WE ARE THE CHAMPIONS.

The emotion-triggering tune that blares nightly at sports stadiums across the country was pretty much a slogan at SHM’s annual meeting, held April 8-11 at the Gaylord National Resort & Convention Center in National Harbor, Md., just outside Washington, D.C.

From new SHM President Jeff Weise’s use of the lyric to analogize HM’s arrival as a force in healthcare reform to the Hall of Fame-tinged ceremony inducting the first three Masters in Hospital Medicine—John Nelson, Robert Wachter, and Winthrop Whitcomb—this once-a-year gathering is no longer about seeking respect as a specialty. It’s blossomed into a sold-out, four-day strategy session looking at various ways to improve the delivery of care to patients.

“What we say is going to be taken seriously,” said Dr. Wiese, MD, FACP, SFHM, associate professor of medicine at Tulane University Health Sciences Center in New Orleans. “Which means that it has to be the right message—which means that it has to be about patient care.”

PICTURED: SHM President Jeff Wiese, MD, SFHM, challenges hospitalists to think of their patients and provide a higher quality of care.

PHOTO CRAIG MATTHEWS
Quality Control

As specialty matures, annual meeting flourishes with practical, educational, and social takeaways

BY RICHARD QUINN

NATIONAL HARBOR, Md.—As HM10 wound down in this tony Washington, D.C., outpost, a trio of hospitalists from St. Louis smiled widely and brightly as a stranger took their picture in front of the main stage.

Each raved about the quality of the meeting they had just completed, particularly the way it linked HM leaders from across the country to such ubiquitous problems as transitional care and patient falls found in institutions from Seattle to Cincinnati to South Carolina. And with a record 2,500 hospitalists attending SHM’s annual meeting this year, what better time to smile?

“Your world suddenly becomes much smaller because you can reach out to people, rather than feel like you’re lost in this massive machine,” said Lois Richard, MD, PhD, FHM, a hospitalist with Washington University Physicians at the Washington University School of Medicine in St. Louis.

Dr. Richard’s commentary on belonging to a larger scene is a fitting allegory for the state of HM, as the field has grown beyond its neophyte stage. Now that the field has swelled to an estimated 30,000 nationwide, SHM’s new president said the time has come to move past the adolescent phase. Jeff Wiese, MD, FACP, SFHM, associate professor of medicine at Tulane University Health Sciences Center in New Orleans, wants hospitalists to continue championing quality-improvement (QI) programs and patient-safety efforts.

“We’re at a stage as an organization that we need to continue to do the quality-education efforts, but we need to start rising to that next level, which is the quality execution and solutions,” he said during a keynote address, adding later that “we have great heterogeneity in the society. Some people are quality experts because they received great training from SHM. Intermountain Health, IHI, but then there are many members that are interested and really want to be that quality expert but are to the left on the continuum, still learning how to do it.”

The path to quality development began anew with the four-day meeting April 8-11 at the Gaylord National Resort & Convention Center on the banks of the Potomac River. The largest meeting in SHM history kicked off with its largest menu of pre-course sessions, designed to offer educational credits to CME-hungry physicians. This year’s choices included a pair of new sessions, one geared toward neurology and the other aimed at early-career hospitalists. The increased offerings worked, as SHM officials reported a preliminary pre-course attendance increase of 10% from last year’s meeting.

Another big draw for the meeting was the keynote address from Paul Levy, president and CEO of Beth Israel Deaconess Medical Center in Boston. Levy has quickly built himself a national platform to push for QI in the nation’s hospitals, along with public reporting and transparency. Levy said “we still do too much harm in our hospitals,” but wants to see that changed not because of radical changes in payment streams, but because of physicians who want to do better by their patients.

“Ignore the healthcare reform bill,” he said in his address. “Ignore all the fuss about it. Focus instead on the underlying values that you each have individually, and that you have collectively, as to why you became docs in the first place.”

The theme of quality and the future continued speaker after speaker, session after session. Meeting faculty used their microphones to expound on how the recently passed health-care legislation does more to expand access to healthcare than change the current rules governing it. Most talked about the potential role hospitalists can play in the fluid landscape bound to develop in the next few years, with SHM CEO Larry Wellikson, MD, SFHM, going as far as to describe the field as “the rocketship moving upward almost to a limitless future.”

Still, the future only comes once the past has been recognized, and this year’s meeting will be remembered for the first three physicians who were honored as Masters in Hospital Medicine: John Nelson, Robert Wachter, and Winthrop Whitcomb. The latter described the ceremony as a moving experience for himself and his family.

“When John and I first started working on this in October 1996, and we had the first substantive conversation, I had a really strong feeling that this was going to be successful,” Dr. Whitcomb said. “I saw the forces gathering to drive this, but I definitely didn’t have any idea it was going to be this thing. I don’t think any of us
NATIONAL HARBOR, Md.—Amie Dlouhy, RN, BSN, hospitalist program manager with Saint Mary’s Health Care in Grand Rapids, Mich., couldn’t scribble notes furiously enough during the practice-management pre-course at HM10. Dlouhy was promoted to her new position as an administrator some six weeks before the annual meeting at the Gaylord National Resort & Convention Center in early April.

So the first-time meeting attendee decided she would jot down as many tips as she could. She quickly realized the trip was worth it, as she learned that a departmental dashboard is a relatively simple way to gather key information in one place. She also likes the idea of drawing up a brochure that tells patients what they can expect from their hospitalists—and perhaps vice versa. And what new HM group leader doesn’t want advice on building a schedule that adds individualized wrinkles to the “seven-on, seven-off” structure?

“It is a business and you need to treat it as if it’s a business,” Dlouhy said. “It’s an ongoing process, and you want to make sure you have a concrete foundation.”

The tidbits Dlouhy gleaned from her pre-course were among scores of nuggets discussed during eight of the accredited educational sessions. This year’s pre-courses boosted to a new high of 20 the number of Category 1 credits physicians could earn toward the American Medical Association’s (AMA) Physician Recognition Award. Last year, the total was 15.

