The definition of “hospitalist,” according to the SHM website, is a clinician “dedicated to delivering comprehensive medical care to hospitalized patients.” For years, the hospital setting was the specialties’ identifier. But as hospitalists’ scope has expanded, and post-acute care (PAC) in the United States has grown, more hospitalists are extending their roles into this space.

“Previously, physicians considered post-acute care only within the limited scope of what’s in their own care universe – such as skilled nursing facilities [SNFs], inpatient rehabilitation facilities [IRFs], long-term acute care hospitals [LTACHs], and home health visits,” says Allison Hoffman, JD, professor of law at UCLA School of Law and an expert on health care law and policy. “It was hard before the Affordable Care Act, and it will be hard after. There is not an easy solution.”

By 2016, the ACA had expanded health coverage to 20 million people through Medicaid and private insurance on health care marketplaces. It extended the solvency of the Medicare Hospital Insurance Trust Fund. It accelerated the pace of delivery system and payment reform through creation of the Center for Medicare & Medicaid Innovation (CMMI).

“The Republicans now have a hard issue in their hands,” says Hoffman. “It was hard before the Affordable Care Act, and it will be hard after. There is not an easy solution.”

It’s not clear whether Trump will agree with Congress. As a candidate, he did little to advance policy ideas around health care, though Price’s selection “sends a strong signal that the Trump administration is serious about undoing the ACA,” Eibner says. “The Republicans now have a hard issue in their hands,” says Hoffman. “It was hard before the Affordable Care Act, and it will be hard after. There is not an easy solution.”

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The law has not been without its challenges.
Vishal Kuchaculla, MD, New England regional post-acute medical director of Boston-based TeamHealth, says new service lines also developed as Medicare ramped down on long-term inpatient hospital stays by giving financial imperus to discharge patients as soon as possible.

“Over the last few years, there’s been a major shift from fee-for-service to risk-based payment models,” Dr. Kuchaculla says. “The government’s financial incentives are driving outcomes to improve performance initiatives.”

Another reason for increased Medicare spending on PAC stems from the fact that patients no longer need to be hospitalized before going to a PAC setting.

“Today, LTACHs can be used as substitutes for short-term acute care,” says Sean R. Muldoon, MD, MPH, FCCP, chief medical officer of Kindred Healthcare in Louisville, Ky., and former chair of SHM’s Post-Acute Care Committee. “This means that a patient can be directly admitted from their home to an LTACH. In fact, many hospice and home-care patients are referred from physicians’ offices without a preceding hospitalization.”

Hospitalists can fill a need More hospitalists are working in PACs for a number of reasons. Dr. Mathew says that PAC facilities and services have typically lacked the clinical structure and processes to obtain the results that patients and payers expect.

“These deficits needed to be quickly remedied as patients discharged from hosp- itals have increased acuity and higher disease burdens,” he adds. “Hospitalists were the natural choice to fill roles requiring their expertise and experience.”

Dr. Muldoon considers the expanded scope of practice into PACs an additional layer to hospital medicine’s value proposition to the health care system.

“As experts in the management of inpa- tient populations, it’s natural for hospitalists to expand to other facilities with inpatient-like populations,” he says, noting SNFs are the most popular choice, with IRFs and LTACHs also being common places to work. Few hospitalists work in home care or hospice.

PAC settings are designed to help patients who are transitioning from an inpatient setting back to their home or other setting.

“Many patients go home after a SNF stay, while others will move to a nursing home or other long-term care setting for the first time,” says Tiffany Radcliff, PhD, a health economist in the depart- ment of health policy and management at Texas A&M University College of Public Health in College Station. “With this in mind, hospitalists working in PAC have the opportunity to address each patient’s ongoing care needs and prepare them for their next setting. Hospitalists can manage medication or other care regimen changes.

Medicare claims for 30-day episodes beginning with hospitalization

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**Initial acute stay**  **Postdischarge care**
That resulted from an inpatient stay, reinforce discharge instructions to the patient and their caregivers, and identify any other issues with continuing care that need to be addressed before discharge to the next care setting.”

Transitional care

Even if a hospitalist is not employed at a PAC, it’s important that they know something about them.

“As patients are moved downstream earlier, hospitalists are being asked to help make a judgment regarding when and where an inpatient is transitioned,” Dr. Muldoon says. As organizations move toward becoming fully risk capable, it is necessary to develop referral networks of high-quality PAC providers to achieve the best clinical outcomes, reduce readmissions, and lower costs.

“Therefore, hospitalists should have a working knowledge of the different sites of service as well as some opinion on the suitability of available options in their community,” Dr. Muldoon says. “The hospitalist can also help to educate the hospitalized patient on what to expect at a PAC.”

If a patient is inappropriately prepared for the PAC setting, it could lead to incomplete management of their condition, which ultimately could lead to readmission.

“When hospitalists know how care is provided in a PAC setting, they are better able to ensure a smoother transition of care between settings,” says Tochi Iroku-Malize, MD, MPH, MBA, FAAP, SFHM, chair of family medicine at Northwell Health in Long Island, N.Y. “This will ultimately prevent unnecessary readmissions.”

Further, the quality metrics that hospitals and thereby hospitalists are judged by no longer end at the hospital’s exit.

“The ownership of acute-care outcomes requires extending the accountability to outside of the institution’s four walls,” Dr. Mathew says. “The inpatient team needs to place great importance on the transition of care and the subsequent quality of that care when the patient is discharged.”

Robert W. Harrington Jr., MD, SFHM, chief medical officer of Plano, Tex.–based Reliant Post-Acute Care Solutions and former SHM president, says the health system landscapes are pushing HM beyond the hospital’s walls.

“We’re headed down a path that will mandate and incentivize all of us to provide: more-coordinated, more-efficient, higher-quality care,” he says. “We need to meet patients at the level of care that they need and provide continuity through the entire episode of care from hospital to home.”

How PAC settings differ from hospitals

Practicing in PAC has some important nuances that hospitalists from short-term acute care need to get accustomed to, Dr. Muldoon says. Primarily, the diagnostic capabilities are much more limited, as is the presence of high-level staffing. Further, patients are less resilient to medication changes and interventions, so changes need to be done gradually.

“Hospitalists who try to practice acute-care medicine in a PAC setting may become frustrated by the length of time it takes to do a work-up, get a consultation, and respond to a patient’s change of condition,” Dr. Muldoon says. Nonetheless, hospitalists can overcome this once recognizing this mind shift.

According to Dr. Harrington, another challenge hospitalists may face is the inability of the hospital’s and PAC facility’s IT platforms to exchange electronic information.

“The major vendors on both sides need to figure out an interoperability strategy,” he says. “Currently, it often takes 1-3 days to receive a new patient’s discharge summary. The summary may consist of a stack of paper that takes significant time to sort through and requires the PAC facility to perform duplicate data entry. It’s a very highly inefficient process that opens up the doors to mistakes and errors of omission and commission that can result in bad patient outcomes.”

Arif Nazir, MD, CMD, FACP, AGSF, chief medical officer of Signature Healthcare-CARE and president of SHC Medical Partners, both in Louisville, Ky., cites additional reasons the lack of seamless communication between a hospital and PAC facility is problematic. “I see physicians order laboratory tests and investigations that were already done in the hospital because they didn’t know they were already performed or never received the results,” he says. “Similarly, I see patients continue to take medications prescribed in the hospital long term even though they were only supposed to take them short term. I’ve also seen patients come to a PAC setting from a hospital without any formal understanding of their rehabilitative period and expectations for recovery.”

Despite some frustrations cited by others, James D. Tollman, MD, FHM, president of Bedford, Mass.–based Essex Inpatient Physicians, believes working in a PAC setting can be a less-demanding environment for a hospitalist than an inpatient facility. “They have much more flexibility with their schedule,” he says. “In the hospital, hospitalists have longer, more physically demanding shifts. At SNFs, the level of decision making is often easier; usually they house lower-acuity patients. However, there might be more challenges with disposition, family issues, and follow-ups. Plus, you have to do more to coordinate care.”

What’s ahead?

Looking to the future, Surafel Tsega, MD, clinical instructor at Mount Sinai Hospital in New York, says he thinks there will be a move toward greater collaboration among inpatient and PAC facilities, particularly in the discharge process, given that hospitalists have an added incentive to ensure
This advertisement is not available for the digital edition.
Hospitalists working in PAC have the opportunity to address each patient’s ongoing care needs and prepare them for their next setting. Hospitalists can manage medication or other care regimen changes that resulted from an inpatient stay, reinforce discharge instructions to the patient and their caregivers, and identify any other issues with continuing care that need to be addressed before discharge to the next care setting.

“Working with community-based organizations for this purpose will be a valuable tool for any of the population health–based initiatives,” he says.

Dr. Muldoon says he believes health care reform will increasingly view an inpatient admission as something to be avoided. “If hospitalization can’t be avoided, then it should be shortened as much as possible,” he says. “This will shift inpatient care into LTACHs, SNFs, and IRFs. Hospitalists would be wise to follow patients into those settings as traditional inpatient census is reduced. This will take a few years, so hospitalists should start now in preparing for that downstream transition of individuals who were previously inpatients.”

