fellow/research fellow in Geriatrics</td>
<td>Mentor 2001 - 2003</td>
<td>N/A</td>
<td>Associate Professor, Mount Sinai Medical Center, Associate Dean of Curriculum and Evaluation, Mount Sinai School of Medicine</td>
</tr>
<tr>
<td>Iosif Aronov</td>
<td>Medical Student</td>
<td>Career Advisor 2002 - 2003</td>
<td>N/A</td>
<td>Long Island Jewish Hospital Internal Medicine Resident</td>
</tr>
<tr>
<td>Charles Falzon</td>
<td>Medical Student</td>
<td>Career Advisor 2002 - 2003</td>
<td>N/A</td>
<td>Bethesda Naval Hospital Residence in Surgery</td>
</tr>
<tr>
<td>Lisa Brod</td>
<td>Medical Student</td>
<td>Career Advisor 2002 - 2003</td>
<td>N/A</td>
<td>Residency</td>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Career Advisor</th>
<th>Residency</th>
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<tbody>
<tr>
<td>Adam Kawalek</td>
<td>Medical Student</td>
<td>2002 - 2003</td>
<td>N/A</td>
</tr>
<tr>
<td>Brandi Ross-Douglas, MD</td>
<td>PGY 2 - 3</td>
<td>Advisor/Mentor 2002 - 2003</td>
<td>Attending Physician, Occupational Medicine Clinic, Mount Sinai Medical Center</td>
</tr>
<tr>
<td>Neelofar Varjavand, MD</td>
<td>Assistant Professor of Medicine</td>
<td>Advisor/Mentor 2003 - 2004</td>
<td>Associate Program Director, Drexel University College of Medicine, MCP campus</td>
</tr>
<tr>
<td>Payam Saadai</td>
<td>Medical Student</td>
<td>Advisor/Mentor 2003 - 2010</td>
<td>Surgery Resident, Mount Sinai School of Medicine</td>
</tr>
<tr>
<td>Kathryn Artis</td>
<td>Medical Student</td>
<td>Advisor/Mentor 2003 - 2007</td>
<td>N/A, Attending physician</td>
</tr>
<tr>
<td>Richard Lyn-Cook, MD</td>
<td>General Internal Medicine Fellow</td>
<td>Advisor/Mentor 2003 - present</td>
<td>Attending Physician, Montefiore Medical Center</td>
</tr>
<tr>
<td>Ramiro Jervis, MD</td>
<td>Attending Hospitalist</td>
<td>Advisor/Mentor 2004 - 2007</td>
<td>Assistant Professor, Mount Sinai School of Medicine, Department of Medicine</td>
</tr>
<tr>
<td>Cherita Raines</td>
<td>Medical Student</td>
<td>Advisor/Mentor 2004 - 2008</td>
<td>N/A, Family Medicine Resident</td>
</tr>
<tr>
<td>David Alfandre, MD</td>
<td>Attending Physician</td>
<td>Advisor/Mentor 2004 - 2008</td>
<td>N/A, Director of Ethics, VA Medical Systems</td>
</tr>
<tr>
<td>Tonia Kim, MD</td>
<td>Attending Nephrologist</td>
<td>Advisor/Mentor 2005 - 2007</td>
<td>Course Director, Nephrology Mount Sinai School of Medicine</td>
</tr>
<tr>
<td>Jason Cordero</td>
<td>Medical Student</td>
<td>Advisor/Mentor 2005 - 2009</td>
<td>N/A, Residency</td>
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<tr>
<td>Anthony Oparaji, MD</td>
<td>General Internal Medicine Fellow</td>
<td>Advisor/Mentor 2004 - 2006</td>
<td>Attending, North General Hospital, NY, NY</td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Advisor/Mentor Date</td>
<td>Status</td>
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<tr>
<td>Julie Wisniewski, MD</td>
<td>Resident</td>
<td>Advisor/Mentor 2005 - 2009</td>
<td>N/A</td>
</tr>
<tr>
<td>David Kuo, MD</td>
<td>Attending Physician</td>
<td>Advisor/Mentor 2005 - present</td>
<td>N/A</td>
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<tr>
<td>Fedele DePalma</td>
<td>Medical Student</td>
<td>Mentor 2006</td>
<td>N/A</td>
</tr>
<tr>
<td>German Echeverry</td>
<td>Medical Student</td>
<td>Advisor/Mentor 2006 - 2010</td>
<td>N/A</td>
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<tr>
<td>Matthew Whitson</td>
<td>Advisor/Mentor</td>
<td>2006 - present</td>
<td>N/A</td>
</tr>
<tr>
<td>Harish Jasti, MD</td>
<td>Attending, University of Pittsburgh</td>
<td>Mentor 2006 - present</td>
<td>N/A</td>
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<tr>
<td>Jonathan G. Tardos</td>
<td>Medical Student</td>
<td>Career Advisor 2006 - 2008</td>
<td>N/A</td>
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<tr>
<td>Lisa Bensinger, MD</td>
<td>Assistant Professor</td>
<td>2005 - 2011</td>
<td>N/A</td>
</tr>
<tr>
<td>Corinna Manini, MD</td>
<td>Assistant Professor</td>
<td>Mentor 2006 - present</td>
<td>N/A</td>
</tr>
<tr>
<td>Name</td>
<td>Title/Role</td>
<td>Mentoring Period</td>
<td>Affiliation</td>
</tr>
<tr>
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<tr>
<td>Cheryl Adackapara</td>
<td>Medical Student, Johns Hopkins Medical Center</td>
<td>Mentor - 2007</td>
<td>N/A</td>
</tr>
<tr>
<td>Donald Gardenier, NP</td>
<td>Nurse Practitioner</td>
<td>Mentor 2007-2008</td>
<td>N/A Doctor of Nursing Practice dissertation committee/Case Western Reserve University</td>
</tr>
<tr>
<td>Lauren Acinapura, MD</td>
<td>General Internal Medicine Fellow</td>
<td>Mentor 2007-2008</td>
<td>N/A Assistant Professor Cornell Weill Hospital</td>
</tr>
<tr>
<td>Julie Nissim, MD</td>
<td>General Internal Medicine Fellow</td>
<td>Mentor 2007-2008</td>
<td>N/A Assistant Professor &amp; Attending Mount Sinai School of Medicine</td>
</tr>
<tr>
<td>Florence Momplasir</td>
<td>Resident UMDNJ Cooper University Hospital</td>
<td>Mentor 2008</td>
<td>N/A</td>
</tr>
<tr>
<td>Alice Li</td>
<td>Medical Student</td>
<td>Mentor 2007-2008</td>
<td>N/A MSSM Alumni Summer Research Fellowship</td>
</tr>
<tr>
<td>Jessica Taylor</td>
<td>Medical Student</td>
<td>Mentor 2007-2009</td>
<td>N/A Internal Medicine resident, Beth Israel Deaconness Hospital, Boston MA</td>
</tr>
<tr>
<td>Yasmin Meah</td>
<td>Assistant Professor</td>
<td>Mentor 2004-present</td>
<td>N/A Program Director, East Harlem Health Outreach Partnership, Mount Sinai School of Medicine, Medical Education</td>
</tr>
<tr>
<td>Kate M. Liberman</td>
<td>Medical Student</td>
<td>Mentor 2008</td>
<td>N/A Mount Sinai School of Medicine Alumni</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Mentor Period</td>
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<tr>
<td>Theresa Soriano</td>
<td>Assistant Professor</td>
<td>Mentor - 2009</td>
<td>N/A</td>
</tr>
<tr>
<td>Sonia Dayal</td>
<td>Assistant Professor</td>
<td>Mentor - 2009</td>
<td>N/A</td>
</tr>
<tr>
<td>Elizabeth Uchitelle</td>
<td>Assistant Professor</td>
<td>Mentor – 2009 - 2010</td>
<td>N/A</td>
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<tr>
<td>Christopher Smith</td>
<td>Resident</td>
<td>Mentor – 2010</td>
<td>N/A</td>
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<tr>
<td>Lauren Peccoralo</td>
<td>General Internal Medicine Fellow</td>
<td>Mentor – 2009-present</td>
<td>N/A</td>
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<tr>
<td>Erika Yamada</td>
<td>Attending Physician, DGIM</td>
<td>Mentor – 2011-present</td>
<td>N/A</td>
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<tr>
<td>Kathleen Atlas</td>
<td>Chief Resident, Med/Peds</td>
<td>Mentor – 2010-present</td>
<td>N/A</td>
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<tr>
<td>Jane Shin Jue</td>
<td>General Medicine Fellow, University of Pennsylvania</td>
<td>Career Mentor 2011 - present</td>
<td>N/A</td>
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<tr>
<td>Wei Wei Lee</td>
<td>Attending, Assistant Professor, University of Chicago</td>
<td>Career Mentor 2011</td>
<td>N/A</td>
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<tr>
<td>Alison Gault</td>
<td>Attending, Assistant Professor of Pediatrics, MSSM</td>
<td>Medical Education project mentor 2011 - present</td>
<td>N/A</td>
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</table>
## Grants and Contract Support: (Past)