Offering more classes—and more varied topics—worked pretty well, as this year’s slate of pre-courses was more popular than ever, according to SHM officials. At HM09 in Chicago, more than 800 attendees participated in six sessions. At HM10, the total attendance was roughly 10% higher.

A main driver of the growth was the addition of two new courses—“Essential Neurology for the Hospitalist” and “Early Career Hospitalist: Skills for Success.” Another was a packed room of hospitalists answering questions—some right, some wrong—and preparing for the new Focused Practice in Hospital Medicine (FPHM) via the American Board of Internal Medicine’s (ABIM) Maintenance of Certification (MOC). The learning session pre-course debuted last year, but the new HM pathway to board recertification helped push attendance higher this year.

“The nice thing about the audience-response system is that you can actually see that not everybody is always going straight to the right answer on all of the questions,” said Julius Yang, MD, PhD, a hospitalist at Beth Israel Deaconess Medical Center in Boston and the MOC course director. “It’s really serving as an important refresher of our medical knowledge base.”

Dr. Yang said the “mini-retreat” environment of an annual convention is the perfect place to focus on granular professional development. “Trying to do these types of MOCs when you’re working to keep current with all of your other duties, you don’t get as much out of it,” Dr. Yang said. “Here, you get it all.”

He adds that those physicians who take the time and spend the money to travel for an educational session tend to be very focused on taking advantage of the program, not just showing up to be counted.

“All of these [questions] are very much directed at growing as a hospitalist,” Dr. Yang said. “It’s a different focus than the rest of the meeting. This is about every individual bringing something back to their institution.”

Professional Advice

First-class faculty make HM10 pre-courses highly educational, practical  

BY RICHARD QUINN

Professional Advice

First-class faculty make HM10 pre-courses highly educational, practical  

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Most medical meetings have a scientific focus with a couple of practical aspects. SHM’s meeting is very practical. It presents research, but it’s research you will use in your practice.

—Troy Ahlstrom, MD, FHM, Hospitalists of Northwest Michigan, Traverse City

CONTINUED ON PAGE S-13
“The Value Proposition to C-Suites: Aligning Hospital Resources to Support Hospitalist QI”

**By Richard Quinn**

**National Harbor, Md.**—It’s happened to every hospitalist who has pushed for a quality improvement (QI) project in their hospital: A chief says no because there’s no money for it. Doesn’t matter if it was the chief medical officer, chief operating officer, or the chief financial officer—the answer is no, no, no.

The best way to change the answer? Change the question. “Think like they do,” said Mahalakshmi K. Halasymani, MD, SFHM, vice president for quality and systems improvement at Saint Joseph Mercy Health System in Ann Arbor, Mich. “Think about how healthcare is paid for. … [Administrators are] much more likely to release resources if it matters to the institution’s ability to collect money, or get a better survey next time.”

Dr. Halasymani, an SHM board member, co-led the session “The Value Proposition to C-Suites: Aligning Hospital Resources to Support Hospitalist QI” with hospitalist Mark Novotny, MD, FHM, who held several C-suite positions at Southwestern Vermont Medical Center in Bennington, Vt., before parting ways with the hospital in early April. Both physicians urge getting organized before taking any case to hospital or health system administrators. Some of their tips:

* Define the scope of your proposal. Tackling too many issues can appear over-reaching. Attain a reasonable goal and build on success; that works better than swinging and missing with loftier goals.

* Attack topic areas with metrics. QI projects are only as good as the data they produce.

* Be interactive. Bring a C-suite member along on daily rounds for a week to showcase the problem you hope to address. When an administrator sees a need for improvement in real time, the issue is personalized. If administrators won’t come to rounds, go to them wherever they are—medical executive committee meetings, patient safety sessions, etc.

* Create a compelling story so people can see you not as an enemy, but as an ally,” Dr. Halasymani said. “To do that, you have to be where the conversations take place.”

Just placing hospitalists on a unit and giving them patients isn’t the answer. Structure has to support a deliberate strategy. Think of what your strategic goals are. … Don’t just implement a new structure and let that be the end.”

Dr. Holman led a panel, “The Case for Unit-Based Hospitalists: Benefits and Challenges,” in which HM experts agreed that tracking the efficacy of the setup is key to success.

Although the benefits are usually clear—less time spent traveling from floor to floor and more direct communication between physicians and non-physician providers (NPPs)—the challenges can be numerous, including:

* Fairness. The first complaint of most HM groups switching to a unit-based approach is that it unfairly distributes patient loads, leading to daytime shifts for which one physician starts with a patient census of eight, while a colleague starts with 15.

* Interunit transfers. By creating defined geographic areas, a patient’s movement from one unit to another becomes another transition of care and brings with it those issues.

* Buy-in from other stakeholders. Physician assistants (PA), nursing staff, and others are affected by geographic alignment. Make sure to pitch quantifiable goals—increased productivity, increased touch time with patients, reduced staff turnover—when instituting the new approach.

Kevin O’Leary, MD, MS, associate chief of hospital medicine at Northwestern University’s Feinberg School of Medicine in Chicago, urges physicians to be practical, and not to expect the unit-based approach to be a panacea. “This is really the first step,” he said.

Mateen Dawood, MD, applauds an HM10 speaker.
SIT DOWN.
A simple piece of advice, to be sure, but one that can also humanize a hospitalist in the eyes of a patient, said panelists of “The Patient Experience: What Hospitalists Need to Know About Measuring, Reporting and Benchmarking.”

“As many doctors are figuring out, perception is reality,” said Patrick Blakeslee, DO, a hospitalist with Premiere Medical Partners in Cuyahoga Falls, Ohio. The credentialing process at his hospital takes into account patient-satisfaction levels. “This is articulation ability, not necessarily your technical skill,” he said.

But like any other facet of medicine, with training, hospitalists can improve the patient’s interaction with physicians. Some tips:

> Craft a script for introductions. While it might sound rehearsed, it also gives the hospitalist a chance to lay out ahead of time what they want to say instead of curtailing the message because of a daily time crunch.

> Develop a business card with your picture or a brochure with an FAQ. Give the patient a sense of what they can expect from their doctor and vice versa.

> End with an open-ended question. This technique engages the patient in their treatment.

