By Kelly April Tyrrell

Several months into 2017, physicians around the country are preparing for the first benchmark year of MACRA, the Medicare Access and CHIP Reauthorization Act. Passed in 2015, MACRA is the bipartisan healthcare law responsible for eliminating the Sustainable Growth Rate, and it promises to continue to fundamentally alter the way providers are paid. This year determines reimbursement in 2019.

Under the law, physicians must report performance under one of two pathways: MIPS, the Merit-Based Incentive Payment System, or participation in a qualified Advanced Alternative Payment Model, or Advanced APM. The first, MIPS, replaces the Physician Quality Reporting System, Meaningful Use, and the Physician Value-Based Payment Modifier and is the track most providers can expect to follow, at least initially, because most will not meet the requirements for Advanced APMs.1,2

This is especially true for hospitalists, most of whom are not yet participating in qualifying Alternative Payment Models.2

The MIPS track is budget neutral, which means for every physician or physician group that receives a boost in reimbursement, another will receive a cut. Others will receive a neutral adjustment. All physicians see an annual 0.5% increase in payment between 2016 and 2019 and MIPS clinicians receive a 0.25% annual boost starting in 2026. Providers participating in Advanced APMs will also receive a 2.5% annual boost starting in 2026. Providers participating in Advanced APMs will also receive a 2.5% annual boost starting in 2026.

Providers participating in Advanced APMs will also receive a 2.5% annual boost starting in 2026. Providers participating in Advanced APMs will also receive a 2.5% annual boost starting in 2026.
Improve your glycemic control efforts with SHM’s GC eQUIPS program

Inpatient hyperglycemia is a very common condition, affecting approximately 38% of patients in the non-intensive care unit setting. Enhance the efficiency and reliability of your quality improvement efforts to close the gap between best practices and methods for caring for inpatients with hyperglycemia with SHM’s Glycemic Control (GC) Electronic Quality Improvement Program (eQUIPS). The GC eQUIPS program supports the development and implementation of GC programs at hospitals nationwide.

This program offers 2-year access to a data center for performance tracking and benchmarking and aims to support your institution in:

- Gaining understanding in the principles of glycemic control
- Improving glycemic control data collection/analysis/reporting
- Building and obtaining approval for protocols/policies for glycemic control
- Creating a culture for change and change management

When you enroll in the Glycemic Control eQUIPS, you will receive:

- Data center for performance tracking
- Helps track performance on project milestones and outcomes, and benchmark performance against comparison groups at your institution and other participating facilities.
- Glycemic control toolkit. Includes clinical tools and interventions, research materials and literature review, informational papers and case studies, as well as teaching slide sets, and more.
- Online community and collaborative:
  - Glycemic Control Library of site-created tools and documents allowing you to view sample order sets and protocols, awareness campaigns, patient education materials, and various articles.
  - National Discussion Forum lets you share professional questions and discuss-topics related to the planning, implementation, and evaluation of glycemic control interventions.
  - Access to on-demand webinar, facilitated by national experts, topics include IV Insulin Management Strategies, Change Management, and Introduction to Glycemic Control.

Join the webinar on June 28 from 1 to 2 p.m., ET, to receive additional information about SHM’s GC programs. Visit hospitalmedicine.org/gc to register or learn more. If you have questions on the program, please email Sara Platt at splatt@hospitalmedicine.org.

Brett Radler is communications specialist at the Society of Hospital Medicine.

PHYSICIAN EDITOR
Danielle B. Scheurer, MD, SFHM, MSCR
scheurer@musc.edu

PEDIATRIC EDITOR
Weijen Chang, MD, FACP, SFHM
weijen@ucsd.edu

COORDINATING EDITORS
Christine Donahue, MD
THE FUTURE HOSPITALIST
Jonathan Pell, MD
KEY CLINICAL GUIDELINES

CONTRIBUTING WRITERS
Nasim Afsar, MD, SFHM
Kimberly Eisenstock, MD, FHM
William James Frederick III, MD, PhD
Vineet Gupta, MD, FACP, FHM
Sarah Horrman, MD
Christine Hrach, MD
Bryan J. Huang, MD, FHM
James Kim, MD
Leslie Martin, MD
Richard Quinn
Claudia Shahi
Kelly Apri Tyrell
Miguel Villagrasa, MD, FACP, FHM
Win Whitcomb, MD, MHM

FRONTLINE MEDICAL COMMUNICATIONS
EDITORIAL STAFF
Editor in Chief
Mary Jo M. Dales
Executive Directors
Denise Fulton, Kathryn Scarbrough
Editor
Richard Pizzi
Creative Director
Louise A. Koening
Director, Production/Manufacturing
Rebecca Siebobnik

EDITORIAL ADVISORY BOARD
Geeta Arora, MD
Michael J. Beck, MD
Harry Cho, MD
Kevin Conrad, MD, MBA
Stella Fitzgibbons, MD, FHM
Benjamin Frizner, MD, FHM
Nicolas Houghton, MSN, RN, ACNP-BC
James Kim, MD
Melody Misaka, MD
Venkataraman Palabindala, MD
Raj Sehgal, MD
Lonika Sood, MD
Sarah A. Stella, MD
Amanda T. Trask, MBA, MHA, SFHM
Miguel Angel Villagrana, MD
Jill Waldman, MD, SFHM

THE HOSPITALIST is the official newspaper of the Society of Hospital Medicine, reporting on issues and trends in hospital medicine. The HOSPITALIST reaches more than 35,000 hospitalists, physician assistants, nurse practitioners, medical residents, and healthcare administrators interested in the practice and business of hospital medicine. Content for THE HOSPITALIST is provided by Frontline Medical Communications. Content for the Society Pages is provided by the Society of Hospital Medicine. Copyright 2017 Society of Hospital Medicine. All rights reserved. No part of this publication may be reproduced, stored, or transmitted in any form or by any means and without the prior permission in writing from the copyright holder. The ideas and opinions expressed in THE HOSPITALIST do not necessarily reflect those of the Society or the Publisher. The Society of Hospital Medicine and Frontline Medical Communications will not assume responsibility for damages, loss, or claims of any kind arising from or related to the information contained in this publication, including any claims related to the products, drugs, or services mentioned herein.

POSTMASTER: Send changes of address (with old mailing label) to THE HOSPITALIST, Subscription Service, 151 Century Drive, Suite 204, Parsippany, NJ 07054-4609, USA. (Note: Change of address for other nations—air service only to THE HOSPITALIST, Subscription Service, 151 Century Drive, Suite 204, Plainview, NY 11803-1709.)

The Society of Hospital Medicine’s headquarters is located at 1500 Spring Garden, Suite 501, Philadelphia, PA 19103.

To learn more about SHM’s relationship with industry partners, visit www.hospitalmedicine.com/industry.
Scheduling patterns: Time for a change?

By Kimberly Eisenstock, MD, FHM

Over the last several years, thought leaders in the hospital medicine field have expressed concern that this one-size-fits-all schedule model is a threat to the well-being of many physicians and, by extension, the sustainability of their hospital medicine groups. Despite this, the 2016 State of Hospital Medicine Report reveals relatively little change in the way hospital medicine groups schedule their physicians. Most groups (69.2%), report the duration of scheduled day shifts to be between 12 and 13.9 hours, similar to the 16.4% reported in the 2014 survey for this same metric. Likely, most of these shifts are the traditional 12-hour shift displayed on Dr. Wachter’s slide. Groups reporting shorter shifts tended to be either very large, with the number of bodies needed to develop flexible scheduling, or in academic settings where they could utilize house-staff coverage.

Night shifts echo this trend. There is an even greater number of groups utilizing the 12- to 13.9-hour shift length (79%), which has also varied less at just approximately 5% in either direction over the last two surveys. It is likely very hard to be creative with the shift length for your night physicians when the group is structured predominately around a 12-hour day position.

The 12-hour shift scheduled in long blocks is straightforward to employ for the scheduler, limits handoffs of care, and maximizes number of days off. So, why are Wachter et al. calling for change? Seven-day stretches off may seem attractive when you are just starting out, but, as physicians mature, the very long days compete with family time that cannot be made up on weekday mornings when others are at school and work. Furthermore, the very long hours for 7 days straight lead to burn out and eventually retention issues as well. Some argue that this design promotes disengagement. It sets the expectation that, during “off” weeks, physicians might be unavailable for email responses, committee meetings, or participation in quality improvement initiatives, which disrupts integration into the larger hospital community and perhaps even our own career advancement. Some groups are trying to address these concerns with innovative approaches to block scheduling.

While the hallmark hospital medicine schedule of 7on/7off blocks remains the predominant model – 38.1% of all groups – this represents a drop of approximately 15%, compared with the prior survey. A new large contingent of groups entering the survey this year utilize a Monday-Friday model with rotating moonlighter/weekend coverage. This lifestyle and family-friendly model predominates in the Midwest. It is also found more in smaller groups, which may employ this model to keep the most system-knowledgeable worker around during high volume times, as well as to preserve the well-being and retention of their limited physician workforce.

Of note, reconfiguring the 7on/7off model does not necessarily translate into more time off. The median number of shifts per year is also relatively stable at 182 which is the exact number of shifts per year in a strict 7on/7off schedule. This number does not vary by region of the country, group size, or teaching status. Some might argue that working 182 annual shifts is ideal, giving hospitalists a “vacation” every other week. However, this line of thought does not take into account the very long workdays, nor the 52 weekend days spent in the hospital – far more than most specialty peers who serve fewer weekend calls often with more limited in-house hours. In addition, one might argue that defining ourselves as limited in-house hours. In addition, one might argue that defining ourselves as the 29 roles our providers fill each 24-hour period is not a 12-hour shift. Over the years, my hospital medicine group, as well as many others, will heed the thoughts expressed by Dr. Wachter. Finding the flexibility to break out of these rigid scheduling models will be a first step in promoting both physician and system well-being.
Setting discharge goals and visit expectations

By Christine Hrach, MD, SFHM

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 always ensure at the end of my visit with a patient and their family that they know when to expect me to return to see their child again.

Why I do it
One of the biggest frustrations I hear from families pertains to the discharge process. In talking with families, they want to know the approximate time for discharge. Often, during morning rounds, we mention that the patient may be able to go home later in the day and we say that we will come in again later to check on them. However, unless we give families a time frame for when we will come back and do that check, they are left waiting without any clear expectations.

How I do it
One of our goals during morning family-centered rounds is to discuss discharge for every patient, every day. Along with discussing the possibility of going home, we try to give the family goals that they can work on throughout the day that are tied to discharge – for example, the approximate by-mouth intake for a toddler admitted for gastroenteritis and dehydration.

I also give the family an approximate time when either I or the resident team will come back to see if they have achieved this goal. This may be either late afternoon or first thing in the morning if we are planning an early morning discharge before rounds. The families seem to find this helpful because they are not tied to the room all day waiting for the doctor to come back.

I also make sure that the families know they can contact their nurse any time if they need to see any of the doctors sooner than we planned. I let them know that a physician is here on the floor 24 hours a day and that the nurses can easily reach us at any time if they have further concerns. In my experience, this is reassuring to our families.

Dr. Hrach is a pediatric hospitalist at Washington University School of Medicine in St. Louis.
Committee and chapter involvement allows SHM member to give back
Paul Grant, MD, SFHM, contributes to SHM growth

By Felicia Steele

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

This month, The Hospitalist spotlights Paul Grant, MD, SFHM, assistant professor of medicine at the University of Michigan Medical School, Ann Arbor. Dr. Grant is the chair of SHM’s Membership Committee and an active member of SHM’s Michigan Chapter.

Why did you choose a career in hospital medicine, and how did you become an SHM member?

We are developing ways to reach out to residency program directors – particularly those running a hospital medicine track – to find ways they can benefit from SHM’s educational offerings.

—Dr. Paul Grant

During my internal medicine residency, I tried hard to find a subspecialty I could see myself doing for the rest of my career. But I couldn’t. What I loved about general medicine was the variety of patients I saw on a daily basis. My next decision was whether to do hospital medicine or ambulatory medicine. This was a tough choice for me, but choosing hospital medicine was one of the best career decisions I’ve ever made.

After residency, I completed a hospital medicine fellowship at the Cleveland Clinic. During my fellowship, I joined SHM. At that time, I knew nothing about the society, but that soon changed. My fellowship required me to attend the annual meeting and submit an abstract in the RIV competition, which was an extremely valuable experience for me. Not only was I blown away by the meeting, but my poster won the clinical vignette competition, as well! Needless to say, I’ve been an SHM member ever since.