Karen Appold is a freelance medical writer in Pennsylvania.

References

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References
Infectious disease physicians: Antibiotic shortages are the new norm

BY SHARON WORCESTER
Frontline Medical News

NEW ORLEANS — Antibiotic shortages reported by the Emerging Infections Network (EIN) in 2011 persist in 2016, according to a web-based follow-up survey of infectious disease physicians.

Of 701 network members who responded to the EIN survey in early 2016, 70% reported needing to modify their antimicrobial choice because of a shortage in the past 2 years. They did so by using broader-spectrum agents (73% of respondents), more costly agents (58%), less effective second-line agents (45%), and more toxic agents (37%).

Adi Gundlapalli, MD, PhD, reported at an annual scientific meeting on infectious diseases. In addition, 73% of respondents reported that the shortages affected patient care or outcomes, reported Dr. Gundlapalli of the University of Utah, Salt Lake City.

The percentage of respondents reporting adverse patient outcomes related to shortages increased from 2011 to 2016 (51% vs. 73%), he noted at the combined annual meetings of the Infectious Diseases Society of America, the HIV Medicine Association, and the Pediatric Infectious Diseases Society.

The top 10 antimicrobials they reported as being in short supply were piperacillin-tazobactam, ampicillin-sulbactam, meropenem, cefotaxime, cefepime, trimethoprim-sulfamethoxazole (TMP-SMX), doxycycline, imipenem, acyclovir, and amikacin. TMP-SMX and acyclovir were being in short supply were piperacillin-tazobactam, ampicillin-sulbactam, meropenem, cefotaxime, cefepime, trimethoprim-sulfamethoxazole (TMP-SMX), doxycycline, imipenem, acyclovir, and amikacin. TMP-SMX and acyclovir were in short supply at both time points. The most common ways respondents reported learning about drug shortages were from hospital notification (76%), from a colleague (50%), from a pharmacy that contacted them regarding a prescription for the agent (53%), or from the Food and Drug Administration website or another website on shortages (23%).

The most common ways of learning about a shortage changed—from notification after trying to prescribe a drug in 2011, to proactive hospital/system (local) notification in 2016; 71% of respondents said that communications in 2016 were sufficient.

Most respondents (83%) reported that guidelines for dealing with shortages had been developed by an antimicrobial stewardship program (ASP) at their institution.

“The, I think, is one of the highlight results,” said Dr. Gundlapalli, who is also a staff physician at the VA Salt Lake City Health System. “In 2011, we had no specific question or comments received about [ASPs], and here in 2016, 83% of respondents’ institutions had developed guidelines related to drug shortages.”

Respondents also had the opportunity to submit free-text responses, and among the themes that emerged was concern regarding toxicity and adverse outcomes associated with increased use of aminoglycosides because of the shortage of piperacillin-tazobactam. Another – described as a blessing in disguise – was the shortage of meropenem, which led one ASP to “institute restrictions on its use, which have continued,” he said.

Another theme was ‘simpler agents seem more likely to be in shortage.’” Dr. Gundlapalli reported having no disclosures.

“The concerns do persist, and we feel there is further work to be done here,” he said. He specifically noted that there is a need to inform and educate fellows and colleagues in hospitals, increase awareness generally, improve communication strategies, and conduct detailed studies on adverse effects and outcomes.

“One, and now, since ASPs are very pervasive ... maybe it’s time to formalize and delineate the role of ASPs in antimicrobial shortages,” he said.

The problem of antibiotic shortages “backs the day when penicillin was recycled in the urine [of soldiers in World War II] to save this very scarce resource … but that is a very extreme measure to take,” noted Donald Graham, MD, of the Springfield (Ill.) Clinic, one of the study’s coauthors. “It seems like it’s time for the other federal arm – namely, the Food and Drug Administration – to do something about this.”

Dr. Graham said he believes the problem is in part because of economics, and in part because of “the higher standards that the FDA imposes upon these manufacturing concerns. “These drugs often are low-profit items, and it isn’t always in the financial best interest of a pharmaceutical company to upgrade their facilities.

“But they really have to recognize the importance of having availability of these simple agents,” he said, pleading with any FDA representatives in the audience to “maybe think about some of these very high standards.”

Dr. Gundlapalli reported having no disclosures. Dr. Graham disclosed relationships with Astellas and Theravance Biopharma.

rs worcester@frontlinemedcom.com

Long-term opioid use uncommon among trauma patients

BY MICHELE G. SULLIVAN
Frontline Medical News

WASHINGTON — Patients with traumatic injuries don’t appear to be at undue risk of sustained opioid use, a large database review has demonstrated.

More than half of the 13,000 patients in the study were discharged on opioids, but they were able to discontinue them fairly rapidly, Muhammad Chaudhary, MD, said at the annual clinical congress of the American College of Surgeons. Within 3 months, less than one-third were still using the drugs, and 1 year later, only 1% were still taking an opioid pain medication.

“Most of the patients that sustained opioid use was very uncommon among these patients with moderate-severe traumatic injuries,” said Dr. Chaudhary, a postdoctoral research fellow at Brigham and Women’s Hospital, Boston. “Furthermore, we didn’t find any association of opioid use with depression or anxiety.”

Dr. Chaudhary examined opioid use among 13,624 patients included in the Ticare military insurance database. The patients were treated for traumatic injuries between 2007-2011. Most of the patients were men (82%), and the largest age group was 18- to 24-year-olds (39%).

Military rank was used as a proxy for socioeconomic status in this study; 15% of the cohort had an officer rank, while the rest were junior or senior enlisted personnel.

The group was very healthy, with a median Charlson Comorbidity Index score of 0. They were somewhat seriously injured, however. The median Injury Severity Score was 13, and the range was 9-17. Anxiety and depression were uncommon (9% and 7%, respectively).

More than half the patients (54%) were discharged on an opioid medication. That percentage dropped very rapidly. By 90 days after discharge, just 9% of patients were still taking the drugs. By 1 year, only 1% were using opioids.

Dr. Chaudhary conducted a multivariate analysis that controlled for a number of factors, including age, gender, marital status, rank, mental health status, injury severity, comorbidities, and treatment environment. Two factors – black race and younger age (18-24 years) – significantly increased the likelihood of early opioid discontinuation (8% and 11%, respectively). There were no significant interactions with anxiety or depression.

Junior enlisted personnel – the proxy group for lower socioeconomic status – and those with a prolonged length of stay were significantly less likely to get off the medications, Dr. Chaudhary said.

“We only strongly believe that these factors should not be used to determine who can get opioids, it might make sense to enhance perioperative surveillance and engage pain management services early on in patients with risk factors, to reduce the risk of sustained opioid use,” he concluded.

Dr. Chaudhary had no financial disclosures.

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On Twitter @alz_gal
SHM member spotlight

Venkatakraman Palabindala, MD, FHM, leads chapter development, lends expertise to SHM committees

By Brett Radler

Editor’s note: Each month, SHM puts the spotlight on some of our most active members who are making substantial contributions to hospital medicine. Visit www.hospitalmedicine.org/getinvolved for more information on how you can help SHM improve the care of hospitalized patients.

Question: What inspired you to begin working in hospital medicine and later join — and become so involved with — SHM?

A: I was exploring my options during my second year of residency at Greater Baltimore Medical Center as to what my final career path should be. I always loved inpatient medicine, mostly critical care, so I was thinking of completing a pulmonary critical-care fellowship. Completing a hospitalist rotation changed everything about how I saw my future and led me to specialize in hospital medicine.

Once I learned about SHM and the wealth of activities and opportunities membership offered from a few of my attendings, I applied to be part of the Leadership Committee. I attended every meeting and kept my committee work as a top priority. At the time, with little experience in hospital medicine, I knew I might not have as much to contribute as the rest, but my goal was to learn as much as I could. Never once did I feel that my voice was any more or less valuable than those of the rest of the committee members; our committee work was truly a collaborative effort.

As my career in hospital medicine has evolved, so have my contributions to SHM’s committees; I now am a proud member of the IT Committee. We’re currently working on a white paper about hospitalists’ attitudes toward electronic health record (EHR) systems and look forward to sharing more about that next month.

In addition, throughout my time in hospital medicine, I have become a Fellow in Hospital Medicine, attended two “Hill Days” to learn about the policies, and made a concerted effort to be present at as many meetings as possible, especially SHM’s annual meetings. The networking, coupled with the workshops and lectures, is unparalleled. I have missed only one annual meeting, and I felt like I missed a Thanksgiving dinner with my family!

Q: Can you tell us about your role in the revitalization of the Gulf States Chapter and the Chapter Development Program?

A: During my time as a member of the SHM Leadership Committee, I quickly realized that hospitalists in small cities like Dothan, Ala., were not as exposed to networking and education activities as those in big cities. To unite hospitalists in that area of the country, I founded the Wiregrass Chapter; obtaining 20 signatures to start it was an uphill task. After Dan Dressler, MD, [in Atlanta] and I gave a talk about updates in hospital medicine, the Wiregrass Chapter was awarded the Silver Chapter Award [after its first year in inception], and everything changed. The buzz around the chapter helped it continue to grow.