HM leaders looking to go even further with patient-satisfaction programs can develop an in-house survey that might gauge responses more accurately, said Nancy Mihevc, PhD, president of The Research Group in Florence, Mass. Outside surveys can be valuable, depending on the methodology they use, she said.

“We’re all, at this point, being measured in this realm,” said Winthrop Whitcomb, MD, MHM, medical director for healthcare quality at Baystate Medical Center in Springfield, Mass. “Should you as a hospitalist be compared to all programs, or should you be compared to just hospitalists?”

QUALITY

“Quality Improvement Curriculum: How to Get Started and to Keep Going” | BY RICHARD QUINN

BUILDING QUALITY improvement (QI) into the healthcare process starts with education, but to date, standardized QI curriculums have not taken root across academic medical centers. A quartet of academic hospitalists pushed the concept during an HM10 session titled “Quality Improvement Curriculum: How to Get Started and to Keep Going.” All four speakers agreed that QI “empowers providers to create change.”

The presentation was based on a 1998 book from first author David Kern, MD, MPH, FACP, professor at the Johns Hopkins University School of Medicine in Baltimore: “Curriculum Development for Medical Education: A Six-Step Process.” Some of the take-home points included:

> Problem Identification and a general-needs assessment, followed by a targeted needs assessment. Combined, the two steps create a construct for an issue, such as “residents lack knowledge skills in QI,” and then hone in with such queries as “What is the baseline knowledge?”

> Goals and objectives. There is a difference between the two. Goals are broad-based with little specificity; objectives are measurable items that gauge progress.

> Educational strategies. Cognitive objectives can be taught via lectures or team-based projects; however, skill-based objectives traditionally are better taught via hands-on experience.

> Implementation, evaluation, and feedback. Many programs try to move too quickly and put something in place before fully planning out the curriculum.

“Take a step back,” said Arpana Vidyarthi, MD, assistant professor and director of quality University of California at San Francisco. “What you do in implementing your curriculum ought to be connected to what your goals and objectives are.”
**Clinical**

“Controversies in Anticoagulation and Thrombosis”

**Elizabeth Barlow, MD, MPP**

wants all hospitalists to know that upper-extremity DVT (UEDVT) is on the rise. Although most think of it “as a lesser entity,” Dr. Barlow told a jam-packed clinical-track session at HM10 the data show a higher rate of pulmonary embolism (PE) occurrence in UEDVT than was first thought. “So I think treating it seriously is important,” she said.

Judicious use of catheters is necessary. You should leave it in, if you need it.

—Elizabeth Barlow, MD, MPP, section of hospital medicine, University of Chicago Medical Center

Dr. Barlow, a hospitalist at the University of Chicago Medical Center, outlined the case for greater attention to UEDVT during “Controversies in Anticoagulation and Thrombosis.” UEDVTs make up 1% to 4% of all DVTs in the U.S., and nearly 80% of UEDVT cases are provoked.

Much of the rise in—and controversy—UEDVT is due to the increased use of indwelling catheters, primarily how long to leave the catheter in place and when to remove it. “Judicious use of catheters is necessary. You should leave it in, if you need it,” Dr. Barlow said, adding that hospitalists should weigh the benefits and risks of PIC lines.

Some of Dr. Barlow’s key take-home points:

> Treat UEDVT seriously;
> Understand there is a higher rate of PE than previously thought;
> Insert central-vein catheters judiciously, and keep them in if you still need them;
> Manage the duration of therapy parallel to that of lower extremity DVT; and
> Routine thrombolitics use isn’t indicated at this time.

**Practice Management**

“Hospitalist NPPs 301—Advanced Concepts”

**Richard Quinn**

**Physician Assistants (PAs)** and nurse practitioners can do almost anything a physician can do, and many have skill sets physicians lack, according to David Friar, MD, FHM, president of Hospitalists of Northwest Michigan based in Traverse City.

“As we go forward, with continued physician shortages and with the growing responsibilities of the hospitalist movement, we are going to need more and more people with different skill sets,” Dr. Friar said during his presentation at HM10. “I think one of those important areas is nonphysician providers.”

A quick survey of the 300 or so hospitalists at the session showed most HM groups employ NPPs, but less than a third of those thought they were “using NPPs well.” Dr. Friar, who has worked with NPs and PAs for 14 years, said he has found NPPs “to be an integral part of our practice. They have become indispensable to us in the way we provide services to our hospitals and patients.”

Still, many hospitalist groups waste NPP potential, Dr. Friar explained. He suggested HM groups evaluate their NPP roster and duties, and make necessary changes. “Make sure you treat them as if they are part of the team. That is very important,” he said. “NPPs can and should take care of patients throughout all stages of the hospital stay, from admission to discharge.”

When hiring NPPs, look for team players who are flexible and willing to learn. Make sure the NPP knows their limits and is comfortable asking for help. Target local training programs or other departments in the hospi-
**Core Competencies Lay Pediatric HM Foundation**

Framework in place, PHM’s future is in the hands of hospitalists

BY MARK SHEN, MD

**NATIONAL HARBOR, Md.** HM10 kicked off with a pediatric hospitalist leading the way. Patrick Conway, MD, MSc, a chief medical officer with the U.S. Department of Health and Human Services, and one of pediatric HM’s own, was a part of the opening panel discussion that reviewed the implications of healthcare reform. And as the pediatric track coursed over the next two days, amidst the hustle and bustle of value-laden content, the final pediatric presentation just might have escaped routine notice.

Two days after its electronic release, a live preview of the "Pediatric Hospital Medicine Core Competencies" debuted at HM 2010. (The core competencies were printed as a supplement in the April issue of the Journal of Hospital Medicine.)

Mary Ottolini, MD, of Children’s National Medical Center in Washington, D.C., graciously thanked Erin Stucky, MD, Rady Children’s Hospital in San Diego, and Jennifer Maniscalco, MD, Children’s Hospital in Los Angeles, for their collaboration in the core competencies effort, which represented the culmination of years of perseverance and dedication. The core competencies underwent a rigorous development and review process; notably, draft copies were sent to more than 30 academic and certifying societies and stakeholder agencies for input. Vibrant discussion ensued as pediatric, family practice, and med-ped hospitalists engaged in both thoughtful reflection and optimistic forecasts of the relevance and utility of a practical framework to define the field.

