Associate Professor Narrative Statement Example G — *"The Clinician-Investigator"*

Primary Area of Distinction: **Health Care Delivery**
Secondary Area of Distinction: **Investigation**
A candidate who devotes a majority of effort to health care delivery with some effort (and achievements) in investigation.

Expected Achievements:
- **Established** level in **Health Care Delivery**
- **Entry** to **Established** level in **Investigation**
- Entry level in Education
- Entry level in Academic Service

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Assistant Professor, Department of Medicine

My goal is to provide exceptional care for older patients with multiple chronic diseases to improve their quality of life, assure coordination of care, and educate students, residents, patients and families about unique aspects of their care. As a physician trained in general internal medicine, geriatrics, and palliative care, I integrate each of those perspectives to create models of quality care that improve patient outcomes, enhance clinical education, and benefit our health system. As an investigator, I want to understand how to better manage hypertension in my patients. I seek promotion to Associate Professor based on my achievements in my primary Area of Distinction in Health Care Delivery, in my secondary Area of Distinction in Investigation, and in Education and Academic Service.

Area of Distinction in Health Care Delivery

My clinical practice focuses on the care of elderly patients with chronic diseases in the Internal Medicine Clinic, where I attend for seven half-day sessions per week. After completing fellowships in geriatrics and palliative care, I was recruited to UMMS/UMMHC to establish a clinic dedicated to elderly patients within the Division. These patients often present with chronic co-morbid conditions, requiring care by both general internists and specialists. Multiple medications raise adverse drug interaction and compliance issues. Decreased mobility and quality of life are additional concerns that require ancillary services. Navigating our complex health care system—a challenge for the healthiest of our patients—is particularly difficult for these patients. Lastly, poor coordination of care increases the financial burden on both the patient and the health system.

To meet these challenges, on my arrival at UMMS I designed and implemented a patient-centered model for the care of elderly patients in Internal Medicine. With support from my Division Chief and Chair, I recruited an interprofessional team that included nurses, a pharmacist, social worker, and a behavioral psychologist. Particularly important members of this team are two senior nurses who serve as Care Managers. They provide the "front end" of the team, working with each patient as a single point of contact to coordinate care, interact with insurers, and address social issues.

In the four years since the clinic has been established, the rates of emergency room visits and readmission by our patients have progressively decreased. There are fewer incidents of drug interactions and quality of life scores have improved. Our biggest surprise was an increase in the engagement of the patients themselves in managing their care. The number of patients has increased, fuelled in part by word-of-mouth referral, and we have added a physician and a nurse to the team in each of the last two years. A financial analysis demonstrated that the increased efficiency of care and decreased readmission and ED visits resulted in a net decreased cost per patient within the system. The design, implementation and evaluation of our model for geriatric care was reported in the Journal

of General Internal Medicine (Sample et al., 2017). I also presented the model at institutions in New England and the 2018 New England Regional meeting of the Society for General Internal Medicine.

I am constantly seeking to improve the model of care. For example, through participation in the UMMHC Quality Scholars program, I implemented a study to accelerate communication of changes in medications, treatments, and health status by use of inbox/EPIC functionality. This intervention has resulted in a further decreases in hospital readmissions and drug interactions, and increases in quality of life scores in the initial pilot population of 50 patients. We have published the initial pilot data (Sample et al, 2018) and used that to refine our strategies for this project. A Patient Centered Outcomes Research Initiatives (PCORI) award, for which I am the co-PI with my division chief, has enabled us to extend the project to primary care sites throughout the system.

Area of Distinction in Investigation

My research focuses on the management of hypertension in the elderly. Although we typically base treatment of hypertension on younger patients, elderly patients have unique issues, particularly those with co-morbidities requiring multiple medications. To address this problem, we have established a patient registry that enables us to track health conditions, medications, vital signs, and outcomes in a large panel of patients who are 75+ years old. We have identified adverse drug interactions and have developed guidelines for managing hypertension in elderly patients with diabetes (Sample et al, 2015) and kidney disease (Sample et al, 2017). These studies have been supported by the American Heart Association (AHA) and I serve on an AHA expert panel charged with developing national guidelines for managing hypertension in the elderly. Our unique patient population has also attracted interest from the pharmaceutical industry and we have been a site for several clinical trials.

Education

Students and residents rotate with me in the outpatient clinic and I receive above average evaluations for my clinical precepting. Recognizing the brief exposure of learners to patients and their families, I developed a series of “classic” patient stories based on the composition of our clinics. These stories include cases of drug-drug interactions, side effects of chronic disease, and support issues that might come up in the meeting with a patient. But I am most proud of my student and resident mentees. Out of 13 mentees over the last 5 years, 10 have chosen internal medicine and geriatrics for their specialization.

Academic Service

My focus on high risk geriatric populations has led me to serve on the Palliative Care committee, which I will chair next year, the Pain Management Task Force, and to chairing the steering committee for Hospital Readmissions. Each of these committees has made changes in policies and procedures that are advancing our overall care of these patients.

Summary

I came to UMMS to apply my expertise in geriatric medicine and I am pleased that the model of care we established has improved the health of our elderly patients. I look forward to expanding our work on patient-centered care for the elderly and my research on hypertension.