Now that hospitalists have left their stamp on inpatient medicine, specialties like critical care, nephrology, cardiology, and ob.gyn. are moving toward this model. We need to do everything we can to integrate them into our pool, move forward together, and learn from each other.

After I moved to Jackson, I applied for a pilot funding project to start a Jackson Chapter, as I realized the Gulf States Chapter was a bit far away. I thought a local chapter would bring all hospitalists in this area together. However, I received a call from Lisa Chester, our chapter liaison at SHM, about being a part of the Gulf States Chapter and serving as a catalyst to revitalize the chapter.

I was thrilled to work with Randy Roth, MD, and Steven Deitelzweig, MD; both are hospitalist leaders in this area. The Chapter Development Program surely helped us to create new goals and develop a realistic timeline. It kept us on track to achieve what we originally set out to do. By creating coupons to encourage membership and arranging more local meetings using this fund, we have been able to experience even more success. We are now recognizing that residents are very excited about SHM meetings and are identifying young leaders to be part of the hospital medicine movement.

Q: How has your participation in HMX — and, more broadly, engagement with SHM — helped you improve your practice?

A: HMX [connect.hospitalmedicine.org] is a great platform for asking questions and exchanging ideas. Being active on HMX has helped me learn important information about performance metrics, observation unit models, EHRs, coding and billing questions, and sometimes even ethical questions.

Although I still have mentors helping me, I know if I post a question on HMX, that I will get many ideas from hospitalists across the nation. I also make it a point to encourage friends every month to download the HMX app on their phones and present it as a valuable resource to my students and residents. As hospitalists, this is our forum with experts available all the time.

To encourage others to use the platform and make myself and fellow committee members accessible to other members, we actively take turns assuming responsibility for maintaining the momentum on HMX by finding intriguing topics of discussion.

Q: As we ring in 2017 after a year of many changes for HM and the health care system in general, what do you see as the biggest HM opportunities this year?

A: We know physician retention and burnout are some of the biggest challenges in hospital medicine. Given the pace at which we are growing as a specialty, I would like to see more time dedicated to addressing and attempting to alleviate these specific issues.

Also, now that hospitalists have left their stamp on inpatient medicine, specialties like critical care, nephrology, cardiology, and ob.gyn. are moving toward this model. We need to do everything we can to integrate them into our pool, move forward together, and learn from each other.

Lastly, mentorship is of paramount importance as we head into the future. We must encourage young hospitalists to mentor students and residents and recruit them to be part of SHM when they return home. 

Brett Radler is SHM’s communications specialist.

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SOCIETY PAGES | News and information about SHM

SNEAK PEEK

BY JORDAN MESSLER, MD, SFHM

To my next patient:

I often avoid putting my politics on my sleeve, as I don’t want that to get in the way of our relationship. I want you to know that I treat you as a fellow human being, no matter your race, gender, sexual orientation. With the election results, what will change about how I treat you at the bedside? Nothing.

I may know about your criminal past. I see that tattoo underneath your gown. I heard your profanity-filled screed because I see that tattoo underneath your gown. I saw someone like you recently: 28 years old, working hard, with two jobs, neither of which provided insurance. She was doing well, without health problems, but then she became fatigued and swollen. She came to the ER after weeks of suffering with what turned out to be failing kidneys. Lupus. She required expensive medications that would aim to reverse her kidney disease. She left the hospital not knowing what would happen next, as there was no way she could afford the treatment. The fates of medicine handed her an unexpected illness, and we had no good way to reassure her of what would come next. I am sorry that more patients without insurance will arrive, instead of the steady decline I had been used to the past few years.

You also remind me of another patient I saw last week. She was sweet in the face, smiling despite her travails, and wore the skimpy gown with pride. She had some fluid just outside her lung that shouldn’t be there: a pleural effusion. We discussed the different possible diagnoses. She had cancer in the past, surgically treated and presumably cured. Was this the cancer back? Was it an infection, easily treated? We couldn’t tell by the exam or the x-ray.

On Tuesday, we took the fluid out. The results trickled in slowly, and initial tests suggested it was benign. We allowed a smile, but final tests were pending. What will turn up? When the final results return? Can we dance in the room with joy? Or will we hold hands, bear the cross, shed a tear, but then lift our heads up and know we will fight for another day, and another day, and not stop fighting until the cancer upon us is gone?

Read the full post at www.hospitalleader.org.

NEWS & NOTES

Trending at SHM

The latest news, events, programs, and SHM initiatives.

By Brett Radler

Unveiling the hospitalist specialty code

The Centers for Medicare & Medicaid Services announced in November the official implementation date for the Medicare physician specialty code for hospitalists. On April 3, “hospitalist” will be an official specialty designation under Medicare; the code will be C6. Starting on that date, hospitalists can change their specialty designation on the Medicare enrollment application (Form CMS-855) or through CMS’ online portal (Provider Enrollment, Change, and Ownership System, or PECOS).

Appropriate use of specialty codes helps distinguish differences among providers and improves the quality of utilization data. SHM applied for a specialty code for hospitalists nearly 3 years ago, and CMS approved the application in February 2016.

Stand with your fellow hospitalists and make sure to declare, “I’m a C6.”

Develop curricula to educate, engage medical students and residents

The ACGME requirements for training in quality and safety are changing – it is no longer an elective. As sponsoring institutions’ residencies and fellowships mobilize to meet these requirements, leaders may find few faculty members are comfortable enough with the material to teach and create educational content. This faculty need further development.

Sponsored by SHM, the Quality and Safety Educators Academy (QSEA) responds to that demand by providing educational materials and faculty training to help hospitalists deliver the curricula. The 2017 meeting is Feb. 26-28 at the Termeon Mission Palms Hotel in Arizona. This 2½ day meeting aims to fill the current gaps for faculty by offering basic concepts and educational tools in quality improvement and patient safety.

For more information and to register, visit www.shm.qsea.org.

EHRs: blessing or curse?

SHM’s Health Information Technology (HIT) Committee invited you to participate in a brief survey to inform your experiences with inpatient electronic health record (EHR) systems. The results will serve as a foundation for a white paper to be written by the HIT Committee addressing hospitalists’ attitudes toward EHR systems. It will be released next month, so stay tuned then to view the final paper.

SHM chapters: Your connection to local education, networking, leadership opportunities

SHM offers for trainees. Theoretical opportunities to grow professionally, expand your CV, and engage with other hospitalists. With more than 50 chapters across the country, you can network, learn, teach, and continue to improve patient care at a local level. Find a chapter in your area or start a chapter today by visiting www.hospitalmedicine.org/chapters.

Enhance opioid safety for inpatients

SHM enrolled 10 hospitals into a second mentored implementation cohort around Reducing Adverse Drug Events Related to Opioids (RADEO). The program is now in its second month as the sites work with their mentors to enhance safety for patients in the hospital who are prescribed opioid medications by:

• Developing a needs assessment.
• Putting in place formal selections of data collection measures.
• Beginning to take outcomes and process data collection on inter-vision units.
• Starting to design and implement key interventions.

Even if you’re not in this mentored implementation cohort, visit www.hospitalmedicine.org/RADEO and view the online toolkit or download the implementation guide.

Earn recognition for your research with SHM’s Junior Investigator Award

The SHM Junior Investigator Award was created for junior/early-stage investigators, defined as faculty in the first 5 years of their most recent position/appointment. Applicants must be a hospitalist or clinician-investigators whose research interests focus on the care of hospitalized patients, the organization of hospitals, or the practice of hospitalists. Applicants must be members of SHM in good standing. Nominations from mentors and self-nominations are both welcome.

The winner will be invited to receive the award during SHM’s annual meeting, HM17, May 1-4, at Mandalay Bay Resort and Casino in Las Vegas. The winner will receive complimentary registration for this meeting as well as a complimentary 1-year membership to SHM.

For more information on the application process, visit www.hospitalmedicine.org/juniorinvestigator.

Brett Radler is SHM’s communications specialist.

By Leslie Flores, MHA, SFHM

On Tuesday, we took the fluid out. The results trickled in slowly, and initial tests suggested it was benign. We allowed a smile, but final tests were pending. What will turn up? When the final results return? Can we dance in the room with joy? Or will we hold hands, bear the cross, shed a tear, but then lift our heads up and know we will fight for another day, and another day, and not stop fighting until the cancer upon us is gone?

Read the full post at www.hospitalleader.org.

POST: An open letter to hospital executives about their hospitalist programs

By Leslie Flores, MHA, SFHM

POST: What’s under the hoist? A quick look at hospital expenses

By Brad Flansbaum, DO, MPH, MMM

POST: A quick lesson on bundled payments

By John Nelson, MD, MMM

POST: The ABIM Has new plans for MOC and wants your opinion. Give it to ’em!