These guidelines, however, are just the beginning. Much dialogue centered on the future role of the core competencies in such arenas as education and professional development. It became clear that work remains if pediatric hospitalists are to make the best use of this sentinel publication.

Nonetheless, this journey that is the advancement of a vibrant—and now well-defined—field of medicine has a stellar launching pad from which to take flight. HM10

**DR. SHEN IS A PEDIATRIC HOSPITALIST AND DIRECTOR OF THE HOSPITAL MEDICINE PROGRAM AT DELL CHILDREN’S HOSPITAL IN AUSTIN, TEXAS.**

**REFERENCE**


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**CLINICAL**

**“The New C. Diff”**

BY JASON CARRIS

**JOHN G. BARTLETT, MD**

professor of medicine in the Department of Infectious Diseases at Johns Hopkins University School of Medicine in Baltimore, mesmerized a standing-room-only crowd of more than 500 at his lecture about the disease and where it comes from, Dr. Bartlett encouraged providers to punt that question: “The fact is, we don’t know most of the time.”

Most patients acquire C. diff during a hospital stay (74%) or a previous hospital stay (21%), and research shows the longer patients stay in the hospital, the more likely they are to acquire the disease.

“It’s embedded in the fabric of hospitals,” Dr. Bartlett said. “The longer you are in the hospital, the more likely you are to get colonized.”

**Prevention guidelines include:**

> Hand hygiene;
> Advocate gloves and gowns;
> Patients with C. diff should be in single rooms;
> Maintain precautions until diarrhea resolves; and
> Clean with chlorine antiseptic.

**If your lab does PCR, it’s the best test currently available.**

—John G. Bartlett, professor, Department of Infectious Diseases, Johns Hopkins University School of Medicine, Baltimore

Dr. Bartlett was excited to share his experience with RT-PCR testing, which he termed the “new, slick, fast” testing option for C. diff. In trials, it has been shown to be 99% sensitive and 98% specific. “If your lab does PCR, it is the best test currently available,” Dr. Bartlett said, although he cautioned that “this test detects the bug, not the toxin.”

Treatment of C. diff disease happens in the colon, and medications must make it there to be effective. The most common treatments, vancomycin and metronidazole, have pluses and minuses, Dr. Bartlett explained. Vancomycin is FDA-approved and unbeaten in clinical trials; however, it is the more expensive choice. Metronidazole is cheap ($5 per day) and proven to be effective in mild to moderate cases, but is not FDA-approved and is proven in severe cases.

Dr. Bartlett’s guidelines for C. diff treatment:

> Mild cases: no treatment;
> Moderate: metronidazole 250 mg four times a day for 10 to 14 days; and
> Serious: vancomycin 125 mg four times a day for 10 to 14 days.

“If metro doesn’t work, switch to oral vanco,” Dr. Bartlett said.
IT’S 11 MINUTES to 8 o’clock, and the sun is still climbing over the Potomac River just outside the Gaylord National Resort & Convention Center in National Harbor, Md. Day two of SHM’s annual meeting is about to begin.

Hospitalists file into a cavernous ballroom as the day kicks off with a panel discussion on healthcare reform and a speech by that rarest of breed: a popular hospital CEO. The back of the room fills quickly, but front and center, second row—that’s the seat for Nasim Asfarmanesh, MD, director of HM quality initiatives at Ronald Reagan UCLA Medical Center in Los Angeles.

“If I’m not in the front, I zone out,” she admits. Dr. Asfarmanesh (who often adds a hyphen to her surname—Asfar-manesh—to help others pronounce it) knows herself and she knows how to plan ahead, from taking notes on her mini-laptop to knowing when to sit up front. And this day in her life is no different. Her schedule is a 12-hour dervish, yet it’s a simple roadmap of how to navigate HM10 and its scores of sessions, speeches, and seminars.

INNOVATOR AT HEART
Dr. Asfarmanesh did her residency in 2007 at UCLA. She stayed on to take a faculty position and is now assistant clinical professor of internal medicine (IM) and neurosurgery. Her days are split about 20% clinical, 40% on quality for neurology issues, and 40% on general quality-improvement (QI) projects. In her free time, she’s an SHM activist and the incoming chair of its Hospital Quality and Patient Safety (HQPS) Committee.

“I get to be an innovator,” she boasts as she picks up a Danish, a chocolate pastry, and a cup of tea following two hours of listening to others talk. “I love that. You can’t really be an innovator when you’re practicing.”

Innovation requires preparation, though. Dr. Asfarmanesh spends countless hours creating PowerPoint presentations, so she hit a new feature at this year’s meeting: a limited-seating workshop on drawing up effective slides. The presentation is helpful, but she’s partially distracted. “Look up healthcare from talk,” she types as a note to herself for later. She follows that with “Look up Levy’s talk” (a nod to Paul Levy, the well-liked CEO of Beth Israel Deaconess in Boston).

FACIAL RECOGNITION
The distraction ratchets up as she’s already looking forward to introducing herself to the editorial board of the Journal of Hospital Medicine’s editorial board lunch meeting at the Gaylord National Resort & Conference Center in National Harbor, Md.

PHOTOS CRAIG MATTHEWS

Dr. Afsarmanesh sits in on the Journal of Hospital Medicine’s editorial board lunch meeting at the Gaylord National Resort & Conference Center in National Harbor, Md.

Dr. Afsarmanesh is an active participant in the special interest forum.

Dr. Afsarmanesh types notes to herself during the “Making Your Mark: How to Create Effective PowerPoint Presentations” limited-seating workshop at HM10.
Hospital Medicine, where she serves as an assistant editor. There are a few people she’d like to meet in person, so she gracefully sneaks out the side door a few minutes before noon. Handshakes, a box lunch, and a chat with 40 other journal editors ensue for the next hour.

“You can meet people you talk on the phone with for several years,” she says. “You can put a face to the name. That’s important.”