What prompted you to join the Membership Committee? Can you discuss some of the projects the committee is currently working on?

Because SHM has done so much for my career as a hospitalist, I’ve tried to give back by volunteering on committees. After

CONTINUED ON PAGE 12

ENHANCED USER EXPERIENCE

LEARNING PORTAL

New features and functionality requested by you include:

• Mobile Friendly
• Polling
• Intuitive Navigation
• And more!

Over 85 CME credits FREE to members.

www.shmlearningportal.org
The latest news about upcoming events, new programs, and SHM initiatives

By Brett Radler

HM17 On Demand now available

- Couldn’t make it to Las Vegas for SHM’s annual meeting, Hospital Medicine 2017? HM17 On Demand gives you access to over 80 online audio and slide recordings from the hottest tracks, including clinical updates, rapid fire, pediatrics, comanagement, quality, and high-value care.

Additionally, you can earn up to 70 American Medical Association Physician Recognition Award Category 1 Credit(s) and up to 30 American Board of Internal Medicine Maintenance of Certification credits. HM17 attendees can also benefit by earning additional credits on the sessions you missed out on.

To easily access content through SHM’s Learning Portal, visit shmlearningportal.org/hm17-demand to learn more.

Chapter Excellence Awards

- SHM is proud to recognize outstanding chapters for the fourth annual Chapter Excellence Awards. Each year, chapters strive to demonstrate growth, sustenance, and innovation within their chapter activities.

View more at www.hospitalmedicine.org/chapterexcellence. Please join SHM in congratulating the following chapters on their success!

Silver Chapters
- Boston Association of Academic Hospital Medicine (BAAHM)
- Charlotte Metro Area
- Houston
- Kentucky
- Los Angeles
- Minnesota
- North Jersey
- Pacific Northwest
- Philadelphia Tri-State
- Rocky Mountain
- San Francisco Bay
- South Central PA

Gold Chapters
- New Mexico
- Wiregrass

Platinum Chapters
- Iowa
- Maryland
- Michigan
- NYC/Westchester
- St. Louis

Outstanding Chapter of the Year
- Michigan

Rising Star Chapter
- Wiregrass

Student Hospitalist Scholar grant winners

- SHM’s Student Hospitalist Scholar Grant provides funds with which medical students can conduct mentored scholarly projects related to quality improvement and patient safety in the field of hospital medicine. The program offers a summer and a longitudinal option.

Congratulations to the 2017-2018 Student Hospitalist Scholar Grant recipients:

**Summer Program**

Anton Garazha
Rosalind Franklin University of Medicine and Science

“Effectiveness of communication during icu to ward transfer and association with medical ICE readmission”

Cole Hirschfeld
Weill Cornell Medical College

“The role of diagnostic bone biopsies in the management of osteomyelitis”

Farah Hussain
University of Cincinnati College of Medicine

“Better understanding clinical deterioration in a children’s hospital”

**Longitudinal Program**

Monisha Bhatia
Geisel School of Medicine at Dartmouth

“Reducing CAUTI with noninvasive uc alternatives and measure-vention”

Yui Li
Geisel School of Medicine at Dartmouth

“Developing and implementing clinical pathway(s) for hospitalized infection drug users due to injection-related infection sequelae”

Learn more about the Student Hospitalist Scholar Grant at hospitalmedicine.org/scholargrant.

SPARK ONE: A tool to teach residents

- SPARK ONE is a comprehensive, online self-assessment tool created specifically for hospital medicine professionals. The activity contains 450+ vignette-style multiple-choice questions covering 100% of the American Board of Internal Medicine’s Focused Practice in Hospital Medicine (FPHM) exam blueprint. This online tool can be utilized as a training mechanism for resident education on hospital medicine.

As a benefit of SHM membership, residents will receive a free subscription. SPARK ONE provides in-depth review of the following content areas:

- Cardiology
- Pulmonary Disease and Critical Care Medicine
- Gastroenterology and Hepatology
- Nephrology and Urology
- Endocrinology
- Hematology and Oncology
- Neurology
- Allergy, Immunology, Dermatology, Rheumatology, and Transitions in Care
- Palliative Care, Medical Ethics, and Decision Making
- Perioperative Medicine and Consultative Comanagement
- Patient Safety
- Quality, Cost, and Clinical Reasoning

“SPARK ONE provides a unique platform for academic institutions, engaging learners in directed learning sessions, rein-forcing teaching points as we encounter specific conditions,” Rachel E. Thompson, MD, MPH, SHM said.

Visit hospitalmedicine.org/sparkone to learn more.

Sharpen your coding with the updated CODE-H

- SHM’s Coding Optimally by Documenting Effectively for Hospitalists (CODE-H) has launched an updated program with all new content. It will now include eight recorded webinar sessions presented by expert faculty, downloadable resources, and an interactive discussion forum through the Hospital Medicine Exchange (HMX), enabling participants to ask questions and learn the most relevant best practices.

Following each webinar, learners will have the opportunity to complete an evaluation to redeem continuing medical education credits.

Webinars in the series include:

- E/M Basics Part I
- E/M Basics Part II
- Utilizing Other Providers in Your Practice
- EMR and Mitigating Risk
- Putting Time into Critical Care Documentation
- Time Based Services
- Navigating the Rules for Hospitalist Visits
- Challenges of Concurrent Care

To purchase CODE-H, visit hospitalmedicine.org/CODEH. If you have questions about the new program, please contact education@hospitalmedicine.org.

Set yourself apart as a Fellow in Hospital Medicine

- The Fellow in Hospital Medicine (FHM) designation signals your commitment to the hospital medicine specialty and dedication to quality improvement and patient safety. This designation is available for hospital medicine practitioners, including resident teaching administrators, nurse practitioners, and physician assistants. If you meet the prerequisites and complete the requirements, which are rooted in the Core Competencies in Hospital Medicine, you can apply for this prestigious designation and join more than 1,100 FHMs who are dedicated to the field of hospital medicine. Learn more and apply at hospitalmedicine.org/fellow.

New guide & modules on multimodal pain strategies for postoperative pain management

- Pain management can pose multiple challenges in the acute care setting for hospitalists and front-line prescribers. While their first priority is to optimally manage pain in their patients, they also face the challenges of treating diverse patient populations, managing patient expectations, and considering how pain control and perceptions affect Hospital Consumer Assessment of Healthcare Providers and Systems scores. Furthermore, because of the ongoing opioid epidemic, prescribers must ensure that pain is managed responsibly and ethically.

To address these issues, SHM developed a guide to address how to work in an interdisciplinary team, identify impediments to implementation, and provide examples of appropriate pain management. In conjunction with this Multimodal Pain Strategies Guide for Postoperative Pain Management, there are three modules presented by the authors which supplement the electronic guide.

To download the guide or view the modules, visit hospitalmedicine.org/pain.

Proven excellence through a unique education style: Academic Hospitalist Academy

- Don’t miss the eighth annual Academic Hospitalist Academy (AHA), Sept. 25-28, 2017, at the Lakeway Resort and Spa in Austin, Tex. AHA attendees experience an engaging, interactive learning environment featuring didactics, small-group exercise, and skill-building breakout sessions. Each full day of learning is facilitated by leading clinician-educators, hospitalist researchers, and clinical administrators in a 1:10 faculty-to-student ratio.

The principal goals of the Academy are to:

- Develop junior academic hospitalists as the premier teachers and educational leaders at their institutions
- Help academic hospitalists develop scholarly work and increase scholarly output
- Enhance awareness of the value of quality improvement and patient safety work
- Support academic promotion of all attendees

Don’t miss out on this unique, hands-on experience. Register before July 18, 2017, to receive the early-bird rates. Visit academichospitalist.org to learn more.
Dr. Howell began practicing there in the early days of hospital medicine. “The ED said the medicine service was too slow, and the hospitalists said, ‘We’re working as fast as we can,’” Dr. Howell recalled of his real-world introduction to implementation science. “So, I took on triage over-shift in 2000 and began streamlining flow.”

Dr. Howell, who enjoys a good process engineer who helped him figure out how to make the people who would make his projects successful. Skill development in areas such as leadership principles and processes such as lean will benefit those on a QI pathway, but finding the right mentors is just as critical. Dr. Howell looked to multiple people from diverse backgrounds, none of which included QI, to “help me move my skill set forward,” he said. “A clinical educator helped me to interact with other people, learn to facilitate an educational initiative, and lead people to change.”

Another mentor, he recalled, was an engineer who helped him figure out how to measure the success of his projects. And a third mentor cleared the pathway of obstructions, providing access to the people who would make his projects successful.

Being able to pivot is also important, Dr. Howell said. “Whether it is looking at data or the people you need to approach to solve a problem, be able to change your approach. Flip-flopping is a good thing in QI, because you’re always adjusting your tactics based on new information.”

Today, as SHM’s senior physician advisor to its Center for Quality Improvement, Dr. Howell holds multiple roles within the Johns Hopkins system and has received numerous awards for excellence in teaching and practice. The core principles that he started with on the path remain the same: “Be humble,” he said, “and give away credit. We are often collaborating with other professionals, so shining a light on the great work that they do will make projects more successful and improve the likelihood that they will want to collaborate with you in the future.”

Claudia Stahl is a content manager for the Society of Hospital Medicine.

NEWS & NOTES

Choosing Wisely Case Study compendium now available
➤ The Choosing Wisely Case Study Competition, hosted by SHM, sought submissions from hospitalists on innovative improvement initiatives implemented in their respective institutions. These initiatives reflect and promote movement toward reducing unnecessary medical tests and procedures and changing a culture that dictates, “More care is better care.”

Submissions were judged by the Choosing Wisely Subcommittee, a panel of SHM members, under adult and pediatric categories. One grand prize winner and three honorable mentions were selected from these categories. The compendium includes these case studies along with additional exemplary submissions. View the Choosing Wisely Case Study Compendium at hospitalmedicine.org/choosingwisely.

Strengthen your interactions with the 5 Rs of Cultural Humility
➤ Look inside this issue for your 5 Rs of Cultural Humility pocket card. It can easily referenced on rounds and shared with colleagues. We hope to achieve heightened awareness of effective interactions. In addition to the definitions of each of the Rs, the card features questions to ask yourself before, during, and after every interaction to aid in attaining cultural humility.

For more information, visit hospitalmedicine.org/5Rs. Brett Radler is communications specialist at the Society of Hospital Medicine.

Register Before July 18, 2017 and Save. www.academichospitalist.org
Making sense of MACRA: MIPS and Advanced APMs

CONTINUED FROM PAGE 9

spending several years on the Early Career Hospitalist Committee, I felt the transition to the Membership Committee was a natural fit. Because SHM membership had been growing every year, our committee felt some pressure to keep this trend going. Thankfully, we have continued to see growth each year in every membership category.

Our committee has been working on several projects. One of the key demographics we have been targeting is members to SHM. Because hospital medicine is quite new, hospitalists have been discussing ways to attract international hospital medicine track – to find ways they can benefit from program directors – particularly those running a hospitalist program. We are developing ways to reach out to residency the resident member. Residents play a significant role in continued to see growth each year in every membership category.

Our committee has been working on several projects. One of the key demographics we have been targeting is members to SHM. Because hospital medicine is quite new, hospitalists have been discussing ways to attract international hospital medicine track – to find ways they can benefit from program directors – particularly those running a hospitalist program. We are developing ways to reach out to residency the resident member. Residents play a significant role in continued to see growth each year in every membership category.

Our committee has been working on several projects. One of the key demographics we have been targeting is members to SHM. Because hospital medicine is quite new, hospitalists have been discussing ways to attract international hospital medicine track – to find ways they can benefit from program directors – particularly those running a hospitalist program. We are developing ways to reach out to residency the resident member. Residents play a significant role in continued to see growth each year in every membership category.
“We’re working to ensure the program is structured so that providers can confidently report on just the measures applicable to them, even if it’s fewer than six.”

– Dr. Greeno

Dr. Berenson

Cable to hospitalists. Public Policy Committee chair and SHM president Ron Greeno, MD, MHM, says most clinicians will be able to reliably report on only four:

“We’re working to ensure the program is structured so that providers can confidently report on just the measures applicable to them, even if it’s fewer than six,” he said.