<table>
<thead>
<tr>
<th>Funding source, Project title &amp; Number</th>
<th>Role in Project</th>
<th>Dates</th>
<th>Direct Costs</th>
<th>Supplemental Info</th>
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</thead>
<tbody>
<tr>
<td>John A. Hartford Foundation</td>
<td>Co-PI –</td>
<td>3/01/01 – 9/30/01</td>
<td>$50,000</td>
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<tr>
<td>Geriatric Training of Internal Medicine Residents</td>
<td>David C. Thomas, MD</td>
<td>10%</td>
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<tr>
<td>The Geriatric Education and Research Fund Award</td>
<td>PI –</td>
<td>2001 - 2002</td>
<td>$5000</td>
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<td></td>
<td>David C. Thomas, MD</td>
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<tr>
<td>Pfizer Sexual Health Medical School Curriculum Grant: Sexual and Reproductive Health Education Project</td>
<td>Co-PI –</td>
<td>2001 - 2004</td>
<td>$100,000</td>
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<td></td>
<td>David C. Thomas, MD</td>
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<tr>
<td>Mount Sinai Auxiliary Board</td>
<td>PI –</td>
<td>2002 - 2005</td>
<td>$6,678</td>
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<tr>
<td>The Development, Implementation and Evaluation of an Acute Musculoskeletal Medicine Clinic for Internal Medicine Housestaff</td>
<td>David C. Thomas, MD</td>
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<tr>
<td>AAMC Caring for Community Grant Program. East Harlem Health Outreach Partnership (EIHOP)</td>
<td>CO-PI –</td>
<td>6/1/04 – 5/30/08</td>
<td>$30,000</td>
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<td></td>
<td>David C. Thomas, MD</td>
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<tr>
<td>Society of General Internal Medicine, IDEA Task Force. Improving the care of older adults provided by practicing generalist</td>
<td>Co-PI –</td>
<td>3/1/05 – 10/1/06</td>
<td>$25,000</td>
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<td></td>
<td>David C. Thomas, MD</td>
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<tr>
<td>Funding Source, Project Title &amp; Number</td>
<td>Role in Project</td>
<td>Dates</td>
<td>Direct Costs</td>
<td>Supplemental Info</td>
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<tr>
<td>GCO 06-0725 Attorney General Prescribing Education Program</td>
<td>PI -- Ethan Halm, Investigator -- David C. Thomas, MD</td>
<td>12/1/06 – 11/30/09</td>
<td>$400,000</td>
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<tr>
<td>Josiah Macy, Jr. Foundation via AAMC (renewal). Enhancing Education of Chronic Illness Care for Medical Students and Internal Medicine Residents</td>
<td>Co-PI -- David C. Thomas, MD</td>
<td>7/1/07 – 6/30/08</td>
<td>$50,000</td>
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### Grants and Contracts (Present)