Hobnobbing at a board meeting is only a brief respite, however, before it’s back to professional development. At 1:15, there’s a 60-minute lesson on how to improve care from the patient perspective. Dr. Asfarmanesh, again, is distracted. She’s a first-time presenter in a few minutes, part of a four-woman panel on building QI into a medical school curriculum.

She scrolls through slides, rehearsing her thoughts. She wonders whether her PowerPoint presentation would have made the grade at this morning’s session.

She is smart enough not to judge her performance too soon—someone in an audience once reached out to her a year later—as she knows the impact of a training session is more than the round of applause at its end.

“...I hope that along with some of the content that people take away, the bigger thing is those connections that they make.”

WORK NEVER ENDS

It’s 4:30 p.m. and Dr. Asfarmanesh still has a sales pitch to rehearse. This time, it’s self-promotion for her soon-to-begin poster presentation: “The ABCs of Hospitalized Patients: A Multi-Disciplinary Checklist for Improving Quality of Patient Care.” After umpteen repetitions of her spiel, the presentation doesn’t win a prize, but, once again, she showcases her attention to detail: A stack of 8.5”x11” versions of her slide are available for handouts, a feature few others in the competition have.

Some 12 hours into her tour of this massive convention center, the day is coming to a close. But not before SHM CEO Larry Wellikson, MD, SFHM, drops by to say hello.

He points out how strong her research is. Unfortunately, he uses a pen in the process. “Don’t poke a hole in my poster,” she jokes.

Moments later, it’s back to working the line queued up at her placard.

“Hi, would you like to hear about my poster?”

Richard Quinn is a freelance writer based in New Jersey.
Special Interests

From IT to education to community issues, hospitalists want to be part of the healthcare solution

FROM STAFF REPORTS

HOSPITALISTS FROM ALL PARTS OF THE COUNTRY—

and a few other countries—discussed a wide swath of topics during a community-based HM special-interest forum at HM10. Issues that were discussed included unit-based rounding, changes to Medicare consult codes, strategies for avoiding “dumps,” and working with specialists.

Two established community hospitalists—SHM co-founders John Nelson, MD, MHM, and Winthrop Whitcomb, MD, MHM—moderated the one-hour session.

Dr. Jacquelin Holubka of St. Barnabas Medical Center in Morristown, NJ, listens during a special interest forum at HM10.

Much of the debate centered on defining a hospitalist’s role and relationships with others in the hospital. One hospitalist said he’d noticed significant changes in the 15 years since he began HM practice; however, some issues remain unresolved: Primary-care physicians (PCPs) still know the patients better, and medical specialists still want hospitalists to be their “interns.”

“We have two things to sell: your expertise and your availability. It’s up to your group to determine which one you want to sell,” said Tony Lin, MD, FHM, a hospitalist and chief of the Department of Internal Medicine at Kelsey-Seybold Clinic in Houston. “I don’t think you have to pick one. So I think you have to ask yourself: What does our group want to sell to the specialist? Sometimes you might have to turn them down to make that point.”

Dr. Lin also described a phenomena emerging in the Houston area: independent, one-physician HM groups taking root in community hospitals. “A lot of the surgeons are using them because they are willing to work as the interns and residents, the first people the nurses call at 2 a.m.,” he said. “There is a market for them.”

Dr. Nelson advised community hospitalists to avoid doing “the things that make you appear different from everyone else. Build social connections with specialists; call them by their first name; eat lunch in the cafeteria; and dress professionally.”

One community hospitalist spoke of an ethical situation she regularly encounters at her hospital, which contracts with multiple HM groups. Anna Rodriguez, MD, of Chesapeake Hospitalists in Chesapeake, Va., explained that her group’s issue is acutely ill patients who are assigned to one of the other HM group services—which, unlike Dr. Rodriguez’s group, are not responsible for codes or 24/7 patient coverage. So what happens when the “other” group’s patient has a sudden deterioration and the hospital staff calls us to run the rapid response? Dr. Rodriguez asked the group.

Dr. Whitcomb suggested Dr. Rodriguez’s group, which is not contracted to run the code, work to iron that situation out. “Then, that is your job and contractually recognized,” he said.

“We get into the exact same situation in our hospital. We created a hospital medicine section and ... established expectations for who responds to codes,” said Dennis Kold, MD, medical director of the hospitalist service Tri-Health in Cincinnati. “If the patient is declining, we will respond to code, but we have it set up where the expectation is that the [attending] will be in to take care of the patient in one hour, or if the patient is admitted overnight to the ICU at 10 p.m., that the [admitting] will be in the ICU to take care of the patient within four hours.”

Dr. Kold added that when the attending doesn’t show up in time that penalties are enforced (e.g., taken off the ER call schedule, restriction of hospital privileges).

“If you are not dealing with rapid response, then you are just hurting yourself,” added Edward Rosenfeld, MD, a hospitalist with Lehigh Valley Medical Associates in Allentown, Pa. “You need to do it; that’s your code prevention.”

Community hospitalists also discussed bundled payments and the recent changes in Medicare consult codes. “As a hospitalist service, I want to be involved in divvying up the money,” said Dan Allen, MD, a group director in Des Moines, Iowa. “I don’t know where it’s going, but I want to have a seat at the table.”

When asked by Dr. Nelson if they had noticed a significant change in reimbursement due to Medicare’s elimination of consultation codes, few in the room raised their hands. In fact, Dr. Nelson explained, “you can bill initial hospital care instead of initial hospital consult.”

“If done right, you might get paid better,” Dr. Rosenfeld added.

—JASON CARRIS

HEALTH INFORMATION TECHNOLOGY ON THE HOSPITALIST RADAR

Health information technology (HIT) isn’t for geeks anymore. A year after a mostly tech-savvy room discussed the basics of introducing more IT aspects to HM, nearly three dozen hospitalists clamored for SHM to take advocacy positions on everything from best practices to best vendors.

“SHM could help us all speak the language we need to speak,” said Tosh Wetterneck,
Mario Reyes, MD, FHM, of the University of Miami Hospital, makes a point during the pediatric HM special interest forum.

Bob Lineberger, MD, medical information officer at Durham Regional Hospital in North Carolina, says a nuanced message will take time.