To ensure physicians are not penalized or disadvantaged for being unable to report the required number of measures, CMS is working to develop a validation test, though it has not yet released details, Dr. Greeno said.

The measures most applicable to hospitalists include two related to heart failure (ACE inhibitor/angiotensin receptor blocker for left ventricular systolic dysfunction [LVSD] and beta-blocker for LVSD), one stroke measure (DC on antithrombotic therapy), advance care planning, prevention of catheter-related bloodstream infection (central venous catheter insertion protocol), documentation of current medications, and appropriate treatment of methicillin-resistant Staphylococcus aureus bacteremia.

“This isn’t one of those things that will impact everybody equally,” said Dr. Afsar. For example, most hospitalists should be able to easily report on advanced care planning and medication documentation, she said, but in some hospitals the stroke measures may be captured in the emergency department; many hospitalists may not achieve enough reportable stroke management cases.

However, Dr. Afsar expects hospitalists will shine in the improvement activities category. “It’s part of our DNA,” she said. “Improvement activities ... have become part of the core responsibilities for many of us within hospitalist groups, hospitals, and health systems.”

In 2017, CMS requires providers to report four improvement activities, which may include – among many other options – implementing antibiotic stewardship programs, connecting patients to community chronic-disease management programs, and integrating pharmacists into a patient care team. Dr. Afsar suggests hospitalists visit SHM’s Quality and Innovation guide for ideas, implementation toolkits, and more.

In the cost category, “for the most part, hospitalists aren’t acquainted with cost and there is not a lot of cost transparency around what we do ... In general, medical care needs to be discussed between physicians and patients so they can weigh the cost benefit,” she said, which includes not just dollars and cents, but the impact associated with procedures, like radiation exposure from a CT scan.

However, Dr. Afsar acknowledges this is challenging, given the overall lack of cost transparency in the American health care system. “It is disjointed, and we don’t have any other system where the professionals who do the work are so far removed from the actual cost,” she said. “The good thing is, I think we are heading toward an era of more cost-conscious practice.”

In addition, hospitalists are poised to help with overall cost reduction in the hospital. “I could imagine something relevant around readmissions and total cost,” said Dr. Patel. “But risk adjustment is key.”

This category will increase to 30% of a provider’s or group’s overall score by payment year 2021, CMS says. It will be determined using claims data to calculate per-capita costs for all attributed beneficiaries and a Medicare Spending per Beneficiary measure. The CMS also says it is finalizing 10 episode-based measures determined to be reliable and that will be made available to providers in feedback reports starting in 2018. Clinicians may report MIPS data as individual providers (a single National Provider Identifier tied to a single Tax Identification Number) by sending data for each category through electronic health records, registries, or qualified clinical data registries. Quality data may be reported through Medicare claims.

Hospitalists who report through a group will receive a single payment adjustment based on the group’s performance, using
This advertisement is not available for the digital edition.
or more clinicians will see an increase in reimbursement.\(^6\)

“It’s not an easy piece of legislation to understand, and there are still areas that need to be clarified in the coming months.” – Dr. Afsar

---

**CONTINUED FROM PAGE 13**

group-level data for each category. Groups can submit using the same mechanisms as individual providers, or through a CMS web interface (though groups must register by June 30, 2017).\(^5\)

The SHM has also asked CMS to consider allowing employed hospitalists to align with and report with their facilities, though Dr. Greeno says this should be voluntary since not every hospitalist may be interested in reporting through their hospital. Dr. Greeno says CMS is "very interested and receptive" to how it could be done.

“We are trying to create the incentive for everybody to provide care at lower costs,” Dr. Greeno said. “There are two goals: Create alignment, and decrease the reporting burden on hospitalist groups.”

Create alignment, and decrease the report burden on hospitalist groups.”

Dr. Greeno said. “There are two goals:

1. To align with and report with their facilities.
2. To consider allowing employed hospitalists to align with and report with their facilities.

One of the most important things, she and Dr. Berenson said, is adequately capturing the quality and scope of the care physicians provide.

“I know hospitalists complain how little their care is reflected in HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems) and the quality measures they have now, and readmission rates don’t reflect what doctors do inside the hospital. My colleagues are telling me they want something better,” Dr. Patel said.

Advanced APMs

Physicians who participate in Advanced APMs are exempt from MIPS. Advanced APMs must use Certified Electronic Health Record Technology (CEHRT) and take on a minimum amount of risk. For 2017 and 2018, providers must risk and the Oncology Care Model. (APMs that do not qualify must report under MIPS.)\(^3\)

The CMS also says that services provided at critical access hospitals, rural health clinics, and federally qualified health centers may qualify using patient counts, and medical home models may be considered Advanced APMs using financial criteria.\(^4\)

At this time, SHM is unable to quantify the number of hospitalists participating in Advanced APMs, and some, Dr. Greeno said, may not know whether they are part of an Advanced APM.

Currently, BPCI (Bundled Payments for Care Improvement) is the only alternative payment model in which hospitalists can directly take risk, Dr. Greeno says, but it does not yet qualify as an Advanced APM. However, that could change.

Prior to the passage of MACRA, Brandeis University worked with CMS to create the Episode Grouper for Medicare (EGM), software that converts claims data into episodes of care based on a patient’s condition or procedures. The American College of Surgeons (ACS) has since proposed an alternative payment model, called ACS-Brandeis, that would use the diagnostic grouper to take into account all of the work done by every provider on any episode admitted to the hospital and use algorithms to decide who affected a particular patient’s care.

“Anyone who takes care of the patient can take risk or gain share if the episode initiator allows them,” said Dr. Greeno. For example, if a patient is admitted for surgery, but has an internist on their case because they have diabetes and heart failure, and they also have an anesthesiologist and an infectious disease specialist, everybody has an impact on their care and makes decisions about the resources used on the case. The risk associated with the case is effectively divided.

The ACS submitted the proposal to PTAC (the Physician-Focused Payment Model Technical Advisory Committee) in 2016 and SHM submitted a letter of support.

“In this model, everybody’s taking risk and everybody has the opportunity to gain share if the patient is managed well,” said Dr. Greeno. “It’s a very complicated, very complex model... Theoretically, everybody on that care team should be optimally engaged – that’s the beauty of it – but we don’t know if it will work.”

The SHM got involved at the request of ACS, because it would not apply solely to surgical patients. Dr. Greeno says ACS asked SHM to look at common surgical diagnoses and review every medical scenario to see if it could come to pass, from heart failure and pneumonia to infection.

“There’s bundles within bundles, medical bundles within surgical bundles,” he said. “It’s fascinating and it’s daunting but it is truly a big data approach no-episodes of care. We’re thrilled to be invited and ACS was very enthusiastic about our involvement.”

Dr. Patel, who sits on PTAC, is heartened by the amount of physician-led innovation taking place. “Proposals are coming directly from doctors; they are telling us what they want,” she said.

For Dr. Greeno, this captures the intent of MACRA: “There is going to be a continual increase in the sophistication of models, and hopefully toward ones that are better and better and create the right incentives for everyone involved in the health care system.”

**References**


1. Family reports provide additional information regarding adverse events.

**CLINICAL QUESTION:** Do family reports of adverse events improve incident detection, compared with clinician reports and hospital incident reports? 

**BACKGROUND:** Hospital incident reports, which are voluntary and suffer from underreporting, capture only a fraction of errors and adverse events (defined as errors resulting in harm). Systematic, prospective surveillance by researchers is the gold standard but is time consuming and expensive. The authors hypothesized that family reports would improve error and adverse event detection.

**STUDY DESIGN:** Prospective cohort study.

**SETTING:** Four U.S. pediatric hospitals.

**SYNOPSIS:** The authors developed a Family Safety Interview, administered weekly and on discharge, and compared reporting of errors and adverse events to clinician reports, hospital incident reports, and systematic review of records by researchers. Of 985 hospitalized pediatric patients, 746 parents/caregivers completed interviews between December 2014 and July 2015. From all sources, the authors found a total of 179 errors and 113 adverse events. Families reported a total of 39 of these 179 errors (including 19 unique errors not reported elsewhere) and 33 of 113 adverse events (8 unique).

Overall, error rates with family-reported errors were 15.5% higher (95% confidence interval, 9.0%-22.3%) than without. Adverse event rates with family reporting were 9.8% higher (95% CI, 3.1%-16.9%) than without. Family-reported error rates were 5 times higher (95% CI, 1.9-13.0) than hospital incident report rates.

The study showed that family-reported error and adverse event rates were significantly higher than voluntary, clinician-only hospital incident report rates. The study was limited to pediatric hospitals on general pediatric and subspecialty services, though findings potentially may be applicable more broadly (for example, adult and surgical services).

**BOTTOM LINE:** Using a structured interview, families report significantly higher rates of errors and adverse events, compared with other sources.


2. Lactulose plus albumin is more effective than lactulose alone for treatment of hepatic encephalopathy.

**CLINICAL QUESTION:** Is the combination of lactulose plus albumin more effective than lactulose alone for treatment of hepatic encephalopathy?

**BACKGROUND:** Hepatic encephalopathy is caused by the effect of toxins that build up in the bloodstream when the liver is not able to perform its normal functions. Lactulose is primarily directed at the reduction of blood ammonia levels. Albumin is thought to minimize oxidative injury and improve circulatory dysfunction present in cirrhosis.

**STUDY DESIGN:** Prospective, open-label, randomized controlled trial.

**SETTING:** Tertiary care centers in India.

**SYNOPSIS:** 120 patients with overt hepatic encephalopathy were randomized to treatment with lactulose plus albumin (1.5 gm/kg/day; n = 60) versus lactulose alone (n = 60). Patients with serum creatinine greater than 1.5 mg/dL on admission, active alcohol intake less than 4 weeks prior to presentation, other metabolic encephalopathies, or hepatocellular carcinoma were excluded. Treatment was continued up to a maximum of 10 days until complete resolution of hepatic encephalopathy was assessed independently by two expert hepatologists.

Of patients receiving lactulose plus albumin, 73% had complete reversal of hepatic encephalopathy within 10 days, compared with 53% of patients receiving lactulose alone (P = .03). Patients in lactulose plus albumin group had shorter hospital length-of-stay (6.4 vs. 8.6 days; P = .01). There was lower mortality at 10 days in the lactulose plus albumin group (18.3% vs. 31.6%; P = .04).

**LIMITATIONS:** The study includes the noted exclusion factors, including presence of alcohol intake, limitation to a single country (India), and a relatively high mortality rate in both groups.

**BOTTOM LINE:** Combination of lactulose plus albumin is more effective than lactulose alone at reversing hepatic encephalopathy and is also associated with decreased length-of-stay and mortality.


3. 2017 GOLD report: Update on COPD management

**CLINICAL QUESTION:** What medications should be used to treat patients with chronic obstructive pulmonary disease (COPD) who are minimally symptomatic but have severe obstructive defect on spirometry?

**BACKGROUND:** COPD treatment is geared toward reducing exacerbations and improving quality of life. This report is an updated management guideline based on peer-reviewed evidence published through October 2016.

**STUDY DESIGN:** The Global Initiative for Chronic Obstructive Lung Disease is an international collaboration of experts that intermittently releases guidelines for the diagnosis and management of COPD.

**SETTING:** An international committee of experts meets regularly, reviews evidence, and updates the guideline.

**SYNOPSIS:** The revised ABCD disease severity assessment tool is based on symptoms and exacerbation frequency (rather than spirometry). For patients with mild symptoms and infrequent exacerbations, a short-acting bronchodilator is recommended. For patients with mild to moderate symptoms, a long-acting beta-agonist or long-acting muscarinic antagonist should be prescribed. Dual therapy is the next step if symptoms are not controlled on single agent. If there are persistent symptoms beyond dual therapy, an inhaled corticosteroid should be added. PDE4 inhibitors may reduce frequency of exacerbations in patients with severe obstructive defect, chronic bronchitis, and severe symptoms.

For acute exacerbations, short-acting bronchodilators and a 5-day course of oral systemic glucocorticoids should be prescribed. Antibiotics are controversial but, in general, recommended for patients who report increased sputum purulence. In acute respiratory failure, noninvasive ventilation is preferred over invasive ventilati...
4 Resumption of warfarin after intracranial hemorrhage

CLINICAL QUESTION: In patients with atrial fibrillation and intracranial hemorrhage (ICH) who are restarted on warfarin, is bleeding risk dependent on etiology of ICH (traumatic vs. hemorrhagic stroke)?