<table>
<thead>
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<th>Funding Source, Project Title &amp; Number</th>
<th>Role in Project</th>
<th>Dates</th>
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<th>Supplemental Info</th>
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<tbody>
<tr>
<td>AAMC Caring for Community Grant Program.</td>
<td>Co-PI — David C. Thomas, MD</td>
<td>6/1/08 – 5/30/12</td>
<td>$20,000</td>
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| East Harlem Health Outreach Partnership (EHHOP) |                    |            |              |                   |

### Clinical Trial Participation (Past)

<table>
<thead>
<tr>
<th>Project</th>
<th>Role in Project</th>
<th>Dates</th>
<th>Award</th>
<th>Other Info.</th>
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</thead>
<tbody>
<tr>
<td>Aventis Pharmaceuticals An Epidemiological Observational study of Deep Vein Thrombosis (DVT)</td>
<td>Co-Principal Investigator</td>
<td>2001 - 2002</td>
<td>5%</td>
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</table>

### Teaching Activities:

<table>
<thead>
<tr>
<th>Teaching Activity/Topic</th>
<th>Level</th>
<th>Role</th>
<th>Number of Learners</th>
<th>Number of hours per week/month/year</th>
<th>Years Taught</th>
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</thead>
<tbody>
<tr>
<td>Supervise patient care/Rehabilitation residents</td>
<td>Medical School Course</td>
<td>Preceptor</td>
<td>4 to 6</td>
<td>4 Hrs per week 52 sessions/yr</td>
<td>1997 - 1999</td>
</tr>
<tr>
<td>Medical School Course</td>
<td>Clinic / Preceptor</td>
<td>4 - 7 Hrs per session</td>
<td>240 sessions / yr</td>
<td>1997 - present</td>
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<tr>
<td>Medical School Lecture Series: Medical Complications Immobility</td>
<td>Medical School Course</td>
<td>Lecturer</td>
<td>2.5 hrs per session</td>
<td>2 sessions / yr</td>
<td>1998 - present</td>
</tr>
<tr>
<td>1st year Medical students: Introduction to Medicine course</td>
<td>Medical School Course</td>
<td>Preceptor</td>
<td>4 hrs per session 12 sessions / yr</td>
<td>1999</td>
<td></td>
</tr>
<tr>
<td>3rd year Medical students/Clinical Preceptor</td>
<td>Medical School Course</td>
<td>Preceptor</td>
<td>2 hrs per session 12 sessions / yr</td>
<td>1999 - present</td>
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</tr>
<tr>
<td>Geriatric Rehabilitation Medicine: Internal Medicine residents/medical students</td>
<td>Medical School Course</td>
<td>Co-Teacher</td>
<td>1 hr per session 13 sessions / yr</td>
<td>1999 - present</td>
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</tr>
<tr>
<td>Rehabilitation Medicine Residents: Primary Care for People with Disabilities Clinic/Preceptor</td>
<td>Medical School Course</td>
<td>Co-Teacher</td>
<td>4 hrs session 40 sessions / yr</td>
<td>1999 - 2003</td>
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<tr>
<td>Internal Medicine Residents: Domestic Violence Seminars</td>
<td>Medical School Course</td>
<td>Co-Teacher</td>
<td>3 hrs per session 6 sessions / yr</td>
<td>1999 - 2003</td>
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</tr>
<tr>
<td>Inpatient Rounds ACE unit (6W)</td>
<td>Teaching / Attending</td>
<td>1 - 2 hrs per session 150 sessions / yr</td>
<td>1999 - 2003</td>
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<tr>
<td>Ambulatory Morning Report: Internal Medicine residents</td>
<td>Medical School Course</td>
<td>Preceptor</td>
<td>1 hr per session 20 sessions / yr</td>
<td>1999 - present</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Morning Report: Internal Medicine Interns</td>
<td>Medical School Course</td>
<td>Preceptor</td>
<td>1 hr per session 10 sessions / yr</td>
<td>2000 - present</td>
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<tr>
<td>Program</td>
<td>Type</td>
<td>Hours/Session</td>
<td>Sessions/Year</td>
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<tr>
<td>1st year Medical students: clerkship</td>
<td>Course, Preceptor</td>
<td>1 per session</td>
<td>4 - 6 hrs per session</td>
<td>2000 - present</td>
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<tr>
<td>1st year Medical Students: Art and Science of Medicine</td>
<td>Medical School Course, Preceptor</td>
<td>13 per session</td>
<td>16 sessions/yr</td>
<td>2000</td>
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<tr>
<td>4th year Medical Students: Aging from the Outside In Geriatrics Clerkship</td>
<td>Medical School Geriatric Clerkship, Lecturer</td>
<td>10 - 15 per session</td>
<td>1.5 hrs per session 12 sessions/yr</td>
<td>2000 - 2003</td>
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<tr>
<td>4th year Medical Students: Ambulatory Medicine</td>
<td>Medical School Course, Preceptor</td>
<td>1 per session</td>
<td>4 hrs per session 28 sessions/yr</td>
<td>2000 - present</td>
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<tr>