“Our focus is just coming into focus,” Dr. Lineberger conceded. “We do need to come up with a position statement.”

—RICHARD QUINN

EDUCATION IN HM:
HOW TO GROW ROCK STARS AND CHAMPIONS

What skills does a hospitalist need to know to practice well that they didn't learn in residency? That was the question new SHM President Jeff Weise, MD, SFHM, posed to about 20 hospitalists attending the special-interest forum on educational initiatives at HM10. Led by Dr. Weise and SHM Education Committee co-chair Vikas Parekh, MD, FHM, the discussion focused on what SHM can do—or perhaps do better—in this capacity.

Dr. Parekh said hospitalists should be experts in quality-improvement (QI) and patient safety, and HM must incorporate additional training and career planning. “It’s an MBA paradigm of learning what we do,” he said. “What compels residents to join fellowship programs and earn $50K per year when they can start practicing and earning $150K?”

Educating the membership requires innovation and more than just bench-to-bedside research, Dr. Weise explained. Translational research and best-evidence practices will improve the field. “Five or 10 programs are rock stars,” he said, “but there are 377 that are terrible.”

Future SHM goals include an educational grant vision in which in five years 20% of all residency-program directors are hospitalists; developing best practices, not unfunded mandates; establishing protected academic time; and encouraging mentorship that positions hospitalists as heroes for the next generation.

An education committee sub-group has been tasked to focus on the recruitment of hospitalists and expose them to the best the society and field have to offer.

—PHAEDRA CRESS
Democrats and Republicans have trumpeted that unprecedented changes in the healthcare system are on the way, but the dean of HM cautions that significant change is still years away.

“The reform bill, to my mind, mostly kicked the hard decision for cost, quality, and safety down the road,” said Bob Wachter, MD, MHM, chief of the hospitalist division, professor, and associate chair of the Department of Medicine at the University of California at San Francisco. “All of these issues have been raised, though.”

Dr. Wachter, former SHM president, author of the blog Wachter's World (www.wachtersworld.com), and recently named the 10th-most-powerful physician executive in the nation by Modern Healthcare, used his annual HM10 address to paint a cautiously optimistic picture of HM playing a leading role in quality, safety, and innovation in the delivery of healthcare.

“It is a completely open question, whether we will be capable of snapping our fingers and creating a set of incentives or policy drivers that will allow the creation of the next Geisinger [Health System] without waiting 50 years,” Dr. Wachter said. “These cultures take a long time to develop. It’s not just about the [organizational] chart and the way money flows. You have to develop the culture of shared governance.”

In what has become a rite, Dr. Wachter gives the closing address at SHM’s annual meeting. This year’s title: “Use Your Words: Understanding the New Language of Healthcare Reform.”

Medical care on the “flat part of the curve” equates to tests, procedures, or other engagements that might have prophylactic value but little clinical benefit. From a purely clinical point of view, that is acceptable, but layering in a cost-benefit analysis adds a more objective way of deciding whether the care delivered is “worth the cost,” Dr. Wachter said.

“The question is: Where do we want to live on this curve?” he added. “As you spend more money, you may be getting more benefit, but the incremental amount . . . pushes us past the flat part of curve.”

Dr. Wachter boiled his lesson down to two philosophies. In one, the practice of HM means a test, a procedure, or a consult is ordered because the benefits outweigh the risks. In the other, that same episodic treatment is ordered only if every less-expensive option has already been attempted. “These are absolutely fundamental tensions,” he admitted.

But not all that is reform must be contentious, he said. Take the renewed push toward “accountable-care organizations,” in which providers partner and share responsibility for both the quality and cost of healthcare for a specific population of beneficiaries. The healthcare reform bill contains incentives for such a structure, which Dr. Wachter views as the government’s latest attempt to improve care by controlling how much reimbursement physicians and their employers receive.

While other specialists might not be experienced with data-point discussions on cost savings, with hospital administrators, HM leaders are all too familiar with the concept, as most have those discussions during annual hospital subsidy negotiations. Correspondingly, those who listened to Dr. Wachter’s advice agreed that there is ample opportunity to lead the charge for quality and safety improvement—and the likely savings to be associated with those changes.

“Let’s be patient for what’s coming around the corner,” said Daniel Dressler, MD, SFHM, director of hospital medicine at Emory University Hospital in Atlanta and an SHM board member. “But let’s not miss the boat.”

Richard Quinn is a freelance writer based in New Jersey.
Quality Control
CONTINUED FROM PAGE S-2

did... What we did want was to have a community.”

This year’s meeting continued to draw scores of first-timers looking to experience a bit of that community. Meeting attendance has nearly doubled since the 2008 meeting in San Diego, with a significant percentage of attendees falling into the early-career hospitalist category.

That includes physicians like Matthew Mechtenberg, DO, a hospitalist at Parkview Adventist Medical Center in Brunswick, Maine. A two-year hospitalist who formerly worked in private practice, he traveled to the meeting as part of his hospital’s focus on performance measures and QI. He was heartened to learn tricks of the trade—billing for encephalopathy instead of “altered mental status” might capture more costs for some patients—but just as importantly, it was comforting to know many of his institution’s problems are universal.

“Some of the issues I have in my hospital are the same as they have in Beth Israel Deaconess,” Dr. Mechtenberg said. “Issues translate whether you’re in a 50-bed hospital or an 800-bed hospital. That’s reassuring.”

And then there was Bihar Dianati, MD, a hospitalist at Belleville Memorial Hospital in Belleville, Ill., who previously couldn’t attend the annual meeting because he worked a Monday-Friday schedule. With his recent switch to “seven-on, seven-off,” he decided to use his week off for professional development.

Dr. Dianati bounced between sessions, finding some “self-promoting” but others “incredibly helpful.” But any professional meeting is only successful if it draws repeat business. So will Dr. Dianati be back next year for HM11 at the Gaylord Hotel in Grapevine, Texas?

“Oh, definitely,” Dr. Dianati said. “I already took the registration papers for next year.”

RICHARD QUINN IS A FREELANCE WRITER BASED IN NEW JERSEY.