By Burke Kealey, MD, SFHM

ALSO ON “THE HOSPITAL LEADER” BLOG

APRIL 2017

SNEAK PEEK: The Hospital Leader blog

Post election, what will change about how I treat the bedside? Nothing.
Discharges against medical advice at a county hospital: Provider perceptions and practice

By Cordelia R. Stearns, MD, Allison Bakamjian, BA, Subrina Sattar, MD, Miranda Ritterman Weintraub, PhD, MPH

FEATURED ABSTRACT

BACKGROUND: Patients discharged against medical advice (AMA) have higher rates of readmission and mortality than patients who are conventionally discharged. Bioethicists have proposed best practice approaches for AMA discharges, but studies have revealed that some providers have misconceptions about their roles in these discharges.

OBJECTIVE: This study assessed patient characteristics and provider practices for AMA discharges at a county hospital and provider perceptions and knowledge about AMA discharges.

DESIGN: This mixed-methods cross-sectional study involved chart abstraction and survey administration.

PARTICIPANTS: Charts were reviewed for all AMA discharges (n = 319) at a county hospital in 2014. Surveys were completed by 178 health care providers at the hospital.

RESULTS: Of 12,036 admissions, 319 (2.7%) ended with an AMA discharge. Compared with conventionally discharged patients, patients who left AMA were more likely to be young, male, and homeless and less likely to be Spanish speaking. Of the AMA patients, 29.6% had capacity documented, 21.4% had medications prescribed, and 25.7% had follow-up arranged. Of patients readmitted within 6 months after AMA, 23.5% left AMA again at the next visit. Attending physicians and trainee physicians were more likely than nurses to say that AMA patients should receive medications and follow-up (94% and 84% vs. 64%; P < .05).

CONCLUSIONS: Although providers overall felt comfortable determining capacity and discussing AMA discharges, they rarely documented these discussions. Nurses and physicians differed in their thinking regarding whether to arrange follow-up for patients leaving AMA, and in practice, arrangements were seldom made.

Read the full article at journalofhospitalmedicine.com.

Also in the January 2017 issue of JHM...

Characteristics and outcomes of fasting orders among medical inpatients
Authors: Atsushi Sorita, MD, MPH, Charat Thongprayoon, MD, John T. Ratelle, MD, Ruth E. Bates, MD, Katie M. Rieck, MD, Aditya P. Devalapalli, MD, Adil Ahmed, MD, Deanne T. Kashiwagi, MD

The lived experience of the hospital discharge “plan”:

A longitudinal qualitative study of complex patients
Authors: Soo Chan Carusone, PhD, Bill O’Leary, MSW, Simone McConnell, MPH, Ann Stewart, MSc, MD, Shelley Craig, MSW, PhD, David J. Brennan, MSW, PhD

Do clinicians understand quality metric data? An evaluation in a Twitter-derived sample
Authors: Sushant Govindan, MD, Vineet Chopra, MD, MSc, Theodore Iwashyna, MD, PhD

Routine replacement of peripheral intravenous catheters
Authors: Sanjay A. Patel, MD, Michael A. Arluch, DO, Leonard S. Feldman, MD

Physicians are often incorrect about the telemetry status of their patients
Authors: Sajan Patel, MD, Sayumi De Silva, MD, Erin Dowling, MD
Read the chart

Elevate your patients’ confidence

By Trina Dorrah, MD, MPH

Editor’s note: “Everything We Say and Do” is an informational series developed by SHM’s Patient Experience Committee to provide readers with thoughtful and actionable communication tactics that have great potential to positively impact patients’ experience of care. Each article will focus on how the contributor applies one or more of the “key communication” tactics in practice to maintain provider accountability for “everything we say and do that affects our patients’ thoughts, feelings, and well-being.”

What I say and do
I inform my patients that I have reviewed their chart and that I am familiar with their diagnosis.

Why I do it
In the hospital setting, in particular, patients are concerned about communication between their various health care professionals. Many times, the patient’s primary-care provider works strictly in the outpatient setting, so the hospitalist is the person who assumes total care of the patient throughout hospitalization. This understandably creates anxiety for patients and families because they wonder if the hospitalist really knows their medical history. One way to alleviate this anxiety is to review your patients’ charts prior to speaking with them and to verbally let your patients know you are familiar with their diagnoses.

How I do it

STEP 1: Before entering the room, I review my patient’s chart. If I am taking over the service from my colleague, I review all notes from the current hospitalization to ensure I understand everything that has happened. I also review tests, procedures, and radiographic studies. To gain a better understanding of my patient, I read the most recent discharge summary and outpatient clinic note. Likewise, if I am admitting a new patient to the hospital, before entering the room to do the history and physical examination, I review recent hospitalizations, clinic notes, and emergency department visits.

I also like to review the chart to see if I have taken care of the patient before. Patients often remember me even though I may not remember them, so reviewing my prior notes may be helpful. Thankfully, my electronic health record (EHR) has a search function where I can enter my name or any other keyword and it searches for patient records based on this keyword.

STEP 2: Even though reading the chart and being informed about my patient is important, it is only the first step. The next step is to let my patient and family know that I have read the chart and that I am up-to-date on my patient’s diagnosis. I feel it is very important for me to verbalize that I have read the chart because without doing this, my patients never really know that I took the time prior to entering the room to learn about them.

I might say:
• “I was reviewing your chart before I came in, and I saw that your daughter brought you to the hospital for chest pain.”
• “I read your chart and saw that you have been to the emergency room twice in the last week.”
• “I read your primary-care doctor’s note, and I saw that she recently treated you for pneumonia.”
• “I read your chart, and I wanted to confirm a few things I read to ensure we are on the same page.”

There are many different ways you can phrase this, but the important point is to make sure your patients know you read the chart by specifically referencing something you learned. This helps your patients feel more confident that you know their medical history.

I know some of the doctors reading this column see patients in the outpatient setting. One way to help yourself remember pertinent facts about a patient’s medical history is to include these facts in a specific place in your clinic note. That way, prior to seeing the patient, you can always review your last note and know the important information about your patient’s medical history will always be in the same place in each note. Another tip is to use your EHR’s note function. My EHR has “sticky notes,” and they provide a place for the PCP to store information about the patient without it becoming part of the permanent medical record.

These notes allow the PCP to record important events that happen between one clinic visit and the next. Thus, when the patient returns to the clinic, the PCP opens the chart, reviews the sticky note, and enters the exam room prepared to discuss significant events in the patient’s recent medical history.

In the end, it does not matter which technique you use. It simply matters that you take time to review your patient’s chart prior to entering the room and that you verbalize what you have learned. In patients, this inspires confidence and trust and helps alleviate concerns that the physician does not know important information in their medical history.

Dr. Dorrah is regional medical director for quality and the patient experience at Baylor Scott & White Health in Round Rock, Tex. She is a member of SHM’s Patient Experience Committee.
Physician reviews of HM-centric research

By Jorge Florindez, MD; German Giese, MD; Raja Ramesh Gummalla, MD; Jessica Zuleta, MD, FHM; Maria Antonietta Mosetti, MD; Shreenvinaya Menon, DO, MPH; Aymara Fernandez de la Vara, MD; and Alan Briones, MD, FHM

University of Miami Health System

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Physicians and EHR time

CLINICAL QUESTION: How much time do ambulatory-care physicians spend on electronic health records (EHRs)?

BACKGROUND: There is growing concern about physicians’ increased time and effort allocated to the EHR and decreased clinical face time and meaningful interaction with patients. Prior studies have shown that increased physician EHR task load is associated with increased physician stress and dissatisfaction.

STUDY DESIGN: Time and motion observation study.

SETTING: Ambulatory-care practices.

SYNOPSIS: Fifty-seven physicians from 16 practices in four U.S. states participated and were observed for more than 430 office hours. Additionally, 21 physicians completed a self-reported after-hours diary. During office hours, physicians spent 49.2% of their total time on the EHR and desk work and only 27% on face time with patients. While in the exam room, physicians spent 52.9% of the time on direct clinical face time and 37% on the EHR and desk work.

Self-reported diaries showed an additional 1-2 hours of follow-up work on the EHR. These observations might not be generalizable to other practices. No formal statistical comparisons by physicians, practice, or EHR characteristics were done.

BOTTOM LINE: Ambulatory-care physicians appear to spend more time with EHR tasks and desk work than clinical face time with patients.


Dr. Briones is an assistant professor at the University of Miami Miller School of Medicine and medical director of the hospitalist service at the University of Miami Hospital.

By German Giese, MD

Nonischemic cardiomyopathy does not benefit from prophylactic ICDs

CLINICAL QUESTION: Do prophylactic implantable cardioverter defibrillators (ICDs) reduce long-term mortality in patients with symptomatic nonischemic systolic heart failure (NISHF)?

BACKGROUND: ICDs are associated with significant reductions in the rate of sudden cardiac death and mortality in NISHF patients. However, no trials of NISHF patients have shown an effect on total mortality.

STUDY DESIGN: Multicenter, nonblinded, randomized controlled prospective trial.

SETTING: Danish ICD centers.