<td>Intern Lecture Series, Medicine Interns: Shoulder and Knee Exam</td>
<td>Medical School Course, Lecturer</td>
<td>6</td>
<td>1 hr per session 6 - 10 sessions/yr</td>
<td>2001 - present</td>
<td></td>
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<tr>
<td>Med-Peds Lecture Series/residents</td>
<td>Medical School Course, Lecturer</td>
<td>12</td>
<td>1.5 hr per session 2 sessions/yr</td>
<td>2001 - present</td>
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<tr>
<td>Fellows in Geriatric Medicine: Domestic Violence Training Seminar</td>
<td>Department, Co-facilitator</td>
<td>14</td>
<td>2.0 hrs per session 1 session/yr</td>
<td>2001 - 2004</td>
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<tr>
<td>2nd year Medical students: Art and Science of Medicine II</td>
<td>Medical School Program, Small Group Leader</td>
<td>12</td>
<td>4 hrs per session 34 sessions/yr</td>
<td>2001 - 2003</td>
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<tr>
<td>2nd year Medical students: Art and Science of Medicine II: Musculoskeletal Medicine</td>
<td>Medical School Course, Lecturer</td>
<td>104-110</td>
<td>1.5 hrs per session 1 session/yr</td>
<td>2001 - present</td>
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<tr>
<td>Course</td>
<td>Institution</td>
<td>Role</td>
<td>Credits</td>
<td>Hours per Session</td>
<td>Frequency</td>
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<tr>
<td>2nd year Medical Student: Art and Science of Medicine II: The Nervous System</td>
<td>Medical School Program</td>
<td>Lecturer</td>
<td>104-110</td>
<td>1.5 hrs per session</td>
<td>1 session/yr</td>
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<tr>
<td>2nd year Medical Student: Art and Science of Medicine II:</td>
<td>Medical School Program</td>
<td>Lecturer</td>
<td>104-110</td>
<td>1.5 hrs per session</td>
<td>1 session/yr</td>
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<tr>
<td>Teaching Interns: Acute Musculoskeletal Medicine Clinic</td>
<td>Medical School Program</td>
<td>Lecturer</td>
<td>3</td>
<td>1 hr per session</td>
<td>52 sessions/yr</td>
</tr>
<tr>
<td>Teaching Interns: Acute Musculoskeletal Medicine Clinic</td>
<td>Medical School Program</td>
<td>Director &amp; Preceptor</td>
<td>3</td>
<td>3 hrs per session</td>
<td>52 sessions/yr</td>
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<tr>
<td>1st year Medical Students: East Harlem Tour Guide</td>
<td>Medical School Program</td>
<td>Group Facilitator</td>
<td>12</td>
<td>4 hrs per session</td>
<td>1 session/yr</td>
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<tr>
<td>Housestaff: Medical Ethics Seminar</td>
<td>Medical School Program</td>
<td>Facilitator/Small group leader</td>
<td>12</td>
<td>2 hrs per session</td>
<td>4 sessions/yr</td>
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<tr>
<td>3rd year Medical Student: Sexual and Reproductive Health Selective</td>
<td>Medical School Program</td>
<td>Facilitator/Small group leader</td>
<td>21</td>
<td>4 hrs per session</td>
<td>1 session/yr</td>
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<tr>
<td>3rd year medical student: Health Policy Selective</td>
<td>Medical School Program</td>
<td>Facilitator/Small group leader</td>
<td>21</td>
<td>2 hrs per session</td>
<td>1 session/yr</td>
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<tr>
<td>1st year Medical Student: ASM 1 Clinical Preceptor</td>
<td>Medical School Program</td>
<td>Teach History &amp; Physical Exam</td>
<td>1</td>
<td>3 hrs per session</td>
<td>6 sessions/yr</td>
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<tr>
<td>1st year Fellows: Geriatric Fellows OSCE</td>
<td>Department Level</td>
<td>Evaluator</td>
<td>7</td>
<td>5 hrs per session</td>
<td>1 session/yr</td>
</tr>
<tr>
<td>MD/PhD 3rd year Medical Students: MSTP Clinical Refresher</td>
<td>Medical School Program</td>
<td>Teach History and Physical Exam</td>
<td>7</td>
<td>3 hrs per session</td>
<td>10 session/yr</td>
</tr>
<tr>
<td>Interns in Internal Medicine: Cultural Competency East Harlem Tour</td>
<td>Medical School Program</td>
<td>Tour &amp; Teach history &amp; Culture</td>
<td>4 hrs per session</td>
<td>2004 - present</td>
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<tr>
<td>2nd year Medical students: MORE Program: Transition to Clerkship Years</td>
<td>Medical School Program</td>
<td>Teach &amp; Mentor</td>
<td>5 hrs per session</td>
<td>2 sessions/yr</td>
<td>2005</td>
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<tr>
<td>Harvard Macy Institute for Medical Educators</td>
<td>Medical School Program</td>
<td>Teaching Poster &amp; Abstract Development &amp; Submission</td>
<td>2 hrs per session</td>
<td>1 session/yr</td>
<td>2005</td>
</tr>
<tr>
<td>Ambulatory Care Elective for Medical Students</td>
<td>Medical School Program</td>
<td>Director</td>
<td>2 - 3</td>
<td>13 sessions/yr</td>
<td>2008 - present</td>
</tr>
</tbody>
</table>