D.C. DISCUSSIONS

That’s what keeps bringing Troy Ahlstrom, MD, FHM, back. Dr. Ahlstrom, of Hospitalists of Northwest Michigan in Traverse City, has been to three annual meetings, and he said he tries to hit a pre-course every time. Last year, it was a session on how to more completely capture costs from billing and coding.

This year: “Comprehensive Critical Care in 2010: An Interactive Course.” The former appealed to him given that every HM group needs to capture as many of its charges as possible, and the latter because his group helps staff the critical-care units of three hospitals.

Several physicians noted that the critical-care pre-course was particularly appealing to attendees, as more hospitalists are handling those duties at their respective institutions. The format was popular, too, and was structured in the same way as the ABIM learning session, with course director David Schuman, MD, MPH, chief of pulmonary and critical-care medicine at Emory University Hospital in Atlanta, leading a room full of hospitalists through a multiple-choice exam.

Dr. Ahlstrom and others noted that aside from the engagement in education that the daylong pre-courses offer, the sessions are set up with take-home guides, reference materials, and earnest pledges for mentoring from speakers and SHM staff.

“Most medical meetings have a scientific focus with a couple of practical aspects,” Dr. Ahlstrom said. “SHM’s meeting is very practical. It presents research, but it’s research you will use in your practice.”

Gerald Johnson, MD, a hospitalist at Texoma Medical Center in Denison, Texas, signed up for the “Best Practices in Managing a Hospital Medicine Program” pre-course during his first visit to an SHM meeting. A hospitalist for about four years, Dr. Johnson decided to take the pre-course at the urging of senior colleagues. He said the most helpful lessons he gleaned were about compensation plans, scheduling, and staffing.

“It’s not one person getting up there and presenting. This is how it needs to be done,” Dr. Johnson said. “They present you with several ways. It really gives you something to adapt to your personal environment.”

Dr. Johnson, who gushed about “the gurus” of HM leading his session, also likes the fact that people with both a financial pedigree and a background in clinical work present the information. In fact, several attendees of the best-practices session noted that the attention to both medicine and management helps fill in the gaps between being a clinician and being a businessman.

“You’ve got to do both well,” Dr. Ahlstrom said. “You’ve got to take good care of patients. But in order to take good care of patients, you have to run a good business model, too.”

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Professional Advice
CONTINUED FROM PAGE S-3

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SAMSCA® (tolvaptan) tablets for oral use

Brief Summary of Prescribing Information. For complete prescribing information consult official package insert.

WARNINGS: INITIATE AND RE-INITIATE IN A HOSPITAL AND MONITOR SERUM SODIUM

SAMSCA should be initiated and re-initiated in patients only in a hospital where serum sodium can be monitored closely.

Too rapid correction of hyponatremia (e.g., >12 mEq/L/24 hours) can cause osmotic demyelination syndrome (spastic quadriplegia, mutism, dysphagia, lethargy, agitation, seizures, spastic quadriaparesis, seizures, coma and death). In susceptible patients, including those with severe malnutrition, alcoholism or advanced liver disease, slower rates of correction may be advised. In controlled trials in which tolvaptan was administered in titrated doses starting at 15 mg once daily, 7% of patients with cirrhosis treated with tolvaptan had a rise greater than 8 mEq/L at approximately 8 hours and 2% had an increase greater than 12 mEq/L at 24 hours. None of the patients in these studies had evidence of osmotic demyelination syndrome or related neurological sequelae, but such complications have been reported following too rapid correction of serum sodium. In a double-blind, placebo-controlled trial (mean duration of treatment was 9 months) of patients with hyponatremia treated with tolvaptan, the incidence of death, or related neurological symptoms should not be treated with SAMSCA.

SAMSCA® (tolvaptan)

Drug Interactions:

Concomitant use of strong CYP 3A inhibitors: Ketokonazole 200 mg administered with tolvaptan increased tolvaptan exposure by 5-6-fold. Larger doses would be expected to produce larger increases in tolvaptan exposure. There is no adequate experience to define the dose adjustment that would be needed to allow safe use of tolvaptan with strong CYP 3A inhibitors such as clarithromycin, ketoconazole, itraconazole, ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, and telithromycin.

Acute renal failure:

Inability of the patient to sense or appropriately respond to thirst: Patients who are unable to auto-regulate fluid balance are at substantially increased risk of incuring an overly rapid correction of serum sodium, hyponatremia and hypovolemia.

Hypovolemic hyponatremia: Risks associated with worsening hyponatremia, including complications such as hypotension and renal failure, outweigh possible benefits.

Important Limitations

Patients requiring intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms should not be treated with SAMSCA.

The following are subsumed under the referenced ADR in Table 1:

Hyperglycemia

14 (6) 2 (1)

Metabolism and Nutrition Disorders

14 (6) 2 (1)

Renal and Urinary Disorders

2 (1)

Gastrointestinal bleeding in patients with cirrhosis: In patients with cirrhosis treated with tolvaptan in hyponatremia trials, gastrointestinal bleeding was reported in 6 out of 63 (10%) tolvaptan-treated patients and 1 out of 57 (2%) placebo-treated patients. SAMSCA should be used in cirrhotic patients only when the need to outweigh this risk.

Dehydration and hypovolemia: SAMSCA therapy induces copious aquaresis, which is more pronounced in hypovolemic patients. Dehydration can occur following too-rapid correction of serum sodium or related neurological sequelae. In susceptible patients, including those with severe malnutrition, alcoholism or advanced liver disease, slower rates of correction may be advised.

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SAMSCA® (tolvaptan)

The following adverse reactions occurred in < 1% of hyponatremic patients treated with SAMSCA that were not also observed in placebo-treated patients: skeletal disorders (2%), fractures (2%), and stress fractures (3%).

Adverse Reactions:

The most common adverse reactions reported in at least 3% of patients were nausea, vomiting, dry mouth, constipation, and flatulence. These events occurred more frequently in patients receiving tolvaptan than in placebo recipients.

Other adverse reactions, reported in < 3% of patients and at least a degree of seriousness comparable to placebo recipients, included tachycardia, hypertension, impotence, and fever.