SYNOPSIS: A total of 1,116 patients with symptomatic NISHF (left ventricular ejection fraction of less than 35%) were randomized to either receive an ICD or usual clinical care. The primary outcome, death from any cause, occurred in 120 patients (21.6%) in the ICD group (4.4 events/100 person-years) and in 131 patients (23.4%) in the control group. The hazard ratio for death from any cause in the ICD group, as compared with the control group, was 0.87 (95% CI, 0.68-1.12; P = .28). The HR for death from any cause in the ICD group, as compared with the control group, was 0.87 (95% CI, 0.68-1.12; P = .28).

BOTTOM LINE: Prophylactic ICD implantation in patients with symptomatic NISHF does not reduce long-term mortality.


Dr. Giese is an assistant professor at the University of Miami Miller School of Medicine and a hospitalist at the University of Miami Hospital and Jackson Memorial Hospital.

By Shreenvinaya Menon, DO, MPH

**Evaluating the qSOFA**

**CLINICAL QUESTION:** How does the quick Sepsis-Related Organ Failure Assessment (qSOFA) compare with other sepsis scoring tools?

**BACKGROUND:** The qSOFA score has been shown to be superior to the Sepsis-Related Organ Failure Assessment (SOFA) with respect to predicting in-hospital mortality outside of the ICU. It has not been compared to other scoring systems or tested among ED patients.

**STUDY DESIGN:** Single-center, retrospective analysis.

**SETTING:** Hospital ED in China.

**SYNOPSIS:** A total of 516 adult ED patients with clinically diagnosed infections were followed for 28 days. Calculated scores for qSOFA, SOFA, Mortality in ED Sepsis (MEDS), and Acute Physiology and Chronic Health Evaluation (APACHE) II were compared using ROC curves. qSOFA was similar to the other scoring systems to predict ICU admission. The area under the curve for qSOFA to predict 28-day mortality was lower than all other scoring systems but was statistically significant only when compared to MEDS. A qSOFA score of 2 had a positive likelihood ratio of 2.47 to predict mortality (95% CI, 2.3-5.4) and a positive likelihood ratio of 2.08 (95% CI, 1.7-4.1) to predict ICU admission.

**BOTTOM LINE:** qSOFA was similar to other scoring systems to predict 28-day mortality and ICU admission but slightly inferior than MEDS to predict mortality.


Dr. Menon is an assistant professor at the University of Miami Miller School of Medicine and a hospitalist at University of Miami Hospital and Jackson Memorial Hospital.

By Jorge Florinendez, MD

**Instability of INRs**

**CLINICAL QUESTION:** Does an initial stable international normalized ratio (INR) predict long-term stability?

**BACKGROUND:** Warfarin decreases stroke risk among patients with atrial fibrillation; however, it interacts with food and drugs and requires monitoring to achieve a therapeutic INR. It is unclear if patients on warfarin with an initial stable INR value remain stable over time. Additionally, it is controversial whether patients on warfarin with previously stable INRs should benefit from switching to a non–vitamin K oral anticoagulant.

**STUDY DESIGN:** Retrospective study.

**SETTING:** Outpatient clinics.

**SYNOPSIS:** Data were collected from the Massachusetts Registry for Better Informed Treatment of Atrial Fibrillation. Included in the study were patients taking warfarin at baseline with three or more INR values in the first 6 months and six or more INR values in the subsequent year. Stability was defined as 80% or more INRs in therapeutic range (2.0-3.0).

Only 26% of patients taking warfarin had a stable INR during the first 6 months, and only 34% continued to have a stable INR in the subsequent year.

**BOTTOM LINE:** Initial stable INR within the first 6 months among patients taking warfarin does not predict long-term INR stability in the subsequent year.


By Jorge Florinendez, MD

**Inhalers used incorrectly at least once-third of the time**

**CLINICAL QUESTION:** What are the most common errors in inhaler use over the past 40 years?

**BACKGROUND:** The most frequent MDI errors were lack of initial full expiration (48%), inadequate coordination (45%), and no postinhalation breath hold (46%). DPI errors were lower, compared with MDI errors: incorrect preparation (29%), no initial full expiration before inhalation (46%), and no postinhalation breath hold (37%).

The overall prevalence of correct technique was the same as poor technique (31%). There was no difference in the rates of incorrect inhaler use between the first and second 20-year periods of investigation.

**BOTTOM LINE:** Incorrect inhaler use in patients with asthma and COPD persists over time despite multiple implemented strategies.

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By Raja Ramesh Gummalla, MD

10 Updated recommendations for managing gout

CLINICAL QUESTION: What are the new treatment options for gout?

BACKGROUND: The 2006 European League Against Rheumatism (EULAR) guidelines recommend that acute flares of gout be treated as early as possible with either oral colchicine, oral corticosteroids, or intra-articular corticosteroids. Experts recommend starting urate-lowering therapy (ULT) only when certain severe clinical features occur, such as recurrent acute attacks and tophi.

STUDY DESIGN: Systematic review.

SETTING: EULAR task force members from 12 European countries.

SYNOPSIS: Since the last guidelines, interleukin-1 blockers (IL-1) were found to play a crucial role in crystal-induced inflammation. IL-1, NSAsIDs, and corticosteroids should be considered in patients with frequent flares and contraindications to colchicine.

Unlike in the previous guidelines, ULT should be considered from first presentation of gout; for severe disease, serum uric acid (SUA) levels should be maintained at less than 6 mg/dL and less than 5 mg/dL. Allopurinol is recommended for first-line ULT, and if the SUA target cannot be reached, it should be switched to another xanthine oxidase inhibitor (febuxostat) or a uricosuric or combined with a uricosuric. Pegloticase is recommended for refractory gout.

BOTTOM LINE: The updated 2016 EULAR guidelines recommend new treatment options for gout and updated indications for ULT.


11 Home treatment of PE remains rare

CLINICAL QUESTION: What is the prevalence of outpatient treatment of acute pulmonary embolism (PE)?

BACKGROUND: PE traditionally is perceived as a serious condition requiring hospitalization. Many studies, however, have shown that outpatient treatment of PE in low-risk, compliant patients is safe. Several scoring systems have been derived to identify patients with PE who are at low risk of adverse events and may be candidates for home treatment.

STUDY DESIGN: Retrospective cohort study.

SETTING: Five U.S. EDs.

SYNOPSIS: Among 983 patients diagnosed with acute PE, 237 (24.1%) were unstable and hypoxic. Only a small proportion of patients (1.7%) were eligible for outpatient therapy, and an additional 16.2% of hospitalized patients were discharged early (2 days or less). Novel oral anticoagulants were administered to fewer than one-third of patients.

BOTTOM LINE: In the era of novel anticoagulants, the majority of patients with acute PE were hospitalized, and home treatment was infrequently selected for stable low-risk patients.


BACKGROUND: FMT restores the normal composition of gut microbiota and is recommended when antibiotics fail to clear CDI. To date, only case series and open-label clinical trials support the use of FMT.

STUDY DESIGN: Randomized, controlled, double-blinded clinical trial.

SETTING: Academic medical centers.

SYNOPSIS: This study included 46 patients with three or more recurrences of CDI who received a course of vancomycin for their most recent acute episode. FMTs with donor stool or patient’s stool (autologous) were administered by colonoscopy.

The primary endpoint was resolution of diarrhea without anti-CDI therapy after 8 weeks of follow-up. In the donor FMT group, 90.9% achieved clinical cure, compared with 62.5% in the autologous group. Patients who developed recurrent CDI were free of further disease after subsequent donor FMT.

The study included only patients who experienced three or more recurrences but excluded immunocompromised and older patients (older than 75 years of age).

BOTTOM LINE: Donor stool administered via colonoscopy was more effective than autologous FMT in preventing further CDI episodes.


Dr. Fernandez de la Vara is an instructor at the University of Miami Miller School of Medicine and chief medical resident at the University of Miami Hospital.

By Maria Antonietta Mosetti, MD

14 Overnight extubations associated with worse outcomes

CLINICAL QUESTION: Are overnight extubations in intensive care units associated with higher mortality rate?

BACKGROUND: Little is known about the frequency, safety, and effectiveness of overnight extubations in the ICU.

STUDY DESIGN: Retrospective cohort study.

SETTING: One-hundred sixty-five ICUs in the United States.

SYNOPSIS: Using the Project IMPACT database, 97,844 adults undergoing mechanical ventilation (MV) in 172 ICUs were studied. Overnight extubation was defined as occurring between 7 p.m. and 6:59 a.m. Primary outcome was reintubation; secondary outcomes were ICU and hospital mortality and ICU and hospital length of stay.

Only one-fifth of patients with MV underwent overnight extubations. For MV duration of at least 12 hours, rates of reintubation were higher for patients undergoing overnight extubation (14.6% vs. 12.4%; P < .001). Mortality was significantly higher for patients undergoing overnight versus daytime ventilation (11.2% vs. 6.1%; P < .001) and in the hospital (16.0% vs. 11.1%; P < .001). Length of ICU and hospital stays did not differ.

BOTTOM LINE: Overnight extubations occur in one of five patients in U.S. ICUs and are associated with worse outcomes, compared with daytime extubations.