* Average evaluation relative to maximum score

Publications:

Peer Reviewed Original Contributions


Invited Contributions


3. Mid-Atlantic Region has overwhelming success at the 22nd Annual Meeting in New York City Thomas, David C., MD, MS, and Marchese, Peter N., MIA, The FORUM, Society of General Internal Medicine, May, 2002.

4. Free and Flexible, Basic Flexibility Exercises Focus on Healthy Aging, Mount Sinai School of Medicine, December 2002.


6. Mobility Devices can Help You Remain Independent, Focus on Healthy Aging, Mount Sinai School of Medicine, April 2007.

7. My Joints Ache all the Time, Focus on Healthy Aging, Mount Sinai School of Medicine, October 2010.
Books and Chapters in Books

1. Ragnarsson, Kristjan T., Thomas, David C., Principles of Cancer Rehabilitation Medicine, Cancer Medicine, 5th edition, Chapter 71, pp. 125-141, B.C. Decker Inc, Publisher.

2. Ragnarsson, Kristjan T., Thomas, David C., Principles of Cancer Rehabilitation Medicine, Cancer Medicine, 6th edition, Section 19, Chapter 72, pp. 1063-1077, B.C. Decker Inc, Publisher. 2003.


4. Thomas, David C., Ragnarsson, Kristjan T., Principles of Cancer Rehabilitation Medicine, Cancer Medicine, 7th edition, Section 19, Chapter 61, pp. 922-934, B.C. Decker Inc, Publisher 2006.


Invited Lectures/Presentations:

1. Primary Care for Persons with Disability. Mount Sinai Medical Center, New York, January 22, 1997.

2. Primary Care for Persons with Disability. St Vincent's Hospital, New York, NY, March 27, 1997.


12. Effects of Prolonged Immobilization. Mount Sinai Medical Center, Department of Physical and Occupational Therapy, November 9, 2000.

13. Clinical Assessment of Stroke. Mount Sinai Medical Center, Department of Medicine Faculty Development Series, January 12, 2001.


18. An Evidence-Based Unfolding Case with a Linked Objective Structured Clinical Exam (OSCE): A Curriculum in In-Patient Geriatric Medicine, Brookdale Department of Geriatrics and Adult Development Research Presentations, Mt. Sinai School of Medicine, New York, NY, April 4, 2002.

19. Developing an Unfolding Case and a Linked Objective Structured Clinical Exam (OSCE) for your practice, Fellows in Geriatric Medicine, Mt. Sinai Medical Center, April 18, 2002.


24. Musculoskeletal Problems and Immobility in Older Adults: Enhancing Diagnosis and Treatment Approaches for Primary Care Practitioners. Session Coordinator for the Geriatrics Interest Group of SGIM: Workshop at the 26th Annual Meeting of The Society of General Internal Medicine, Vancouver, BC, May 2, 2003.