BACKGROUND: Patients with a history of atrial fibrillation who take warfarin and suffer from an ICH remain at risk for future ischemic strokes without anticoagulation. This study examines if the rebleeding risk is different for patients who have had a traumatic ICH or a hemorrhagic stroke after being restarted on warfarin.

STUDY DESIGN: Retrospective observational cohort study of 2,415 patients.

SETTING: Denmark national registry-based study.

SYNOPSIS: Using national registry databases, investigators linked patients admitted with atrial fibrillation on warfarin with diagnosis codes of traumatic ICH and hemorrhagic stroke. Prescription claim data were used to track resumption of warfarin after discharge. For patients with traumatic ICH, the warfarin treatment group had a lower (but not significant) rate of ischemic stroke and a higher rate of recurrent ICH. Rate of recurrent ICH with warfarin was higher in the hemorrhagic stroke group than it was in the traumatic ICH group. All-cause mortality rate was lower for patients taking warfarin than in patients not on anticoagulation in both hemorrhagic stroke and ICH groups. This study was limited by lack of direct assessment of bleeding severity, intensity of warfarin treatment, and potential inaccuracy of the prescription database.

BOTTOM LINE: Spontaneous hemorrhagic stroke and traumatic ICH may confer a different risk and benefit profile with resumption of anticoagulation, but more studies are needed to further guide practice.


Dr. Herman is assistant clinical professor in the division of hospital medicine, department of medicine, University of California, San Diego.

By Leslie M. Martin, MD

5 Sooner may not be better: Study shows no benefit of urgent colonoscopy for lower GI bleeding

CLINICAL QUESTION: In patients hospitalized for a lower gastrointestinal bleeding (LGIB), does an urgent colonoscopy (less than 24 hours after admission) result in any clinical benefits, compared with waiting for an elective colonoscopy?

BACKGROUND: LGIB is a common cause of morbidity and mortality, often requiring hospitalization. While colonoscopy is necessary for appropriate work-up and treatment, it remains unclear if time to colonoscopy (urgent vs. elective) confers any clinical benefit in hospitalized patients.

STUDY DESIGN: Systematic review and meta-analysis.

SETTING: Twelve studies meeting inclusion criteria.

SYNOPSIS: Computerized bibliography databases were searched for appropriate studies, and 12 met inclusion criteria, resulting in a total sample size of 10,172 patients in the urgent colonoscopy arm and 14,224 patients in the elective colonoscopy arm.

Outcome measures included bleeding source identified on colonoscopy, therapeutic endoscopic interventions performed, patients requiring blood transfusions, rebleeding, adverse events, and mortality.

Urgent colonoscopy was associated with increased use of endoscopic therapeutic intervention (relative risk, 1.70; 95% CI, 1.08-2.67). There were no significant differences in bleeding source localization (RR, 1.08; 95% CI, 0.92-1.25), adverse event rates (RR, 1.05; 95% CI, 0.65-1.71), rebleeding rates (RR, 1.16; 95% CI, 0.74-1.78), transfusion requirement (RR, 1.02; 95% CI, 0.73-1.41), or mortality (RR, 1.17; 95% CI, 0.45-3.02) between urgent and elective colonoscopy.


Dr. Martin is vice chief of hospital medicine at the University of California, San Diego.
LAS VEGAS – The path to improved health care in the United States may never be straight – and it certainly won’t be easy – but the three plenary speakers at HM17 think its destination is pretty clear: a system that increasingly rewards quality care delivered at lower costs.

And the three experts agreed that there may be “no finer group” than hospitalists to continue leading the charge.

Hospitalists “have been at the center of change, not only in building a new field and showing us that medicine doesn’t have to be the way it always was,” said Karen DeSalvo, MD, MPH, MSc, former acting assistant secretary for health in the U.S. Department of Health & Human Services. “You have been at the forefront of seeing that we’re getting better value out of our health care system.”

Dr. DeSalvo believes HM’s scope of practice must evolve to include a focus on social determinants – such as economic stability, neighborhood and physical environment, education, and access to healthy options for food – because they have “direct relationships with mortality and morbidity and cost.”

In other words, Dr. DeSalvo wondered aloud, what good is treating a grandmother’s heart failure over and over if she’s always going to return to the hospital because her home, her neighborhood, or her finances mean she is unable to prevent recurring issues?

“If you listen to the hoof-beats that are coming, there is definitely a financial imper- maturer to do this,” Dr. DeSalvo said. “There is going to be an expectation from public and private payers ... that we are going to be taking into account and addressing social factors. Just look at the data from the people of this country – they are shouting loudly to you that they need help.”

Patrick Conway, MD, MSc, MHM, deputy administrator for innovation and quality at the Centers for Medicare & Medicaid Services and director of its Center for Medicare and Medicaid Innovation, echoed Dr. DeSalvo’s idea that HM needs to look at health care more holistically to help work on social issues. Dr. Conway, who still moonlights as a pediatric academic hospitalist on weekends, knows the problem first-hand as he often sees children on Medicaid who have multiple chronic conditions.

“I can tell you our system still does not have a highly reliable, whole health system for those children and their families,” he said. “Every weekend, I have a family that I can’t discharge because they don’t have the social and home-based supports for them to go home. So they literally sit in the hospital until Monday. That makes no sense for our overall health system.”

Dr. Conway assured attendees that health system transformation is a bipartisan ideal in the meeting – as is tradition – by telling hospitalists the field remains positioned to take the lead for hospital transformation. And technology, despite its myriad frustrations, is still the tool that will get the field there.

“Even though there are a lot of fiascos and frustrations, the work on value, the work on accountability, the work on bundled payments ... will continue and will continue to be important to you and the patients you serve,” he said.

Robert Wachter, MD, MHM, concluded the meeting – as is tradition – by telling hospitalists the field remains positioned to take the lead for hospital transformation. And technology, despite its myriad frustrations, is still the tool that will get the field there.

“Digital is really important here, because it becomes an enabling for those stakeholders who care about what we do to measure what we do, and our ability to change what we do in a far more robust way than we could ever do before, if we get our acts together,” Dr. Wachter said. “We’re well past the time where you can nibble around the edges here, you can get this done with little mini projects. You really have to remake your whole delivery system, the way you do your work in order to succeed in this environment.”

Dr. Wachter agreed that social determinants must be addressed. He said HM might do better to partner with folks handling those issues, rather than tackling them head on. Instead, HM needs to be “focusing on the right things” amid mounting pressures from digitization, consolidation of everything from health systems to insurance companies to HM companies, and the gravitation toward population health.

“We have successfully positioned ourselves as the people who are leaders in this work,” Dr. Wachter said, “and it is increasingly important that we continue to do that as we go forward.”
Grassroots policy demands that hospitalists team up

By Richard Quinn

LAS VEGAS – Alla Zilbering, MD, sat at attention for hours during HM17, jotting notes like a scribe about the myriad of federal rules that are pretty rapidly pushing hospitalists and health care as a whole away from fee-for-service payments to a world where doctors are paid for quality.

So, why did she do it? Why all that time on policy, instead of practice?

Because Dr. Zilbering felt compelled to get more involved. As a lead hospitalist at Cigna-HealthSpring, a Medicare Advantage program in Philadelphia, she’s already part of initiatives to improve transitions of care and reduce readmissions.

However, she said she wants to do more. “I’m feeling like, unless you actually address the policy, you can’t get that far in terms of what you can physically do with a patient.”

SHM, this year, unveiled its first Health Policy Mini Track, dedicated to updating attendees on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Bundled Payments for Care Improvement initiative, and a host of other federal programs. Hospitalists were updated on a litany of advocacy efforts, including observation status, interoperability of electronic health records, and pressing people at home via conduits like SHM’s Grassroots Network, which has nearly 1,200 members from 490 states.

However, she said she wants to do more. “I’m feeling like, unless you actually address the policy, you can’t get that far in terms of what you can physically do with a patient.”

SHM, this year, unveiled its first Health Policy Mini Track, dedicated to updating attendees on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Bundled Payments for Care Improvement initiative, and a host of other federal programs. Hospitalists were updated on a litany of advocacy efforts, including observation status, interoperability of electronic health records, and pressing people at home via conduits like SHM’s Grassroots Network, which has nearly 1,200 members from 490 states.

Two of the meeting’s three keynote speakers were Washington veterans who confirmed that, while nightly news reports may suggest that health care reforms contained in the Affordable Care Act don’t have a “single word dealing with the Innovation Center,” which is the government agency tasked with supporting the development and testing of new payment and service delivery models.

He added that the policy’s gravitation away from fee-for-service toward alternative payment models will ideally lead to better patient outcomes, more coordinated care, and financial savings.

M.A. Williams, MD, FHM, the medical director of peripertative services at Porter Adventist Hospital in Denver, said that the way to help design those systems is to get involved. Individual practitioners can make more impact than they think. “Learn enough to be dangerous and go to your [Chief Medical Officer or] whoever you can get a meeting with because MACRA is going to affect all physicians in the organization, even if the system is not doing anything active about it,” Dr. Williams said.

And that traction isn’t just within the walls of a given institution, Dr. Greeno said. He wants more hospitalists involved in the society’s overall advocacy efforts. That includes lobbying Congress both in person and with phone calls, letters, and emails.

“It is an identity within Medicare,” said Josh Boswell, SHM’s director of government affairs.

While the ACA and the potential repeal and replace of the Affordable Care Act don’t have a “single word dealing with the Innovation Center,” which is the government agency tasked with supporting the development and testing of new payment and service delivery models.

He added that the policy’s gravitation away from fee-for-service toward alternative payment models will ideally lead to better patient outcomes, more coordinated care, and financial savings.

M.A. Williams, MD, FHM, the medical director of peripertative services at Porter Adventist Hospital in Denver, said that the way to help design those systems is to get involved. Individual practitioners can make more impact than they think. “Learn enough to be dangerous and go to your [Chief Medical Officer or] whoever you can get a meeting with because MACRA is going to affect all physicians in the organization, even if the system is not doing anything active about it,” Dr. Williams said.

And that traction isn’t just within the walls of a given institution, Dr. Greeno said. He wants more hospitalists involved in the society’s overall advocacy efforts. That includes lobbying Congress both in person and with phone calls, letters, and emails.

“Learn enough to be dangerous and go to your [Chief Medical Officer or] whoever you can get a meeting with because MACRA is going to affect all physicians in the organization, even if the system is not doing anything active about it,” Dr. Williams said.

And that traction isn’t just within the walls of a given institution, Dr. Greeno said. He wants more hospitalists involved in the society’s overall advocacy efforts. That includes lobbying Congress both in person and with phone calls, letters, and emails.

“This bill will have a greater impact on ... providers than any piece of legislation in our lifetime,” he noted. “Now, the ACA had a bigger impact on consumers, but, in terms of us as providers, MACRA is a sea change.”

— Dr. Ron Greeno

AND RULE-MAKING VIA MACRA.

The bill, which eliminated the Sustainable Growth Rate formula, states that, starting in 2019, Medicare payments will be provided through one of two pathways. The first is the Merit-Based Incentive Payment System that combines the Physician Quality Reporting System, the Physician Value-Based Modifier, and Meaningful Use into a single performance-based payment system.

The second option is Alternative Payment Models, which is meant to incentivize the adoption of payment models that move physicians away from fee-for-service models more quickly. For this pathway, the criteria require elements of “upside and downside financial risk,” as well as meeting threshold requirements for either patients or payments. Those physicians that meet the criteria qualify for a 5% incentive payment. The first payments in 2019 are based on performance data for 2017. As most hospitalists won’t qualify for APMs in the first year, they will default to the MIPS pathway, Dr. Greeno said. “This bill will have a greater impact on ... providers than any piece of legislation in our lifetime,” he noted. “Now, the ACA had a bigger impact on consumers, but, in terms of us as providers, MACRA is a sea change.”

The topic is so important, SHM has created a website at www.macraforhm.org that is meant to serve as a tutorial to the law’s basics. The guide is intended to educate hospitalists and to motivate them to get involved in the policy work that affects them all, Dr. Greeno said.
By Richard Quinn

LAS VEGAS – Masih Shinwa, MD, stood beside a half-circle of judges at SHM's annual Research, Innovations, and Clinical Vignettes poster competition and argued why his entry, already a finalist, should win.

To think, his work, “Please ‘THINK’ Before You Order: A Multidisciplinary Approach to Decreasing Overutilization of Daily Labs,” was borne simply of a group of medical students who incredulously said that they were amazed patients would be woken up in the night for tests.