WEB FILE CONTINUED ON PAGE 16

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Low-risk FN patients in the ED received more aggressive treatment than recommended. Further research is needed to strategize means of better aligning FN management with standards of care.

By Jessica Zuleta, MD, FHM

**CLINICAL QUESTION:** Does emergency department management of patients with febrile neutropenia (FN) follow current guidelines?

**BACKGROUND:** Chemotherapy-related FN is an oncologic emergency frequently leading to hospitalization and intravenous antibiotics. Familiarity with FN guidelines allows risk stratification for inpatient versus outpatient therapy.

**STUDY DESIGN:** Single-center, retrospective, cohort study.

**SETTING:** Large, urban, tertiary-care academic hospital.

**SYNOPSIS:** Of 173 patient visits, 25% were risk stratified as eligible for outpatient treatment and 75% as inpatient care. All patient care was assessed for guideline concordance at the time of ED disposition and therapy. Primary outcome analysis demonstrated management was guideline discordant in 98% of low-risk patients versus 7% of high-risk patients. Secondary 30-day clinical outcomes showed high-risk patients were more likely to have positive blood cultures (54%), sepsis-induced hypotension (9.3%), and death (5.4%). Seventeen percent of all patients who received IV antibiotics were prescribed vancomycin without guideline support.

**BOTTOM LINE:** Low-risk FN patients in the ED received more aggressive treatment than recommended. Further research is needed to strategize means of better aligning FN management with standards of care.


**16 Do not overtreat febrile neutropenia**

**17 What to do with isolated calf DVT**

**CLINICAL QUESTION:** Does therapeutic anticoagulation of isolated calf deep vein thrombosis (DVT) decrease risk for proximal DVT or PE?

**BACKGROUND:** Optimal management of isolated calf DVT lacks consensus.

**STUDY DESIGN:** Single-center, retrospective, cohort study.

**SETTING:** Large academic hospital.

**SYNOPSIS:** Researchers evaluated 14,056 lower-extremity venous duplex studies and identified 243 patients with an intent to treat with therapeutic anticoagulation as well as 141 patients without anticoagu-
A printout of the first ED pulse oximetry reading was used to obtain the PImax and Pimin as below:

\[
\text{PVI} = \frac{\text{PImax} - \text{Pimin}}{\text{PImax}}
\]

Researchers followed patients after the initial evaluation to determine disposition from the ED, which included either discharge to home, admission to a general pediatrics floor, or admission to the PICU. The hospital utilized specific criteria for disposition from the ED (see Table 1).

Of the 117 patients who were analyzed after application of exclusion criteria, 48 were discharged to home, 61 were admitted to a general pediatrics floor, and eight were admitted to the PICU. The three groups were found to be demographically similar. Researchers found a significant difference between the PVI of the three groups, but pairwise analysis showed no significant difference between the PVI of patients admitted to the general pediatrics floor versus discharged to home (see Table 2). PVI shows promise as a tool to rapidly assess disease severity in pediatric patients being evaluated and treated for asthma, but further studies are needed to validate this in the ED and hospital setting.


**References**

“It was a strong achievement to get 20 million people insured, but it’s not clear that it bend the cost curve,” says Dr. Eibner. “There are high premiums on the individual market and still 31 million people without coverage. There is still opportunity to improve.”

Where we stand January 2017

Whether the Republicans can or will repeal the ACA in its entirety and improve it remains unknown. It could take months or even years to replace. But, the experts say, the landmark law has left its mark on the American health care system.

“Everyone is complaining about the uncertainty created by the election, but we have been dealing with a highly uncertain environment for many years,” says Ron Greeno, MD, FCCP, MHM, senior adviser for medical affairs at TeamHealth, chair of the SHM Public Policy Committee, and SHM president-elect. “There will be changes, but things were going to change no matter the outcome of the election. It continues to require tolerance for change and tolerance for uncertainty.”

In an analysis for the Commonwealth Fund, Dr. Eibner investigated the economic implications of aspects of Mr. Trump’s plans as a candidate. Using a computer model that incorporates economic theory and data to simulate the effects of health policy changes, he found that Mr. Trump’s plans (full repeal alone or repeal with tax deductions for health care premiums, Medicaid block grants, or selling health insurance across state lines) would increase the number of uninsured people by 16 million to 25 million, disproportionately impact low-income and sicker patients, expose individual market enrollees to higher out-of-pocket costs, and increase the federal deficit by $0.5 billion to $41 billion.1

The Congressional Budget Office (CBO) estimates full repeal could increase the federal deficit by $137 billion to $353 billion by 2025.2

Rep. Ryan’s A Better Way plan and Price’s Empowering Patients First Act propose providing people more control over their health care, giving tax credits instead of subsidies for premiums, capping the employer-sponsored health insurance tax exclusion, and expanding use of health savings accounts.3 However, specific details vary between them.

Experts say the plans put more onus on individuals and may raise their costs. For example, Price’s plan would offer premium tax credits based on age, rather than income, with a maximum of $3,000 available to individuals older than 55 years.

“Young, healthy, and wealthy people may do quite well under this vision of health care reform,” Larry Levitt, a senior vice president at the nonpartisan Kaiser Family Foundation, told Politico in November. “But people who are older, poorer, and sicker could do a lot worse.”

“While the approach puts more risk on the consumer, it makes government spending more predictable than if the credit amount were tied to premium prices,” says Dr. Eibner. “By divorcing the credit amount from health care cost growth, the approach may help to constrain the growth of the deficit.”

Dr. Eibner says there is “a clear implication” that physicians may lose patients, care for a greater share who are uninsured, and see a return of higher rates of uncompensated hospital care. The experts say Republicans are unlikely to restore cuts to disproportionate-share hospitals that were made under the ACA since more patients were insured.

Joshua Lenchus, DO, RPh, FACP, SFHM, a member of SHM’s Public Policy Committee, and hospitalist at the University of Miami/Jackson Memorial Hospital, is no fan of entitlement programs such as Medicaid but says, “The safety-net hospital where I work would rather have people covered with something than nothing.”

Dr. Lenchus is optimistic that economic reforms under Trump will lead to more jobs, increasing the number of people covered by employer plans. “The economy drives health care reform,” he says. “He has to up his ante now and show people that he can stimulate job growth in this country so we don’t have this middle class that is continuously squeezed.”

Dr. Greeno and Ms. Hoffman, who is also a faculty associate at the UCLA Center for Health Policy Research and vice chair of the Insurance Law Section of the Association of American Law Schools, suggest hospitalists get involved as rules are being shaped and written.

“We want to help reform the delivery system, and we want it to be done right and to be done fairly. We want to have a voice in how our patients are treated,” Dr. Greeno says.

CONTINUED FROM PAGE 1
Key provisions: A delicate balance

Many people equate the ACA with the individual mandate, which requires nearly all Americans to purchase health insurance or pay a fine. The federal government provides subsidies to enrollees 138% - 400% of the federal poverty level so their out-of-pocket costs never exceed a defined threshold, even if premiums go up. These could be on the chopping block.

“The last bill Congress passed to repeal the Affordable Care Act, which Obama vetoed, repealed the individual mandate and subsidies for people to buy insurance,” Ms. Hoffman says. “If they do repeal it, private insurance through the exchanges will crumble.”

The tax deductions to offset premium costs that Trump proposed as a candidate are based on income, making them more generous for higher-income earners than low-income ones, Hoffman adds.

Additionally, “premiums go up way out because many more people can’t afford insurance, so those who choose to buy are the sickest,” says Ms. Hoffman. “Risk pools get extremely expensive, and many more people see it as unaffordable.” As a result, she says, people may choose high-deductible plans and face high out-of-pocket costs if they do seek care.

“It’s asking individuals to save by deciding how they’re going to ration care, where someone says they’re not going to go to the doctor today or fill a prescription they need,” she said.

Meanwhile, Mr. Trump has said he would like to keep the provision of the ACA that bans insurers from denying individuals with preexisting conditions. This, experts agree, may not be possible if other parts of the law are repealed and not replaced with similar protections for insurers.

“If you try to keep the rules about not including preexisting conditions and get rid of subsidies and the individual mandate, it just won’t work,” Ms. Hoffman says. “You end up with extraordinarily expensive health insurance.”

Rep. Ryan’s and Rep. Price’s plans would prohibit insurers from denying patients with preexisting conditions but only if patients maintain continuous coverage, with a single open-enrollment period. Ryan has also promised to provide at least $25 billion in federal funding for state high-risk pools.

Prior to the passage of the ACA, 35 states offered high-risk pools to people excluded from the individual market. The Kaiser Family Foundation shows the net annual losses in these states averaged $5.510/ enrollee in 2011. Premiums ranged from 100% to 200% higher than the Medicaid threshold below 138%.

Some states will struggle to provide for all their enrollees, Ms. Hoffman says, particularly since health spending generally outpaces inflation. Dr. Lenchus is more optimistic. “I believe states that didn’t expand Medicaid, one way or another, will figure out a way to deal with that population,” he says.