32. Musculoskeletal Medicine and the role of Rehabilitation, Department of Veterans Affairs, Annual Primary Care Conference: Update in Primary Care, Tenneck, NJ, June 23, 2004

33. Principles of Geriatric Rehabilitation, Geriatric Medicine: Update & Board Review, Mount Sinai School of Medicine, October 9, 2004.

34. The Musculoskeletal Exam in the Older Patient, Workshop, Geriatric Medicine: Update & Board Review, Mount Sinai School of Medicine, October 9, 2004.

35. Musculoskeletal Clinic Development and Implementation, Division of General Internal Medicine Faculty Development, Mount Sinai School of Medicine, December 3, 2004.

36. Musculoskeletal Medicine: Exam and Diagnosis of Common Primary Care Conditions, Division of General Internal Medicine Faculty Development, Mount Sinai School of Medicine, December 10, 2004.


39. Functional Assessment, Bronx VA Medical Center, April 4, 2005.

40. The Role of Culture in Treating Patients with Disabilities, Jamaica Hospital Medical Center, Department of Family Medicine, April 15, 2005.
41. Melding Mentoring into your Region, Pre-course at the Society of General Internal Medicine's Annual Meeting, New Orleans, LA, May 11, 2005


46. Functional Assessment, Mount Sinai School of Medicine, June 1, 2005.

47. EHHOP: A Mount Sinai student initiative to improve access to healthcare to the uninsured of East Harlem, Department of Medicine Grand Rounds, Mount Sinai School of Medicine, August 23, 2005.

48. From Sri Lanka to the Dominican Republic: Physician Volunteerism in the Global Community, Division of General Internal Medicine Grand Rounds, Mount Sinai School of Medicine, September 8, 2005.

49. Principles in Geriatric Rehabilitation, Geriatric Medicine: Update and Board Review, Mount Sinai School of Medicine, New York, September 12, 2005.

50. Musculoskeletal Medicine Workshop, Geriatric Medicine: Update and Board Review, Mount Sinai School of Medicine, New York, September 12, 2005.

51. Objective Structured Clinical Examinations (OSCE's): Psychometrics and Use in Competency-Based Training Systems, Mount Sinai School of Medicine, Medical Education Grand Rounds, November 16, 2005.


55. Beginning your Teaching Portfolio, Workshops at the Educational Leadership Conference, Mount Sinai School of Medicine, June 12, 2006.

56. Incidentalomas, 2nd Annual Challenges in Internal Medicine, Mount Sinai School of Medicine, June 22, 2006.

57. A Collaborative Peer Mentorship Program for Clinician-Educators, Oral Presentation, Association for Medical Education in Europe, Genoa, Italy, September 16, 2006

58. Principles in Geriatric Rehabilitation, Geriatric Medicine: Update and Board Review, Mount Sinai School of Medicine, New York, September 17, 2006.

59. Musculoskeletal Medicine Workshop, Geriatric Medicine: Update and Board Review, Mount Sinai School of Medicine, New York, September 17, 2006.

60. Vulnerable Populations: Health for the Uninsured, Mount Sinai School of Medicine, October 11, 2006.

61. Caring for the Uninsured: The Role of Student-Run Clinics Conference, Faculty, Mount Sinai School of Medicine, October 22, 2006.

62. Orthopedics for the Primary Care Provider, Mount Sinai Medical Center, November 10-11, 2006.

63. Vamos al Barrio, Department of Medicine Humanism in Medicine Grand Rounds, Mount Sinai School of Medicine, March 13, 2007.


65. The Chronic Care Model: Implications for Medical Education, Bronx VA Medical Center Department of Medicine Grand Rounds, June 14, 2007.
66. How do I tell them that? Providing feedback about professionalism, Workshop, Association of Medical Educators of Europe (AMEE), Trondheim, Norway, August 27, 2007.

67. Principles in Geriatric Rehabilitation, 2007 Intensive Update with Board Review in Geriatric and Palliative Medicine, Mount Sinai School of Medicine, New York, September 30, 2007.

68. Musculoskeletal Medicine Workshop, 2007 Intensive Update with Board Review in Geriatric and Palliative Medicine, Mount Sinai School of Medicine, New York, September 30, 2007.

69. Common Cases: An Internist Perspective, Orthopedics for the Primary Care Provider, Mount Sinai School of Medicine, New York, November 3, 2007.

70. Practice Management and Innovation, Precourse at the Society of General Internal Medicine’s Annual Meeting, Pittsburgh, PA, April 9, 2008.


73. Principles of Geriatric Rehabilitation, Bronx-Lebanon Hospital Center, Albert Einstein College of Medicine, Department of Medicine, Grand Rounds, August 7, 2008.


75. Plenary: Principles in Geriatric Rehabilitation, 2008 Intensive Update with Board Review in Geriatric and Palliative Medicine, Mount Sinai School of Medicine, New York, September 14, 2008.

76. Musculoskeletal Medicine Workshop, 2008 Intensive Update with Board Review in Geriatric and Palliative Medicine, Mount Sinai School of Medicine, New York, September 14, 2008.