Now it was a poster at RIV, one of the biggest highlights of SHM’s annual meeting. The Scientific Abstracts Competition – the event’s formal name – has exploded in popularity over the past few years. Submissions for posters rose from 634 in 2010 to 1,712 this year, and presenters ranged from first-year residents to a former SHM president.

Dr. Shinwa’s project shows just how an idea can blossom into a recognized poster. Some 18 months ago, the students he works with at Mount Sinai Hospital in New York just couldn’t understand why so many tests had to be done overnight while a patient slept. So, Dr. Shinwa and his colleagues looked at ways to reduce unnecessary lab tests and chemistry testing.

Now, Dr. Shinwa was humbled to think his work and that of his colleagues could be a pathway to eliminating tests that don’t need to happen across the country, a focal point of SHM and the American Board of Internal Medicine Foundation's Choosing Wisely Campaign.

Another skill set is self-advocacy.

“He can’t make it to this competition just as quickly as he found that job,” Dr. Burger said. “If you wish to be the best clinician, you will just be best and brightest of a group of doctors, you will be promoted and move forward and move up, you’ve got to put the time in. It’s not a natural assumption anymore that, if you are the best and brightest of a group of doctors, you will be chosen to lead in similar vein, networking is a major boon to career development that can be a double-edged scalpel.

“Having a great social game is important, but if all you bring to the table is a social game, you’ll find yourself out of a job just as quickly as you found that job,” Dr. Burger said. “Meaning, you might be able to get it based on that, but you don’t have to do your best champion.”

Dr. Burger said that he understands that there is a fine line between too much self-promotion and too little. But he urged hospitalists at all career points to take responsibility for marketing themselves.

“Nobody is going to invest in your career unless you yourself invest in it,” he added. “You have to put in as a priority, and not in a selfish way, but in a way that, if you wish to move forward and move up, you’ve got to put the time in. It’s not a natural assumption anymore that, if you are the best and brightest of a group of doctors, you will be chosen to lead.

In a similar vein, networking is a major boon to career development that can be a double-edged scalpel.

“Having a great ‘social game’ is important, but if all you bring to the table is a social game, you’ll find yourself out of a job just as quickly as you found that job,” Dr. Burger said. “Meaning, you might be able to get it based on that, but you’re not going to be able to sustain it. At the same time, being highly accomplished and having no social graces is also a killer. So, you need to be sort of strong in both areas.”

“We are physicians,” he said. “Our role is taking care of patients. Knowing that there are people who are not just focusing on taking care of specific patients but are actually there to improve the entire system and the process – that’s really gratifying.”

“That’s the word that Meredith Prevost, MD, of New Mexico VA Health Care System, Albuquerque, also used to describe presenting her poster, “Improving Accuracy in Measuring Fluid Balance on a General Medicine Ward.”

“If we can improve our little microcosm, then spread it to other folks, then patients all over the country can be helped by what we do,” she said. “And that’s really cool thoughts.”

The RIV also has the unique advantage of letting people have immediate and direct access to lead researchers at the exact moment of reading their research. HM17 attendees had conversations that usually went beyond just the results, which can be downloaded at www.shmabstracts.com.

Dr. Prevost believes that the chats can helpfully highlight the behind-the-scenes pitfalls and mistakes of research that can sometimes be just as valuable as the published results.

“The things that don’t make it to the posters are all the challenges that people experienced on the way to get to this particular work,” she added. “You can brainstorm with every poster that you’re interested in, which is really exciting.”

For a complete list of RIV winners, visit www.the-hospitalist.org

By Richard Quinn

LAS VEGAS – In the view of academic hospitalist Alfred Burger, MD, SFHM, portability was long a dirty word in HM circles. But not anymore.

“My good friends in law and business do this all the time,” said Dr. Burger, associate program director of the internal medicine residency program at Mount Sinai Beth Israel in New York. “You’re not going to make partner in city X, but they’ve got an opening to be partner in city Y if you go there and perform for a year. People up and leave states, people have up and left the country. … Doctors are starting to view it the same way.”

In New York. “Many of us are very good at this and many of us are terrible at this. You may fall somewhere in between, but you do have to be your own champion.”

Dr. Burger said that he understands that there is a fine line between too much self-promotion and too little. But he urged hospitalists at all career points to take responsibility for marketing themselves.

“Nobody is going to invest in your career unless you yourself invest in it,” he added. “You have to put it as a priority, and not in a selfish way, but in a way that, if you wish to move forward and move up, you’ve got to put the time in. It’s not a natural assumption anymore that, if you are the best and brightest of a group of doctors, you will be chosen to lead.

In a similar vein, networking is a major boon to career development that can be a double-edged scalpel.

“Having a great ‘social game’ is important, but if all you bring to the table is a social game, you’ll find yourself out of a job just as quickly as you found that job,” Dr. Burger said. “Meaning, you might be able to get it based on that, but you’re not going to be able to sustain it. At the same time, being highly accomplished and having no social graces is also a killer. So, you need to be sort of strong in both areas.”

“Another skill set is self-advocacy.”

“Be your own champion,” said Brian Markoff, MD, SFHM, chief of hospital medicine at Mount Sinai St. Luke’s in New York. “Many of us are very good at this and many of us are terrible at this. You may fall somewhere in between, but you do have to be your own champion.”

Dr. Burger said that he understands that there is a fine line between too much self-promotion and too little. But he urged hospitalists at all career points to take responsibility for marketing themselves.

“Nobody is going to invest in your career unless you yourself invest in it,” he added. “You have to put it as a priority, and not in a selfish way, but in a way that, if you wish to move forward and move up, you’ve got to put the time in. It’s not a natural assumption anymore that, if you are the best and brightest of a group of doctors, you will be chosen to lead.

In a similar vein, networking is a major boon to career development that can be a double-edged scalpel.

“Having a great ‘social game’ is important, but if all you bring to the table is a social game, you’ll find yourself out of a job just as quickly as you found that job,” Dr. Burger said. “Meaning, you might be able to get it based on that, but you’re not going to be able to sustain it. At the same time, being highly accomplished and having no social graces is also a killer. So, you need to be sort of strong in both areas.”

“Another skill set is self-advocacy.”

“Be your own champion,” said Brian Markoff, MD, SFHM, chief of hospital medicine at Mount Sinai St. Luke’s in New York. “Many of us are very good at this and many of us are terrible at this. You may fall somewhere in between, but you do have to be your own champion.”

Dr. Burger said that he understands that there is a fine line between too much self-promotion and too little. But he urged hospitalists at all career points to take responsibility for marketing themselves.

“Nobody is going to invest in your career unless you yourself invest in it,” he added. “You have to put it as a priority, and not in a selfish way, but in a way that, if you wish to move forward and move up, you’ve got to put the time in. It’s not a natural assumption anymore that, if you are the best and brightest of a group of doctors, you will be chosen to lead.

In a similar vein, networking is a major boon to career development that can be a double-edged scalpel.

“Having a great ‘social game’ is important, but if all you bring to the table is a social game, you’ll find yourself out of a job just as quickly as you found that job,” Dr. Burger said. “Meaning, you might be able to get it based on that, but you’re not going to be able to sustain it. At the same time, being highly accomplished and having no social graces is also a killer. So, you need to be sort of strong in both areas.”

“Another skill set is self-advocacy.”

“Be your own champion,” said Brian Markoff, MD, SFHM, chief of hospital medicine at Mount Sinai St. Luke’s in New York. “Many of us are very good at this and many of us are terrible at this. You may fall somewhere in between, but you do have to be your own champion.”

Dr. Burger said that he understands that there is a fine line between too much self-promotion and too little. But he urged hospitalists at all career points to take responsibility for marketing themselves.

“Nobody is going to invest in your career unless you yourself invest in it,” he added. “You have to put it as a priority, and not in a selfish way, but in a way that, if you wish to move forward and move up, you’ve got to put the time in. It’s not a natural assumption anymore that, if you are the best and brightest of a group of doctors, you will be chosen to lead.

In a similar vein, networking is a major boon to career development that can be a double-edged scalpel.

“Having a great ‘social game’ is important, but if all you bring to the table is a social game, you’ll find yourself out of a job just as quickly as you found that job,” Dr. Burger said. “Meaning, you might be able to get it based on that, but you’re not going to be able to sustain it. At the same time, being highly accomplished and having no social graces is also a killer. So, you need to be sort of strong in both areas.”
In today’s on-demand economy, entrepreneurial physicians deserve a better choice—an easier, hassle-free way to find and manage locum tenens and part-time opportunities, without the agency middlemen.

**Lucidity® is that choice.**

We are a technology company built and managed by physicians who know and understand what other physicians need. Like you, we had enough of the aggressive recruiters, the constant emails for jobs we didn’t want and the hassles of dealing with it all. We built Lucidity with your interests and needs at heart.

**Lucidity puts you in control and eliminates your need for the agency middleman.**

Lucidity is an intuitive, powerful online platform that makes it fast and easy for physicians to find and manage temporary and part-time opportunities. Just sign up and log in on any desktop or mobile device to get started.

Take control of your career. Whether you’re new to freelance work or a locum veteran, Lucidity is a powerful tool that eliminates the need for an agency and gives you exactly what you’re looking for, with complete transparency:

- **personalize** your pay rate and negotiate directly with medical practices;
- **vet opportunities** thoroughly (and anonymously) before you apply;
- **match your schedule** of availability to the opportunity; and much more!

It takes less than two minutes to set up your FREE account. Visit [luciditydirect.com](http://luciditydirect.com) and sign up today.
Hospitalists’ EMR frustrations continue: SHM report

By Richard Quinn

LAS VEGAS – Ronald Schaefer, MD, a hospitalist with Hawaii Pacific Health who also works on creating digital templates for his hospital, can’t input hemoglobin A1 levels from three different labs into his electronic medical records (EMR) system the same way.

Hospitalist George Dimitriou, MD, FHM, who splits his time at Allegheny Health Network in Pittsburgh between clinical work and medical informatics, worries there are so many fields in his EMR that physicians can get distracted.

Yegeyuni “Eugene” Gitelman, MD, a clinical informatics manager at the Perelman School of Medicine at University of Pennsylvania Health in Philadelphia, wonders how good any systems can be with the privacy concerns related to HIPAA.

This was the nexus of IT and HM17, a time when hospitalists said they are stymied and frustrated by continuing issues of interoperability, functionality, and access. The meeting highlighted new smartphone and tablet applications, as well as medical devices available to hospitalists, but tech-focused physicians say the biggest issue remains the day-to-day workings of EMR.

“As end users of technology, we understand the problems better than anybody else. Obviously, the next step would be try to solve the problems. And what better way than to get involved and become experts in what you do?”

– Dr. Rupesh Prasad

Rupesh Prasad, MD, MPH, SFHM, chair of SHM’s Health IT Committee, says the report is meant to foster discussion about the issues surrounding EMRs. The data points, generated from 462 respondents, are stark. Just 40% said they were happy with their EMR. Some 52% would change vendors if they could. One-quarter of respondents would revert to using paper if given the option.

“As end users of technology, we understand the problems better than anybody else,” Dr. Prasad said. “Obviously, the next step would be try to solve the problems. And what better way than to get involved and become experts in what you do?”

While much of the meeting’s tech talk was frustration, both former National Coordinator for Health IT Karen DeSalvo, MD, MPH, MSc, and HM Dean Robert Wachter, MD, MHH, forecast a future when artificial intelligence and intuitive computers work alongside physicians. Imagine the user-friendliness of Apple’s Siri or Google’s Alexia married to the existing functionalities provided by firms such as Epic or Cerner.

But that’s years away, and hospitalists like Dr. Dimitriou want help now.

“The speed of medicine, the speed of what’s happening in real time, is still faster than what our electronic tools seem to be able to keep up with,” he said. “There are encouraging signs that we’ve moved in the right direction. We’ve come a long way … but we aren’t keeping up. We’ve got to do more.”
Practice management skills more relevant than ever

By Richard Quinn

LAS VEGAS – Babatunde Akinsete, MD, took a new job about 18 months ago as a lead hospitalist within Adventist Health System of Florida. The role has the expected leadership responsibilities, but those folks he’s now partly supervising are the same ones who used to be his peers.

The same people he spent time “in the trenches” with, complaining about the problems they saw – issues that are now partly his job to help fix.