Pharmacokinetics:

Tolvaptan has a mean plasma elimination half-life of 5.2 hours. Tolvaptan is metabolized by CYP 3A4 to an inactive metabolite. Tolvaptan is excreted into the milk of lactating rats. Because many drugs are excreted into human milk and because of the potential for serious adverse reactions in nursing infants from SAMSCA, a decision should be made to discontinue nursing or SAMSCA, taking into consideration the importance of SAMSCA to the mother.

Pediatric Use: Safety and effectiveness of SAMSCA in pediatric patients have not been established.

Geriatric Use: Of the total number of hyponatremic subjects treated with SAMSCA in clinical studies, 42% were 65 and over, while 19% were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. Increasing age has no effect on tolvaptan plasma concentrations. Use in Patients with Congestive Heart Failure: The exposure to tolvaptan in patients with congestive heart failure is not clinically relevantly increased. No dose adjustment is necessary.

OVERDOSAGE:

Single oral doses up to 480 mg and multiple doses up to 300 mg once daily for 5 days have been well tolerated in studies in healthy subjects. There is no specific antidote for tolvaptan intoxication. The signs and symptoms of an acute overdose can be anticipated to be those of excessive pharmacologic effect: a rise in serum sodium concentration, polynia, thirst, and dehydration/hypovolemia.

The oral LD50 of tolvaptan in rats and dogs is > 2000 mg/kg. No mortality was observed in rats (13) or dogs following single oral doses of 2000 mg/kg (maximum feasible dose). A single oral dose of 2000 mg/kg was lethal in mice, and symptoms of toxicity in affected mice included decreased locomotor activity, staggering gait, hunched posture, and death. If overdose occurs, exhibition of the following symptoms is an important first step. A thorough history and details of overdose should be obtained, and a physical examination should be performed. The possibility of multiple drug involvement should be considered. Treatment should involve symptomatic and supportive care, with respiratory, ECG and blood pressure monitoring and water/electrolyte supplements as needed. A profuse and prolonged aquaretics should be anticipated, which, if not matched by oral fluid ingestion, should be replaced with intravenous hypotonic fluids, while closely monitoring electrolytes and fluid balance.

EGC monitoring should begin immediately and continue until ECG parameters are within normal ranges. Dialysis may not be effective in removing tolvaptan because of its high binding affinity for human plasma proteins (> 99%). Close medical supervision and monitoring should continue until the patient recovers.

PATIENT COUNSELING INFORMATION:

As a part of patient counseling, healthcare providers must review the SAMSCA Medication Guide with every patient [see FDA-Approved Medication Guide (17.3)].

Concomitant Medication; Advise patients to inform their physician if they are taking or plan to take any prescription or over-the-counter drugs since there is a potential for interactions. Strong and Moderate CYP 3A Inhibitors and P-gp Inhibitors: Advise patients to inform their physician if they use any of the following substances: (e.g., ketoconazole, ritonavir, clarithromycin, telithromycin, nefazodone, saquinavir, indinavir, ritonavir) or moderate CYP 3A inhibitors (e.g., aprepitant, erythromycin, diltiazem, verapamil, furosemide) or P-gp inhibitors (e.g., cyclosporine) [see Dose and Administration (2.4), Contraindications (4.4), Warnings and Precautions (5.5) and Drug Interactions (7.1)].

Nursing: Advise patients not to breastfeed an infant if they are taking SAMSCA [see Use In Specific Populations (8.3)].

For more information about SAMSCA, call 1-877-726-7220 or go to www.samcsa.com.


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Experience the first and only oral vasopressin V₂-receptor antagonist that increases FREE WATER CLEARANCE and serum sodium concentrations.

**Indication and Important Limitations**
- **SAMSCA is indicated for the treatment of clinically significant hypervolemic and euvolescic hyponatremia (serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure, cirrhosis, and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).**
- **Patients requiring intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms should not be treated with SAMSCA. It has not been established that raising serum sodium with SAMSCA provides a symptomatic benefit to patients.**

**IMPORTANT SAFETY INFORMATION**
SAMSCA should be initiated and re-initiated in patients only in a hospital where serum sodium can be monitored closely. Too rapid correction of hyponatremia (e.g., >12 mEq/L/24 hours) can cause osmotic demyelination resulting in dysarthria, mutism, dysphagia, lethargy, affective changes, spastic quadriparesis, seizures, coma and death. In susceptible patients, including those with severe malnutrition, alcoholism or advanced liver disease, slower rates of correction may be advisable.

Contraindications:
- Urgent need to raise serum sodium acutely, inability of the patient to sense or appropriately respond to thirst, hypovolemic hyponatremia, concomitant use of strong CYP 3A inhibitors, anuric patients.
- Subjects with SIADH or very low baseline serum sodium concentrations may be at greater risk for too-rapid correction of serum sodium. In patients receiving SAMSCA who develop too rapid a rise in serum sodium or develop neurologic sequelae, discontinue or interrupt treatment with SAMSCA and consider administration of hypotonic fluid. Fluid restriction should generally be avoided during the first 24 hours.
- Dehydration and hypovolemia can occur, especially in potentially volume-depleted patients receiving diuretics or those who are fluid restricted. In patients who develop medically significant signs or symptoms of hypovolemia, discontinuation is recommended.
- Gastrointestinal bleeding in patients with cirrhosis: Use in cirrhotic patients only when the need to treat outweighs this risk.
- Avoid use with: CYP 3A inhibitors and CYP 3A inducers. Reduced dose of SAMSCA may be needed if used with P-gp inhibitors.
- Co-administration with hypertonic saline is not recommended.
- Monitor serum potassium in patients with levels >5 mEq/L and in those receiving drugs known to increase serum potassium.

Commonly observed adverse reactions: (SAMSCA vs placebo) thirst (16% vs 5%), dry mouth (13% vs 4%), asthenia (9% vs 4%), constipation (7% vs 2%), polyuria or polydipsia (11% vs 3%) and hyperglycemia (6% vs 1%).

Please see Brief Summary of FULL PRESCRIBING INFORMATION, including Boxed WARNING, on previous pages.

For more information please visit www.samsca.com

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