78. Redirecting Unprofessional Behaviors: A Practical Approach. Workshop 2W, Association for Medical Education in Europe (AMEE), Malaga, Spain, August 31, 2009.

79. Curriculum Development: Putting Theory into Practice. Workshop 4V, Association for Medical Education in Europe (AMEE), Malaga, Spain, August 31, 2009.

80. Workplace Assessment in Health Professional Education. Workshop 7V, Association for Medical Education in Europe (AMEE), Malaga, Spain, September 1, 2009.


83. Musculoskeletal Medicine for the Internist. Department of Medicine Grand Rounds, Saint Barnabas Health Care System, Monmouth Medical Center, October 8, 2009.


85. Common Cases: An Internists Perspective, Lecture at Orthopedics for the Primary Care Provider, October 31, 2009, Mount Sinai Medical Center.


89. Musculoskeletal Medicine for the Internist; Grand Rounds, Division of General Internal Medicine, Mount Sinai School of Medicine, September 16, 2010.


92. Musculoskeletal Medicine for the Internist; Grand Rounds, Department of Medicine, Overlook Hospital, October 14, 2010.

93. Common Cases: An Internists Perspective, Lecture at Orthopedics for the Primary Care Provider, October 30, 2010, Mount Sinai Medical Center.

94. Ambulatory Care at Mount Sinai, Seminar series for Ambassador’s Program, Mount Sinai Medical Center, April 14, 2011.

95. Perceptions of Internal Medicine Residents of Methods, Rewards and Challenges of Caring for Patients with Chronic Illness: A Qualitative Pilot Study, Association for Medical Education in Europe (AMEE), Vienna, Austria, August 29, 2011.


98. Hospital Administration for Chinese Healthcare Executives: The Mount Sinai Medical Center’s Ambulatory Care experience. Mount Sinai Medical Center, September 26, 2011.

### Media Resource Educational Materials:

<table>
<thead>
<tr>
<th>Material**</th>
<th>Role</th>
<th>Development time and use</th>
<th>Dissemination</th>
<th>Application</th>
<th>Evaluation (if available)*</th>
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<tbody>
<tr>
<td>Inpatient Geriatric Medicine</td>
<td>Co - Developer</td>
<td>1999 - 2002</td>
<td>Presented at Regional Society of General Internal Medicine conference, 2000</td>
<td>Resident curriculum for inpatient rotation in Geriatric Medicine</td>
<td>N/A</td>
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<tr>
<td>curriculum</td>
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<tr>
<td>Domestic Violence curriculum</td>
<td>Co - Developer</td>
<td>2000 - present</td>
<td>Presented at National Society of General Internal Medicine conference, 2001</td>
<td>3 -hour PGY2 resident seminar, 6 ssn's/yr</td>
<td>4.8/5.0</td>
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<tr>
<td>Rehabilitation Medicine for Fellow in Geriatric Medicine</td>
<td>Co - Developer</td>
<td>2001 - present</td>
<td>N/A</td>
<td>Developing curriculum in Rehab. Medicine for fellows in Geriatric Medicine</td>
<td>N/A</td>
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<tr>
<td>Art and Science of Medicine II 2nd year medical school course</td>
<td>Developer</td>
<td>2001 - present</td>
<td>N/A</td>
<td>Developing curriculum for new 2nd year medical school course</td>
<td>N/A</td>
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<tr>
<td>Art and Science of Medicine II Faculty Development</td>
<td>Co - Developer</td>
<td>2001 - present</td>
<td>N/A</td>
<td>Developing curriculum for faculty teaching small groups in ASM II</td>
<td>N/A</td>
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<tr>
<td>An Unfolding Case in Inpatient Geriatric Medicine</td>
<td>Co - Developer</td>
<td>2001 - present</td>
<td>American Geriatrics Society Annual meeting, May 2002</td>
<td>A unique teaching approach to standardize the curriculum for all Internal Medicine</td>
<td>N/A</td>
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<tr>
<td>Members of the Medical Team</td>
<td>Developer</td>
<td>2002 - present</td>
<td>N/A</td>
<td>Developed Team Member Seminar for Art and Science of Medicine II and Clinical Skills Week</td>
<td>N/A</td>
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<tr>
<td>Web Based Syllabus - ASM II</td>
<td>Co-Developer</td>
<td>July 2001 to July 2003</td>
<td>N/A</td>
<td>Web based resources for teaching 2nd year medical students and review of material for all medical students</td>
<td>N/A</td>
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<tr>
<td>Acute Musculoskeletal Medicine Curriculum</td>
<td>Developer</td>
<td>2003 - present</td>
<td>National and Regional Society of General Internal Medicine (SGIM) Annual Meeting</td>
<td>Developed curriculum for all housestaff and faculty to diagnose and treat common acute musculoskeletal complaints and injuries</td>
<td>5.0/5.0</td>
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<tr>
<td>Geriatric Fellows Objective Structured Clinical Examination</td>
<td>Co-Developer 2004 - present</td>
<td>pending</td>
<td>Developed OSCE with Geriatrics fellowship director to evaluate level of incoming fellows and follow longitudinally</td>
<td>N/A</td>
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<tr>
<td>Development and Implementation of a Patient-Based Musculoskeletal Curriculum for Internal Medicine Residents</td>
<td>Developer 2005</td>
<td>Society of General Internal Medicine National Conference Precourse</td>
<td>Curriculum for dissemination and implementation at 14 other residency programs in US</td>
<td>4.82/5.0</td>
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<tr>
<td>Community Health-Education Program (Good Health is Precious)</td>
<td>Co-Developer 2005 - present</td>
<td>Local Community Organizations of NYC</td>
<td>Developed lecture series for community outreach and cardiovascular screenings</td>
<td>N/A</td>
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<tr>
<td>Geriatric Ambulatory Care Curriculum for Internal Medicine Residents</td>
<td>Co-Developer 2005 - present</td>
<td>N/A</td>
<td>Developed curriculum to instruct internal medicine residents in a geriatric assessment of the older patient</td>
<td>N/A</td>
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<tr>
<td>&quot;That Was Unprofessional!&quot; Strategies for Giving Effective Feedback</td>
<td>Co-Developer 2008</td>
<td>Association of Medical Educators of Europe Conference Prague, The Czech Republic</td>
<td>Developed video module for use in workshops</td>
<td>N/A</td>
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</table>
Community Service:

1983 & 1985  
Haitian Relief Volunteer aiding physician in various clinics in the impoverished areas. Haiti

1985  
Guatemala Pilgrim as a youth leader of group organized by the Brothers of the Christian Schools. Guatemala

1996  
Physician Volunteer at Solidaridad & Vida Asociacion Hondurena in a clinic/hospice for patients with HIV disease and for drug addicted street adolescents. Honduras

1999  
Physician Volunteer with the Catholic Medical Mission Board in San Francisco de la paz, Olancho, working in a clinic for the underserved mountain population. Honduras

2000 - 2005  
Vaccination Program, Homeless Elderly, East Village, New York

2001 – 2004  
Soup Kitchen Volunteer, St. Francis Xavier Church, New York, NY

2004 – present  
East Harlem Health Outreach Project (EHHOP), Student Run Free Clinic Preceptor

Community Screening, Health Education and Promotion, St. Ann’s Church Health Fair, East Harlem, NY

2004  
Community Screening, Health Education and Promotion, Mount Sinai Student Health Community Fair, East Harlem, NY

2005  
Community Screening, Health Education and Promotion, Canaan Baptist Church Health Screening Day, East Harlem, NY

2005 – present  
Community Screening, Health Education and Promotion, East Harlem Healthy Heart Fair, East Harlem, NY

2005  
Faculty Advisor and Physician Volunteer, Alternate Spring Break, working in underserved areas of San Francisco de Macoris, Dominican Republic
2005 - present
Harlem Health Week, Community Screening,
Health Education and Promotion, Harlem Street
Fair, 135th St, New York City

2005 – present
Good Health is Precious, Director Health Education and
Outreach to Harlem Community

2006 - 2007
Green Market Health Screenings, Mount Sinai Medical Center

2006 - present
Founding Member, 136th Street Block Association (between
Lenox and 7th Avenues)

2008
Real Men Get Checked Health Screenings, Harlem, NY

SPECIAL COURSES:

1. New England Epidemiology Institute, Boston, MA. Studied advanced courses in Perinatal

2. Escuela de Espanol, San Jose el Viejo, Antigua, Guatemala. Studied in an intensive Spanish language

3. Evidence Based Medicine Course, New York Academy of Medicine, October 2000.


7. Evidence Based Clinical Practice Workshop, McMaster University Health Sciences. May 2004.


15. Medical Mandarin Introductory Course, Mount Sinai School of Medicine, January 2008


**Addendum**

**Abstracts:**

1. Thomas, David C., Koterstein, Deborah, Foldes, Cara, Training Residents to Recognize Domestic Violence in Primary Care. Regional and National Meeting of the Society of General Internal Medicine, March and May, 2001.


17. Liberman KM, Meah YS, Rolon O, Thomas DC*, Quality of Mental Health Care at a Student-run Free Clinic Care Compare to Publicly and Privately Insured Populations? Mount Sinai School of Medicine Fourteenth Annual Medial Student Research Day, November 6, 2008.


19. Moskowitz A, Meah Y, Akselrod H, McDow K, Fernandez J, Thomas DC*. Evaluating Patient Comprehension of Care and Treatment Instructions at the East Harlem Health Outreach Partnership (EHHOP). Department of Medicine, Mount Sinai School of Medicine, New York, NY. The Institute for Medical Education, Mount Sinai School of Medicine, Educational Research Day, November 5, 2009.


27. Taylor JL, Meah YS, Tornheim J, Thomas DC*. Hypertension Management at a Student-Run Clinic for the Uninsured. The Institute for Medical Education, Mount Sinai School of Medicine, Community Health Week, April 14th, 2010.


35. *mentor