“It’s tough,” Dr. Akinsete said at the annual meeting of the Society of Hospital Medicine. “How do you motivate people?”

Welcome to managing a practice, circa 2017. The day-to-day doings of an HM group – recruiting, retention, compensation, scheduling, and more – are the backbone of the specialty. And SHM’s annual meeting makes the topics a principal point, from a dedicated precourse to dozens of presentations to networking opportunities introducing experienced leaders to nascent ones.

The subject is more relevant than ever these days as the maturing specialty now has three generations of hospitalists practicing side by side, including those who founded the society and laid the groundwork for the specialty some 20 years ago and those who will now infuse it with new blood for the next 20 years, said Jerome Sy, MD, SFHM.

“Many of the presentation titles that we have at SHM these days in our precourses and in our annual meeting opened my eyes to techniques that I’ve actually let go of that,” he said. “Right now, we admit 30%-40% of the patients ... into the hospital. National average is 60%-90% of total hospital admissions. I think that most probably will balance my financial dilemma.”

For Abdul-Hady Kheder, MD, of Hamilton Hospitalists in Central New Jersey, the meeting opened his eyes to techniques he might not have considered.

“An HM17 faculty member and chair of SHM’s Practice Management Committee.

“We’re heading into a cycle of a lot of change,” he said. “Being able to manage change is going to be pretty key.”

The first step in building or bettering a “healthy practice” is building a “culture of ownership,” Dr. Sy said.

“You must have the right culture first if you’re going to tackle any of these issues, whether it’s things like schedules to finances to negotiations,” he added. “Second is this openness and innovation to think outside the box and to allow yourself to hear things that might not work for you. Be open to it because whether you hear something that doesn’t work or not, it may inspire you to figure out … what is the key element you were missing before.”

That’s what Liza Rodriguez Jimenez, MD, is taking away from the meeting. She is moving into a codirector position for her medical group at St. Luke’s in Boise, Idaho. A crash course in alternative-payment models, full-time equivalents (FTEs), relative value units (RVUs) and scheduling was an eye-opener for her.

But to Dr. Sy’s point, it wasn’t the specific examples of how other people do what they do that intrigued Dr. Rodriguez Jimenez. It was more so that people just did it differently.

“It’s just helpful to know that there are other choices,” Dr. Rodriguez Jimenez said. “In other words, why do we do 7 on, 7 off? I don’t know. We just do it. If you don’t know that you don’t know, then how do you know to change it? You get exposed to so much stuff here now that you can theoretically go back and say, ‘Why do we do 7 on, 7 off? … And then let the group say we want 5 on, 10 off, 4 on, 3 off. Whatever people decide.’”

Nasim Asfar, MD, SFHM, chief quality officer of the department of medicine at UCLA Health in Los Angeles, said that idea of just framing the question differently is a big deal, and a leadership skill in and of itself. For example, say a hospital medicine group’s leaders are trying to discuss whether the practice should continue its comanagement focus.

“If you frame a decision as, ‘We are going to lose this comanagement,’ there’s just something, like a gut feeling. You don’t want to lose stuff,” she said. “As opposed to, if you say, ‘Gosh, think about the gains. That we will have all this free time that we now have where we can develop other aspects of our hospital medicine group.’ So when you frame the same exact thing in terms of loss, it becomes so much more difficult for us to actually let go of that.”

Leadership is more than just framing, of course. Dr. Asfar and former SHM president Eric Howell, MD, MFM, said that leadership traits include using standardized processes to make decisions, as well as getting group members involved in those decisions when necessary and using feedback and motivation properly.

But, at day’s end, practice management is managing the needs of your practice.

For Abdul-Hady Kheder, MD, of Hamilton Hospitalists in Central New Jersey, the meeting opened his eyes to techniques he could use to deal with lower reimbursement figures and less patients.

“What can help my situation will be increasing the volume of the practice,” he said. “If you frame a decision as, ‘We are going to lose this comanagement,’ there’s just something, like a gut feeling. You don’t want to lose stuff.”

– Dr. Nasim Asfar

Connecting to EMERGING TRENDS.

We’re taking the mal out of malpractice insurance. In an ever-evolving healthcare environment, we stay on top of the latest risks, regulations, and advancements. From digital health innovations to new models of care and everything in between, we keep you covered. And it’s more than a trend. It’s our vision for delivering malpractice insurance without the mal. Join us at thedoctors.com
Building a practice that people want to be part of

By Miguel Villagra, MD, FACP, FHM

Presenters
Robert Himebaugh MBA, SHM; John Nelson, MD, FACP, MHM; Jerome Sy, MD, SFHM

Session summary
Creating a "culture of ownership" by recruiting the right people, promoting physician leadership, and improving structural elements such as compensation model and schedule were topics discussed in this practice management preconference at HM17. The presenters said leaders must reduce hierarchy and promote shared decision making among the group, while instilling a "thank you culture" that recognizes motivations such as autonomy, mastery, and purpose.

Current challenges related to most hospitalist group includes excessive documentation, clerical and administrative duties, and frequent low-value interruptions. One potential solution discussed was delegation of some of these duties to registered nurses, medical assistants, and possibly scribes, although the latter is currently in early adoption stages.

Leaders must also consider current changes in health care payment models, such as MIPS (Merit-Based Incentive Payment System), bundled payments, and Hospital Value-Based Purchasing. Hospitalist groups must be prepared for these changes by learning about them and looking for potential cost reduction opportunities (e.g., reducing the number of patients going to skilled nursing facilities after joint replacement by sending patients home whenever possible). Promoting a culture of engagement might include the development of interpersonal support strategies (e.g., meditation and mindfulness), innovative staffing (is 7 on/7 off right for everyone?), and comprehensive support for career and leadership development.

Finally, hospitalists should give special attention to the value formula by focusing on improving patient outcomes and experience, but also reducing direct and indirect costs. This is crucial for the sustainability of any hospitalist group.

Key takeaways for HM
• Create a culture of ownership to promote engagement and job satisfaction.
• Make adjustments to schedule and workflow to improve efficiency.
• Prepare for evolving pay-for-performance programs.
• Demonstrate the value of the group by setting expectations with key stakeholders, developing a practice score, and providing effective feedback to providers.

Dr. Villagra is a chief hospitalist in Batesville, Ark., and an editorial board member of The Hospitalist.

The art of story in delivering memorable lectures

By James Kim, MD

Presenter
Ethan Cumbler, MD, FACP, FHM

Session summary
This session was designed to give learners a different paradigm in thinking about the structure and organization of presentations, for a more dynamic and engaging lecture.

Memorable teaching points are tied to a narrative with emotional impact. One study of surgery residents immediately after finishing grand rounds found that learners only remember approximately 10% of the material embedded in a lecture. Therefore, the lecture should not necessarily include a comprehensive amount of information, but make major points as "sticky" as possible.

One must be familiar with the topic, but it is important to empathize with the audience and ask oneself "what do they want out of this?"

This will help anchor your presentation and will hopefully assist in creating an organizational framework. Think about a real patient case to keep the audience engaged. You can add drama and suspense as the audience and the speaker work through the case together.

One should have a "hook" as an analogy to engage with the audience while reinforcing the central message. Dr. Cumbler recommends thinking of slides from a design perspective. In order to provide more content while not burdening slides with more text, consider handouts to provide information that one cannot show during the presentation.

A good talk is not only the information itself, but a presentation that answers a specific diagnostic question or guides a bedside invasive procedure. Adoption by pediatric hospitalists is increasing, aided by multiple training pathways, opportunities for scholarship, and organization development.

The use of POCUS is increasing among nonradiologist physicians because of the expectation for perfection, desire for improved patient experience, and increased availability of ultrasound machines. POCUS is rapid and safe, and can be used serially to monitor, provide procedural guidance, and lead to initiation of appropriate therapies.

Training in POCUS in limited applications is possible in short periods of time. One recent study showed that approximately 40% of POCUS cases led to new findings or alteration of treatment. However, POCUS requires training, monitoring for competence, transparency of training, and a QA process.

Pediatric applications include guidance of bladder catheterization, identifying occult abscesses, diagnosis of pneumonia, and associated parapneumonic effusion, and IV placement. More advanced applications include diagnosis of appendicitis, intussusception, and increased intracranial pressure. Novel applications have included sinus ultrasound.

Key takeaways for HM
• Consider the stand-up comedy concept of the "call-back." Start with a concept, and then return to this concept in different forms through the presentation. One can return to another variation of this for a surprise at the end. One can make a key point memorable by using a theme with multiple variations.
• Think about structure in order to draw listeners into a talk and keep them invested (organizational framework centered around a patient); create a "hook"; think about slides visually, not from a content perspective; keep the tempo, timing, and volume dynamic; and use body language and presence to engage the room.
• If one would like to learn more, consider reading the book Presentation Zen; watch TED talks; practice multiple times to hone various aspects of the talk; give the talk multiple times for iterative improvement; always ask for feedback and try to change at least one thing from one talk to another to continuously improve.

Dr. Kim is a hospitalist who works at Emory University Hospital in Atlanta, and is an editorial board member of The Hospitalist.

Focus on POCUS: Introduction to Point-of-Care Ultrasound for pediatric hospitalists

By Weijen W. Chang, MD, SFHM, FAAP

Presenters
Nilam Soni, MD, FHM; Thomas Conlon, MD; Ria Dancel, MD, FAAP, FHM; Daniel Schobrich, MD

Summary
Point-of-care ultrasound (POCUS) is rapidly gaining acceptance in the medical community as a goal-directed examination that answers a specific diagnostic question or guides a bedside invasive procedure. Adoption by pediatric hospitalists is increasing, aided by multiple training pathways, opportunities for scholarship, and organization development.

The use of POCUS is increasing among nonradiologist physicians because of the expectation for perfection, desire for improved patient experience, and increased availability of ultrasound machines. POCUS is rapid and safe, and can be used serially to monitor, provide procedural guidance, and lead to initiation of appropriate therapies.

Training in POCUS in limited applications is possible in short periods of time. One recent study showed that approximately 40% of POCUS cases led to new findings or alteration of treatment. However, POCUS requires training, monitoring for competence, transparency of training, and a QA process.

Pediatric applications include guidance of bladder catheterization, identifying occult abscesses, diagnosis of pneumonia, and associated parapneumonic effusion, and IV placement. More advanced applications include diagnosis of appendicitis, intussusception, and increased intracranial pressure. Novel applications have included sinus ultrasound.

Key takeaways for HM
• Point-of-care ultrasound (POCUS) is rapidly being adopted by pediatric hospitalists.
• Pediatric applications are still being developed, but include guidance of bladder catheterization, identifying occult abscesses, diagnosis of pneumonia, and IV placement.
• Initial training can be provided by pediatric ED physicians/pediatric ICU physicians or an on-site commercial course for larger groups.
• Relationships with radiologists should be established at the outset to avoid misunderstanding of POCUS.

Dr. Chang is a pediatric hospitalist at Baystate Children’s Hospital and is the pediatric editor of The Hospitalist.
Hospitalist Position in Picturesque Bridgton, Maine: Bridgton Hospital, part of the Central Maine Medical Family, seeks BE/BC Internist to join its well-established Hospitalist program. Candidates may choose part-time (7-8 shifts/month) to full-time (15 shifts/month) position. Located 45 miles west of Portland, Bridgton Hospital is located in the beautiful Lakes Region of Maine and boasts a wide array of outdoor activities including boating, kayaking, fishing, and skiing.

Benefits include medical student loan assistance, competitive salary, highly qualified colleagues and excellent quality of life.

For more information visit our website at www.bridgtonhospital.org

Interested candidates should contact
Julia Lauver, CMMC Physician Recruitment
300 Main Street, Lewiston, ME 04240
email: LauverJu@cmhc.org
call: 800/445-7431   fax: 207/755-5854

For more information visit our website at www.bridgtonhospital.org

Interested candidates should contact
Julia Lauver, CMMC Physician Recruitment
300 Main Street, Lewiston, ME 04240
email: LauverJu@cmhc.org
call: 800/445-7431   fax: 207/755-5854

Helping people live the healthiest lives possible.

Intermountain Healthcare has both outpatient opportunities for INTERNAL MEDICINE & HOSPITALIST positions throughout Utah in all major cities.