And ... Medicare

The other entitlement program facing abrupt change is Medicare, typically considered the third rail of American politics.

“This is the hot political moment,” Ms. Hoffman says. “This is the point where the Republicans think they can tick off their wish list. For many Republicans, this kind of entitlement program is the opposite of what they believe in.”

Though Mr. Trump has said before he would not alter Medicare, he remained quiet on this point in the aftermath of the election. Repealing the ACA would affect Medicare by potentially repealing the Part D prescription drug doughnut hole and eliminating some of the savings provisions in the law. In fact, the CBO estimates Medicare direct spending would increase $802 billion between 2016 and 2025, 3 Rep. Ryan and Rep. Price have discussed privatizing Medicare by offering seniors vouchers to apply toward private insurance.

“At the highest level, it’s moving Medicare from a defined benefit to a defined contribution program,” Ms. Hoffman says. “It shifts financial risk from the federal government to the beneficiary. If Medicare spending continues to grow faster than the rest of the economy, Medicare beneficiaries will pay more and more.”

Settlers may also find themselves rationing or skimping on care.

Despite Rep. Ryan’s statements to the contrary, Medicare is not broken because of the ACA, Ms. Hoffman says. Its solvency thousands of physicians already invested in different models, so I don’t expect anybody has any desire to pull the rug from under physicians who are testing alternative payment models (APMs),” he says. “MACRA was passed on a strong bipartisan vote, and it created an APM track. Obvi- ously, Congress intended APM models to continue to expand.”

Testing of these models could slow if Republicans enact changes to CMMI, says Dr. Greeno.

Hospit alists are helping “shape these models,” working with CMS and the Physi- cian-Focused Payment Model Technical Advisory Committee “to ensure physicians participate in APMs and feel engaged rather than being a worker in a model someone else controls.”

On the campaign trail, Mr. Trump spoke of importing pharmaceuticals from overseas in an effort to control high prices. This policy is no longer part of his online plan. He also proposes allowing the sale of health insurance across state lines.

“It would be giving enrollees in states with stricter regulations the opportunity to circum- vent a lower state, which undermines the state with the stricter regulations,” Dr. Greeno says. “That would really create winners and losers. People who are healthy can buy a policy in a state with looser regulations, and their costs would likely fall. But someone sicker and older, it would be harder.”

Ms. Hoffman defines such a plan as a “race to the bottom.” Without well-estab- lished networks of physicians and hospitals, startup costs in new states are prohibitive, and many insurers may not wish to compete across state lines, she adds.

Repeal of the ACA could also limit some of the health benefits it required plans on the individual market. For example, policy- makers might be allowed to strip the contra- ceptive-coverage regulation, which provides for free birth control.

“The reality is a lot of things changing in health care now were changing before the Affordable Care Act passed — PQRs, value-based purchasing, hospital-acquired infections,” Dr. Greeno says. “MACRA will continue the journey away from fee- for-service toward outcome-based models.”

At such a pivotal time, he strongly encourages hospitalists to join SHM if they are not already members and to get involved
Heart failure readmission metric not linked to care quality

BY ALICIA GALLEGOS
Frontline Medical News
FROM THE AHA SCIENTIFIC SESSIONS

Metrics used by the Centers for Medicare & Medicaid Services to determine penalties for heart failure hospital readmissions are not associated with quality of care or overall clinical outcomes, according to data presented at the annual scientific sessions of the American Heart Association.

Ambarish Pandey, MD, of the University of Texas Southwestern Medical Center in Dallas, and his colleagues analyzed data from centers participating in the American Heart Association’s Get With The Guidelines—Heart Failure (GWTF-HF) registry linked to Medicare claims from July 2008 to June 2011. Centers were stratified as having low risk-adjusted readmission rates and high risk-adjusted readmission rates based on publicly available data from 2013.

The study included 171 centers with 43,143 patients. Centers were almost evenly split between low and high risk-adjusted 30-day readmission rates, with just a few more (51%) falling in the low risk-adjusted category.

Performance was nearly equal (95.7% for centers with a low risk-adjusted readmission rate) for median adherence to all performance measures, as was the case for median percentage of defect-free care (90.0% vs. 91.1%, respectively) and composite 1-year outcome of death or all-cause readmission rates (median 62.9% vs. 65.3%, respectively). The higher readmission group had higher 1-year all-cause readmission rates (median, 59.1% vs. 54.7%), Dr. Pandey and his colleagues reported in the study that was published simultaneously in JACC: Heart Failure (2016 Nov 15. doi: org/10.1016/j. jchf.2016). One-year mortality rates were lower in the higher readmission group with a trend toward statistical significance (median, 28.2% vs. 31.7%; P = 0.07).

Taken together, the findings suggest the 30-day readmission metrics currently used by CMS to determine readmission penalties for heart failure are not associated with quality of care or overall clinical outcomes.

—Ambarish Pandey, MD

Combine qSOFA and SIRS for best sepsis score

BY M. ALEXANDER OTTO
Frontline Medical News

AT CHEST 2016

LOS ANGELES – Instead of replacing the Systemic Inflammatory Response Syndrome (SIRS) score with the new quick Sequential Organ Failure Assessment (qSOFA) score to identify severe sepsis patients, it might be best to use both, according to two studies presented at the American College of Chest Physicians annual meeting.

The gold standard 3rd International Consensus Definitions for Sepsis and Septic Shock Task Force recently introduced qSOFA to replace SIRS, in part because SIRS is too sensitive. With criteria that include a temperature above 38°C, a heart rate above 90 bpm, and a respiratory rate above 20 breaths per minute, it’s possible to score positive on SIRS by walking up a flight of stairs, audience members at the study presentations noted.

The first study at the meeting session – a prospective cohort of 152 patients scored by both systems within 8 hours of ICU admission at the New York–Presbyterian Hospital – found that the two scores performed largely the same when it came to predicting ICU admission and 30-day mortality, but that people who met two or more criteria in both systems were of special concern. Twenty-five percent of patients (1,713) scored 2 or more on both SIRS and qSOFA.

These patients were more likely to be admitted to the ICU and be readmitted to the hospital after a month, compared with those patients who were positive in only one scoring system or negative in both. Additional factors associated with these patients were that they had the longest ICU and hospital lengths of stay. Two hundred (12%) of these patients scoring 2 or more on both SIRS and qSOFA died within 30 days.

“SIRS criteria continue to be more sensitive at identifying severe sepsis, but they are equally as accurate as qSOFA criteria at predicting adverse patient outcomes,” said lead investigator Eli Finkelsztein, MD, of the New York–Presbyterian Hospital.

The second study – a review of 6,811 severe sepsis/septic shock patients scored by both systems within 3 hours of emergency department admission at the University of Kansas Hospital emergency department in Kansas City – found that the two scores performed largely the same when it came to predicting ICU admission and 30-day mortality, but that people who met two or more criteria in both systems were of special concern.

Twenty-five percent of patients (1,713) scored 2 or more on both SIRS and qSOFA. These patients were more likely to be admitted to the ICU and be readmitted to the hospital after a month, compared with those patients who were positive in only one scoring system or negative in both. Additional factors associated with these patients were that they had the longest ICU and hospital lengths of stay. Two hundred (12%) of these patients scoring 2 or more on both SIRS and qSOFA died within 30 days.

“SIRS criteria continue to be more sensitive at identifying severe sepsis, but they are equally as accurate as qSOFA criteria at predicting adverse patient outcomes,” said lead investigator and Kansas University medical student Amanda Deis.

SIRS and qSOFA take only a few seconds to assess at the bedside. Using both builds up a picture of the patient’s clinical picture,” she said.

There was no industry funding for the work, and the investigators had no relevant financial disclosures.

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Penn State Milton S. Hershey Medical Center
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Embrace change as a hospitalist leader
Tales from an insightful dive into SHM leadership training

We work in complex environments and in a flawed and rapidly changing health care system. Caregivers, patients, and communities will be led through this complexity by those who embrace change. Last October, I had the privilege of attending and facilitating the SHM Leadership Academy in Orlando, which allowed me the opportunity to meet a group of people who embrace change, including the benefits and challenges that often accompany it.

SHM Board member Jeff Glasheen, MD, SFHM, taught one of the first lessons at Leadership Academy, focusing on the importance of meaningful, difficult change. With comparisons to companies that have embraced change, like Apple, and some that have not, like Sears, Jeff summed up how complacency with “good” and a reluctance to tackle the difficulty of change keeps organizations—and people—from becoming great.

“Good is the enemy of great,” Jeff preached.

He largely focused on hospitalists leading organizational change, but the concepts can apply to personal change, too. He explained that “people generally want things to be different, but they don’t want to change.”

Leaders in training
Ten emerging hospitalist leaders sat at my table, soaking in the message. Several of them, like me 8 years ago, had the responsibilities of leadership unexpectedly thrust upon them. Some carried with them the heavy expectations of their colleagues or hospital administration (or both) that by being elevated into a role such as medical director, they would abruptly be able to make improvements in patient care and hospital operations. They had accepted the challenge to change—to move out of purely clinical roles and take on new ones in leadership despite having little or no experience. Doing so, they gingerly but willingly were following in the footsteps of leaders before them, growing their skills, improving their hospitals, and laying a path for future leaders to follow.