INTERNAL MEDICINE
• Enjoy a 4 day work week
• Loan repayment and signing bonus
• Eligible for those still in training
• Exceptional benefits, including competitive salaries and relocation

HOSPITALIST
• Medical or hospitalist board certified
• Flexible work schedule
• Competitive salary and signing bonus
• Exceptional benefits, including competitive salaries and relocation

TOP REASONS TO CHOOSE UTAH:
• World-Class Year-Round Skiing, Hiking, and Biking
• 5 National Parks
• 4 Distinct Seasons
• Best State for Business
• Endless Outdoor Recreation Opportunities

Physicians, you’re just one click away from your next job with the new SHM Career Center

You’ve never had a more powerful ally in making your next career move. The new SHM Career Center is designed for busy doctors. Now you can:
• Create job alerts
• Save your jobs
• Quickly search for jobs on your smartphone — works seamlessly!

Create a candidate profile and get matched to your ideal job.

For more information visit www.the-hospitalist.org and click “Advertise” or contact Heather Sienkowsk; 973-290-8289 • hgsienkowsk@frontlinemedcom.com or Linda Wilson • 973-290-8243 • lnelson@frontlinemedcom.com

To learn more, visit www.the-hospitalist.org and click “Advertise” or contact
Heather Sienkowsk; 973-290-8289 • hgsienkowsk@frontlinemedcom.com or Linda Wilson • 973-290-8243 • lnelson@frontlinemedcom.com

www.the-hospitalist.org | JUNE 2017 | THE HOSPITALIST 25
ACADEMIC NOCTURNIST HOSPITALIST

The Division of General Internal Medicine at Penn State Health Milton S. Hershey Medical Center, Penn State College of Medicine (Hershey, PA) is seeking a BC/BE Internal Medicine NOCTURNIST HOSPITALIST to join our highly regarded team. Successful candidates will hold a faculty appointment to Penn State College of Medicine and will be responsible for the care in patients at Hershey Medical Center. Individuals should have experience in hospital medicine and be comfortable managing patients in a sub-acute care setting.

Our Nocturnists are a part of the Hospital Medicine program and will work in collaboration with advanced practice clinicians and residents. Primary focus will be on overnight hospital admission for patients to the Internal Medicine service. Supervisory responsibilities also exist for bedside procedures, and proficiency in central line placement, paracentesis, thoracentesis, and lumbar puncture is required. The position also supervises overnight Code Blue and Adult Rapid Response Team calls. This position directly supervises medical residents and provides for teaching opportunity as well.

Competitive salary and benefits among highly qualified, friendly colleagues foster networking opportunities. Excellent schools, affordable cost of living, great family-oriented lifestyle with a multitude of outdoor activities year-round. Relocation assistance, CME funds, Penn State University tuition discount for employees and dependents, LTD and Life insurance, and so much more!

Appropriate candidates must possess an MD, DO, or foreign equivalent; be Board Certified in Internal Medicine and have or be able to acquire a license to practice in the Commonwealth of Pennsylvania. Qualified applicants should upload a letter of interest and CV at: http://tinyurl.com/j29p3e Ref Job ID#4524

For additional information, please contact:
Brian Mc Giffen, MD — Director, Hospital Medicine
Penn State Milton S. Hershey Medical Center
c/o Heather Peffley, FHR FPSR — Physician Recruiter
hpelfley@hmc.psu.edu

The Penn State Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

Join a Leader in Hospital Medicine

As one of the nation’s largest academic hospitalist programs, we offer a variety of teaching and non-teaching inpatient and consultative services.

OSUWMC Division of Hospital Medicine is dedicated to the health and well-being of our patients, team members, and the OSUWMC community. We are currently seeking exceptional individuals to join our highly regarded team. We focus on improving the lives of our patients and faculty by providing personalized, patient-centered, evidence-based medical care of the highest quality. Our clinical practice meets rigorous standards of scholarship, and we are devoted to serving as expert educators and mentors to the next generation of physicians.

Preferred candidates are BC/BE in Internal Medicine or Internal Medicine–Pediatrics, have work experience or residency training at an academic medical center, and possess excellent inpatient, teamwork, and clinical skills.

We are an Equal Opportunity/Affirmative Action Employer. Qualified women, minorities, Vietnam-era and disabled Veterans, and individuals with disabilities are encouraged to apply. This is not a J-1 opportunity.

Practice Locations:
- University Hospital
- University Hospital East
- James Cancer Hospital & Solove Research Institute
- Richard M. Ross Heart Hospital
- Dodd Rehabilitation Hospital
- OSU Harding Hospital
- Nationwide Children’s Hospital (Med-Peds)

We are interviewing competitive applicants! Forward your letter of interest and CV:
- Natasha Durham, DASPR
- http://go.osu.edu/hospitalmedicine
- hospitalmedicine@osumc.edu
- 614/366-2360

The Ohio State University WEXNER MEDICAL CENTER

Make your next smart move. Visit www.shmcareercenter.org

TEAMHealth.

Hospitalist Opening in Montgomery, Alabama

Put the passion back into practicing medicine by taking control of your time! Enjoy the freedom and flexibility of being a Hospitalist. We have an opportunity for a physician to join our Hospital Medicine team full-time at Baptist Medical Center-East in Montgomery, Alabama. This 150-bed facility features a team of 8 physicians with 2 nurse practitioners. We provide coverage from 4 physicians and 1 nurse practitioner during the day, and 1 physician at night. No procedures are required and the average daily census is 18.

This southern metropolitan area is located on the Alabama River. It’s also an educational hotspot with many public and private colleges and universities, such as Alabama State University, and local campuses of Troy University and Auburn University.

To learn more about these or other Hospital Medicine opportunities, contact Alison Cooper at 865.560.8463 or alison_cooper@teamhealth.com, or visit www.teamhealth.com.

Expanding your reach with an ad in the Journal of Hospital Medicine, SHM’s clinical content journal

For rates or to place an ad, contact:
Heather Gentile • 973-290-8259 • hgentile@frontlinemedcom.com
OR
Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

Ask about our combination discount when advertising in both JHM and The Hospitalist.

To learn more, visit www.the-hospitalist.org and click “Advertise”
You own the night

Do you love the night life? Join the EmCare hospitalist team!

noc•tur•nist

- Superstar Hospitalist that works at night
- Enjoys practice autonomy
- Home to take kids to school and help with homework in the afternoon
- No rushing to an early shift
- Freedom for daytime awesomeness like bike riding, rock climbing or doing absolutely nothing

Opportunities in:

- Atlanta, GA
- Chattanooga, TN
- Ft Pierce, FL
- Ft. Walton, FL
- Miami, FL
- Nashville, TN
- Panama City, FL
- Waycross, GA

Ask about our referral bonus program! Refer a provider. Receive a bonus. It’s that simple!

To join our team, contact: inpatientjobs@evhc.net

Quality people. Quality care. Quality of LIFE.

EmCare
Hospital Medicine
MAKING HEALTHCARE WORK BETTER™
Gundersen Lutheran Medical Center, Inc. | Gundersen Clinic, Ltd. | 21972_0317

ENRICHING EVERY LIFE WE TOUCH... INCLUDING YOURS!

Gundersen Health System in La Crosse, WI is seeking an IM or FM trained hospitalist to join their established team. Gundersen is an award winning, physician-led, integrated health system, employing nearly 500 physicians.

Practice highlights:
- Block or traditional schedules available
- Average Daily Census: 15
- Average admissions: two per day with Advanced Provider Assistance
- Perform direct patient care involving usual inpatient hospital services with strong subspecialist support
- HI-B Visa sponsorship is available
- Codes and procedures are not mandatory
- IU Health Ball also supports Graduate Medical Education programs in Internal Medicine, Family Medicine, and Transitional Year
- Academic Hospitalist positions available and faculty appointments through IU School of Medicine possible
- Nocturnist coverage in place

Opportunities Include:
- Quality Bonuses, Occurrence-Based Malpractice, Medical, Dental, and Vision Insurance, CME, 401K, Sign-On Bonus, Loan Repayment and Relocation

For more information or to submit your CV, please forward to:
- Kalah Haug, Medical Staff Recruitment, Indiana University Health Physicians
  GHaug@iuhealth.org | 317 962 6681

La Crosse is a vibrant city, nestled along the Mississippi River. The historic downtown and riverfront host many festivals and events. Excellent schools and universities, parks, sports venues, museums and affordable housing make this a great place to call home.

For information contact Kalah Haug, Medical Staff Recruitment, at kJHaug@GundersenHealth.org or (608) 775-1005.

Equal Opportunity Employer

To advertise in The Hospitalist or The Journal of Hospitalist Medicine

Contact:
- Heather Gonroski • 973.290.8259 • hgonroski@frontlinemedcom.com
- Linda Wilson • 973.290.8243 • lwilson@frontlinemedcom.com

Now you have more digital options available for your recruiting

- The country’s largest, 100%-validated U.S. physician database—the only one that’s BPA audited
- Candidates who are guaranteed to be licensed, practicing U.S. physicians
- Banner and native ads in the SHM member e-newsletter
- Customized searches to match your job to the exact physician profiles you want

To learn more, visit www.the-hospitalist.org and click “Advertise” or contact
- Heather Gonroski • 973-290-8259 • hgonroski@frontlinemedcom.com
- Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com
Make your next smart move. Visit www.shmcareercenter.org

HOSPITALISTS & NOCTURNISTS

Johnston Memorial Hospital, located in Historic Abingdon, Virginia, is currently seeking Full Time BE/BC, Day Shift Hospitalists & Nocturnists to join their team. These are Full Time positions with the following incentives:

- Hospital Employed (earning potential up to $300k per year)
- Day Shift (7 Days on - 7 Days off) (7am - 7pm)
- Nocturnist (7 Days on - 7 Days off) (7pm - 7am)
- Competitive Annual Salary
- Performance Bonus & Production Bonus
- Excellent Benefits
- Generous Sign On Bonus
- Relocation and Educational Loan Assistance
- Teaching and Faculty opportunities with the JMH FM/IM Residency Training Programs

Please view our online job tour: www.mshajobtour.com/jmh

Please Contact: Tina McLaughlin, CMSR, Johnston Memorial Hospital Office (276) 258-4580, mclaughlint@msha.com

Johnston Memorial Hospital for the Division of General Internal Medicine

The Division of General Internal Medicine at the University Of Maryland School of Medicine is recruiting a full time Hospitalist for a non-tenure track faculty position. This position will provide inpatient attending coverage on our new short stay Observation unit as well as staffing our inpatient hospitalist teams including coverage of, but not limited to, general internal medicine patients on our non-tenure track service, transplant medicine patients, medical consultations for general medicine and transplant medicine, and co-management of surgical services. Please indicate in your response if you have a special interest in transplant medicine.

Candidates must be board certified/eligible in internal medicine and eligible for an unrestricted license in the State of Maryland. This position requires a medical degree from an accredited US (or foreign equivalent), a strong commitment to patient care and teaching, and the ability to work well in a team setting. Faculty rank will be commensurate with the candidate’s qualifications and experience.

We offer competitive salary and benefits. Interested candidates should submit a cover letter, CV and names of four references to Jeffrey Fink, M.D., Search Committee Chair, c/o facultypositions@medicine.umaryland.edu, Department of Medicine, N3810, University of Maryland Medical Center, 22 S. Greene Street, Baltimore, MD 21201. Please cite positions: 3-309-915/916/917/918 when applying.

The University of Maryland, Baltimore is an Equal Opportunity, Affirmative Action employer. Minorities, women, individuals with disabilities and protected veterans are encouraged to apply.

Physicians, you’re just one click away from your next job with the new SHM Career Center

You’ve never had a more powerful ally in making your next career move. The new SHM Career Center is designed for busy doctors. Now you can:

• Create job alerts
• Save your jobs
• Quickly search for jobs on your smartphone — works seamlessly!

Create a candidate profile and get matched to your ideal job.
HOSPITALIST POSITION

Great Lakes Medicine, PLC., invites you to consider an excellent Hospitalist opportunity in and around the suburbs of Detroit, Michigan. We are currently seeking a hard-working Board Eligible/Board Certified Internist to join our dedicated group.

Job requirements:
- Salary starting at $190,000 for full time
- Great medical benefits
- 401k and Profit Sharing at signing
- Partnership opportunity available

Job description:
- 12 weeks’ vacation/ one week per month for full-time hospitalists
- Quarterly bonuses, based on productivity
- One week on, one week off available starting at $180,000
- 12-hour shifts for one week on, one week off

Great Lakes Medicine, PLC was established in 2005. The group is made up of very motivated, dedicated, energetic physicians. We are a hospital group, dedicated to our patients, their families and the primary care physicians whom we represent.