A few weeks prior, I had taken a new leadership position myself. The Cleveland Clinic recently acquired a hospital and health system in Akron, Ohio, about 40 miles away from the city. I assumed the role of president of this acquisition, embracing the complex challenge of leading the process of integrating two health systems. After 3 years overseeing a different hospital in the health system, I finally felt I had developed the people, processes, and culture that I had been striving to build. But like the young leaders at Leadership Academy, I had the opportunity to change, grow, develop, take on new risk, and become a stronger leader in this new role. A significant part of the experience of the Leadership Academy involves table exercises. For the first few exercises, the group was quiet, uncertain, tentative. I was struck both by how early these individuals were in their development and by how much of what is happening today in hospitals and health care is dependent upon the development and success of individuals like these who are enthusiastic and talented but young and overwhelmed.

I believe that successful hospitalists are, through experience, training, and nature, rapid assimilators into their environments. By the third day, the dynamic at my table had gone from tentative and uncertain to much more confident and assertive. To experience this transformation in person at SHM’s Leadership Academy, you are welcome to join us Scottsdale, Ariz., later this year. Learn more about the program at www.shmleadershipacademy.org.

At Leadership Academy and beyond, I implore hospitalists to look for opportunities to change during this time of New Year’s resolutions and to take the opposite posture and want to change—change how we think, act, and respond; change our roles to take on new, uncomfortable responsibilities; and change how we view change itself.
Have you Googled yourself lately?

With a majority of patients relying on physician ratings, hospitalists might consider countermeasures

The online rating business is proliferating in the medical industry. This should really come as no surprise as health care is a service industry and online ratings have long been a staple in most other service industries. It has become routine practice for most of us to search such online reviews when seeking a pair of shoes, a toaster, or a restaurant; we almost can’t help but scour these sites to help us make the best decision possible.

Many of these reviews come in quantitative and qualitative forms, for example, stars or numerical ratings, along with qualitative comments. Of course, when seeking out products and services, these ratings are not usually the sole mechanism that we use to make decisions. For example, with the toaster analogy, I would not only be influenced by the reviews but also by the cost and the accessibility of the toaster (for example, when I can get it shipped or if it is available in a nearby store).

Not dissimilarly, patients these days seek care and make decisions by using a variety of inputs, including:

• Anticipated cost (is the physician or practice in or out of network);
• Availability or access to the service (location of the practice and how long it will take to be seen);
• How good the services and care will be; and whether their location is convenient.

A study in JAMA found the top two factors influencing the selection of physicians were whether they accept a patient’s insurance and whether their location is convenient.

But the study also found that 90% of American adults considered online ratings somewhat important or very important when choosing physicians.

That same article found that, for those who used online physician ratings, about one-third had selected a physician based on good ratings, and about one-third had avoided a physician based on poor ratings. So patients do seem to be paying attention to these sites and seeking or avoiding care based on what information they find.

Based on that evidence, it is not surprising that so many physician rating sites have sprung up; not only is there a market demand for the availability of this information, the rating sites are also profitable for the host companies. Vitals.com, for example, makes most of its revenue from advertising and turns a sizable profit every year. Other profitable health care rating sites include Healthgrades, Yelp, Zocdoc, and WebMD.

When I Google my own name, for example, Vitals.com is the first ratings website that appears in the search results. The first pop-up asks you to rate me and then it takes you to a site with all sorts of facts about me (most of which are notably inaccurate). I’d had any online ratings (which I do not currently), you would then see my star ratings and any comments.

The second rating site that comes up for me via Google search is PhysicianWiki.com. There is a whole host of information on me (most of which is accurate), along with a set of personal ratings, including my office, my staff, and my waiting times (which, of course, do not make any sense given I am a hospitalist). It is unclear how those ratings were generated or what volume of responses they represent.

Because of such limitations with the online rating business for physicians, some health care systems have tried to “take control of the conversation” by posting their own internally collected quantitative and qualitative feedback from patients. The University of Utah was one of the first in the nation to create its own internal site outsourced to a third party to take control of the conversation. It is unclear how those ratings were generated or what volume of responses they represent.

The second article found that, for those who used online physician ratings, about one-third had selected a physician based on good ratings, and about one-third had avoided a physician based on poor ratings. So patients do seem to be paying attention to these sites and seeking or avoiding care based on what information they find.

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I don’t think the controversy over online physician ratings will wane anytime soon, but there is no doubt that they are profitable for companies and are therefore highly likely to continue to multiply.

References

Effective hospitalist roles for NPs, PAs

Single-site study offers success story, isn’t one-size-fits-all solution

I’m often asked about effective roles for nurse practitioners (NPs) and physician assistants (PAs), collectively known as advanced practice clinicians (APCs). My first response is always the same: They have much to contribute and can be effective members of hospitalist groups. Most hospital medicine groups (HMGs) should think about having them in their staffing mix if they don’t already.

Yet despite all that NPs/PAs can offer, my experience is that many (even most) hospitalist groups fail to develop roles that optimize their APCs’ skills.

An October 2016 study in the Journal of Clinical Outcomes Management adds additional data to help think about this issue. You may have seen the study mentioned in several news articles and blogs. Most summarized the study along the lines of “using high levels of PA staffing results in lower hospital costs per case.” Framing it this way is awfully misleading, so I’ll go a little deeper here.

Study context
The study, “A Comparison of Conventional and Expanded Physician Assistant Hospitalist Staffing Models at a Community Hospital,” is a retrospective analysis of performance measures from two hospitalist groups at Anne Arundel Medical Center (AAMC) in Annapolis, Md.1 One HMG is employed by the hospital. The other, called MDICS, is a private company that contracts with AAMC as well as approximately 13 other hospitals and 40 rehabilitation facilities. Tim Capstack, MD, is the AAMC medical director for MDICS and lead author of the study (representing a potential conflict of interest acknowledged in the article). Barry Meisenberg, MD, is a coauthor, a hospitalist in the AAMC-employed group, and chair for quality improvement and health care systems research at AAMC.

Tim told me by phone that both groups have practiced at AAMC for more than 10 years and enjoy a collegial relationship. Both groups employ PAs and pair them with a single physician in a dyad arrangement each day. Tim’s MDICS group, the “expanded PA” group, staffs each day shift with three physicians and three PAs, compared with the nine physicians and two PAs in the hospital-employed “conventional” group. The MDICS PAs are responsible for more patients each day than their conventional-group counterparts and, during the January 2012 to July 2013 study period, averaged 14.2 patients versus 8.3, respectively.

Over the course of the study, PAs in the expanded PA group saw and billed 36% of patient visits independently, compared with 5.9% for the conventional group.

Notable study findings
I think the main value of this study is in showing that the expanded PA group had higher levels of readmission, inpatient mortality, length of stay, and consultant use that weren’t statistically different from the conventional group.

The workloads and years of experience of doctors and PAs in each group were similar. And while there were some differences in the patients each group cared for, they seemed unlikely to have a significant influence on outcomes. Clearly, there are many unmeasured variables (e.g., culture, morale, and leadership) in each group that could have influenced the outcomes, so this one study at one hospital doesn’t provide a definitive answer about appropriate APC staffing levels. However, it didn’t uncover big differences in the measured outcomes.

And this study did show that higher levels of PA staffing were associated with lower hospital charges per case. Although the difference was a modest 3%, it was statistically significant (P less than .001). I’m skeptical there is causation here; this more likely is just correlation.

It would be great to see a larger study of this.

Information applications
So does this study support the idea that HMGs can or should increase APC staffing and workload significantly to realize lower hospital cost per case and not harm patient outcomes? Not so fast.

This study compared only two hospitalist groups at one hospital. It’s probably not very generalizable.

And as described in the paper, and stressed by Tim talking with me by phone, the outcomes of their expanded PA model likely have a lot to do with their very careful recruiting and screening of experienced PAs before hiring them, not to mention a lengthy and deliberate on-boarding process (summarized in the article) to support their ability to perform well. Groups that are not as thoughtful and deliberate in how they hire and position APCs to contribute to the practice may not perform as well.

Any group who thinks this study is evidence that adding more APCs and having them manage a higher number of patients relatively independently will go well in any setting is mistaken. But it does offer a story of one place where, with careful planning and execution, it went OK.

Any group who thinks this study is evidence that adding more APCs and having them manage a higher number of patients relatively independently will go well in any setting is mistaken. But it does offer a story of one place where, with careful planning and execution, it went OK.

In my view, the real take-home message is to think carefully to ensure any APCs in your group have professionally satisfying roles that position them to contribute effectively. While common, I think configuring APCs and physicians as rounding dyads is often underperforming and not working out well because of inefficiency. When well executed, as is apparently the case in this study, it can be fine. But my experience is that positioning APCs to assume primary responsibility for some clinical activities, such as covering the observation unit or serving as an evening admit/cross-cover provider (all with appropriate physician collaboration and backup), more reliably turns out well.

Reference

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