For more info, please call 586-731-8400 or email us at glm@g-l-medicine.com

Network Medical Director for 7 Hospital System in PA/NJ

The Medical Director, Hospitalist Service, is responsible for providing on-site clinical leadership and management of the Hospitalist service for the Network. This individual will serve as the clinical lead for the service and will work closely with physicians, Site Medical Directors, AP leadership and Staff to assure consistently high quality in keeping with the goals of the organization and the group. Must have three to five years’ experience in Hospital Medicine and be board certified; leadership experience strongly preferred. Excellent compensation and benefit package.

SLUHN is a non-profit network comprised of physicians and 7 hospitals, providing care in eastern Pennsylvania and western NJ. We employ more than 450 physicians and 200 advanced practitioners. St. Luke’s currently has more than 180 physicians enrolled in internship, residency and fellowship programs and is a regional campus for the Temple/St. Luke’s School of Medicine. Visit www.slhn.org

Our campuses offer easy access to major cities like NYC and Philadelphia. Cost of living is low coupled with minimal congestion; choose among a variety of charming urban, semi-urban and rural communities your family will enjoy calling home. For more information visit www.discoverlehighvalley.com

Please email your CV to Drea Rosko at physicianrecruitment@sluhn.org

Great Lakes Medicine, PLC., invites you to consider an excellent Hospitalist opportunity in and around the suburbs of Detroit, Michigan. We are currently seeking a hard-working Board Eligible/Board Certified Internist to join our dedicated group.

Job requirements:
- Salary starting at $190,000 for full time
- Great medical benefits
- 401k and Profit Sharing at signing
- Partnership opportunity available

Job description:
- 12 weeks’ vacation/ one week per month for full-time hospitalists
- Quarterly bonuses, based on productivity
- One week on, one week off available starting at $180,000
- 12-hour shifts for one week on, one week off

Great Lakes Medicine, PLC was established in 2005. The group is made up of very motivated, dedicated, energetic physicians. We are a hospital group, dedicated to our patients, their families and the primary care physicians whom we represent.

For more info, please call 586-731-8400 or email us at glm@g-l-medicine.com

TEAMHealth.

Hospitalist Opening in New York.

We are looking for a full-time Hospitalist to join our established team at Mount St. Mary’s Hospital in Lewiston, New York. You’ll be working days only from 7am to 7pm, with advanced practice clinicians. No call is required. Night coverage is provided by one advanced practice clinician from 7pm to 7am. Compensation is in the $260K range plus incentive bonus. Requirements include Board Certified/Board Eligible in Internal Medicine or Board Certified/Board Eligible in Family Medicine with Hospitalist experience, an active New York license, and ACLS certification. This position also offers competitive hourly rate, flexible scheduling for a better work and life balance, paid PIU with tail coverage, comprehensive benefits package and association with a leading hospitalist organization with opportunity for future advancement. Mount St. Mary’s Hospital is located in Lewiston, New York, providing quality care to the greater Niagara Falls region for over 100 years. Founded in 1907, this hospital has since been acknowledged for its superior care in maternity services and stroke treatments. Mount St. Mary’s Hospital is also accredited by the Joint Commission, illustrating that we meet the highest quality and safety standards in our field.

To learn more about these and other opportunities, contact Kim Gary at 855.762.1651 or kim_gary@teamhealth.com, or visit www.teamhealth.com.

Looking to fill an open position?

to advertise in The Hospitalist or the Journal of Hospitalist Medicine, contact:

Heather Gonroski • 973.290.8259 • hgonroski@frontlinemedcom.com OR Linda Wilson • 973.290.8243 • lwilson@frontlinemedcom.com

To learn more, visit www.the-hospitalist.org and click “Advertise”
University of Pittsburgh

The Department of Medicine at University of Pittsburgh and UPMC is seeking an experienced physician as an overall director of its Academic Hospitalist Programs within five teaching hospitals. The individual will be responsible for development of the strategic, operational, clinical and financial goals for Academic Hospital Medicine and will work closely with the Medical Directors of each of the five Academic Hospitalist programs. We are seeking a candidate that combines academic and leadership experience. The faculty position is at the Associate or Professor level. Competitive compensation based on qualifications and experience.

Requirements: Board Certified in Internal Medicine, significant experience managing a Hospitalist Program, and highly experienced as a practicing Hospitalist.

Interested candidates should submit their curriculum vitae, a brief letter outlining their interests and the names of three references to:

Wishwa Kapoor, MD
c/o Kathy Nosko
200 Lotusport Street
933 West MUH
Pittsburgh, PA 15213
Noskoka@umpc.edu
Fax 412-692-4825
EO/AA/M/F/Vets/Disabled

Legacy Health
Portland, Oregon

At Legacy Health, our legacy is doing what’s best for our patients, our people, our community and our world. Our fundamental responsibility is to improve the health of everyone and everything we touch—create a legacy that truly lives on.

Ours is a legacy of health and community. Of respect and responsibility. Of quality and innovation. It’s the legacy we create every day at Legacy Health.

And, if you join our team, it’s yours.

Located in the beautiful Pacific Northwest, Legacy is currently seeking experienced Hospitalists to join our dynamic and well established yet expanding Hospitalist Program. Enjoy unique staffing and flexible scheduling with easy access to a wide variety of specialists. You’ll have the opportunity to participate in inpatient care and teaching of medical residents and interns.

Successful candidates will have the following education and experience:

- Graduate of four-year U.S. Medical School or equivalent
- Residency completed in IM or FP
- Board Certified in IM or FP
- Clinical experience in IM or FP
- Board eligible or board certified in IM or FP

The spectacular Columbia River Gorge and majestic Cascade Mountains surround Portland. The beautiful ocean beaches of the northwest and fantastic skiing at Mt. Hood are within a 90-minute drive. The temperate four-season climate, spectacular views and abundance of cultural and outdoor activities, along with five-star restaurants, sporting attractions, and outstanding schools, make Portland an ideal place to live.

As a nationally known and respected health care provider, Legacy Health offers an outstanding work environment, competitive salary and comprehensive benefits. Learn more about us and apply on our website at www.legacyhealth.org. For additional information please contact Forrest Brown at (503) 415-5982 or toll free, (866) 888-4428. Email: fobrown@lhs.org

AA/EOE/VETS/Disabled

Our legacy is yours.

We are an expanding, progressive, not-for-profit community health system with a 210-bed hospital, and numerous satellite facilities throughout southern coastal Delaware.

- Hospitalists, BC/BE, experience a plus
- 7/12 week pay period
- Employed within multi-specialty hospital network
- Base salary plus incentive and comprehensive benefits package
- Long established Hospitalist program with solid team in Beebe managed hospital with optional off-site locations

Close to Baltimore, DC, Philly, NYC, family-entered Southern Delaware Beach Resort areas among Top 10 Beaches/Boardwalks by Southern Living, Coastal Living, and American Hotel & Restaurant Guide. Standard vacation and holiday packages, paid malpractice and insurance, and American Hotel & Restaurant Guide.

Visit www.the-hospitalist.org to view additional physician opportunities.

University of Pittsburgh, Legacy Health, and UPMC are equal opportunity employers.

Legacy is an equal opportunity employer, a drug-free workplace, and a smoke-free environment.

For additional information please contact Forrest Brown at (503) 415-5982 or toll free, (866) 888-4428. Email: fobrown@lhs.org

AA/EOE/VETS/Disabled

Visit www.the-hospitalist.org for more information.

Physicians, you’re just one click away from your next job with the new SHM Career Center

You’ve never had a more powerful ally in making your next career move. The new SHM Career Center is designed for busy doctors. Now you can:

- Create job alerts
- Save your jobs
- Quickly search for jobs on your smartphone — works seamlessly!

Create a candidate profile and get matched to your ideal job

To learn more, visit www.the-hospitalist.org and click “Advertise” or contact

Heather Girondzki • 973-390-8289 • hgirondzki@frontlinemedcom.com or Linda Wilson • 973-390-8243 • lwilson@frontlinemedcom.com

Find your next job today. Visit www.shmcareers.org

Find your next job today. Visit www.shmcareers.org

www.the-hospitalist.org | JUNE 2017 | THE HOSPITALIST | 31
Nocturnists are supported by physician and NP/PA swing shift staff, PA providers.

**The Opportunity:**
Nocturnist and staff positions: We are seeking BC/BE IM or FM physicians to work in a team environment with NP and PA providers.

Central Maine Medical Center has served the people of Maine for more than 125 years. We are a 250 bed tertiary care facility that attracts regional referrals and offers a comprehensive array of the highest level healthcare services to approximately 400,000 people in central and western Maine. Our experienced and collegial hospitalist group cares for over half of the inpatient population and is proud of our high retention rate and professionalism.

**Culture of Caring:**
Central Maine Medical Center is a place where we get involved. Nocturnist and staff positions. We are seeking BC/BE IM or FM physicians to work in a team environment with NP and PA providers.

**The Opportunity:**
Nocturnist and staff positions: We are seeking BC/BE IM or FM physicians to work in a team environment with NP and PA providers.

**What we can do for you:**
Welcome you to a motivated, highly engaged, outstanding group that offers a competitive compensation package with moving expense reimbursement, student loan assistance and generous sign-on bonus.

**Culture of Caring:**
Central Maine Medical Center has served the people of Maine for more than 125 years. We are a 250 bed tertiary care facility that attracts regional referrals and offers a comprehensive array of the highest level healthcare services to approximately 400,000 people in central and western Maine. Our experienced and collegial hospitalist group cares for over half of the inpatient population and is proud of our high retention rate and professionalism.

**The Opportunity:**
Nocturnist and staff positions: We are seeking BC/BE IM or FM physicians to work in a team environment with NP and PA providers.

Nocturnists are supported by physician and NP/PA swing shift staff, full-time hours are reduced and compensation is highly incented. We also offer:
- The opportunity to expand your professional interests in areas such as our nationally recognized Palliative Care team and award-winning Quality Improvement initiatives.
- Encouragement of innovation and career growth at all stages starting with mentoring for early hospitalists, and progressing to leadership training and opportunities.
- The only Hospital Medicine Fellowship in northern New England with active roles in fellow, resident and medical student education.

**What we can do for you:**
Welcome you to a motivated, highly engaged, outstanding group that offers a competitive compensation package with moving expense reimbursement, student loan assistance and generous sign-on bonus.

We also value your time outside of work, to enjoy the abundance of outdoor and cultural opportunities that are found in our family-friendly state. Check out our website: [www.cmmc.org](http://www.cmmc.org). And, for more information, contact Julia Lauver, CMMC Medical Staff Recruitment at JLauver@cmhc.org, #800/445-7431 or 207/755-5854 (fax).

**Culture of Caring:**
Central Maine Medical Center has served the people of Maine for more than 125 years. We are a 250 bed tertiary care facility that attracts regional referrals and offers a comprehensive array of the highest level healthcare services to approximately 400,000 people in central and western Maine. Our experienced and collegial hospitalist group cares for over half of the inpatient population and is proud of our high retention rate and professionalism.

**The Opportunity:**
Nocturnist and staff positions: We are seeking BC/BE IM or FM physicians to work in a team environment with NP and PA providers.

Nocturnists are supported by physician and NP/PA swing shift staff, full-time hours are reduced and compensation is highly incented. We also offer:
- The opportunity to expand your professional interests in areas such as our nationally recognized Palliative Care team and award-winning Quality Improvement initiatives.
- Encouragement of innovation and career growth at all stages starting with mentoring for early hospitalists, and progressing to leadership training and opportunities.
- The only Hospital Medicine Fellowship in northern New England with active roles in fellow, resident and medical student education.

**What we can do for you:**
Welcome you to a motivated, highly engaged, outstanding group that offers a competitive compensation package with moving expense reimbursement, student loan assistance and generous sign-on bonus.

We also value your time outside of work, to enjoy the abundance of outdoor and cultural opportunities that are found in our family-friendly state. Check out our website: [www.cmmc.org](http://www.cmmc.org). And, for more information, contact Julia Lauver, CMMC Medical Staff Recruitment at JLauver@cmhc.org, #800/445-7431 or 207/755-5854 (fax).

**Culture of Caring:**
Central Maine Medical Center has served the people of Maine for more than 125 years. We are a 250 bed tertiary care facility that attracts regional referrals and offers a comprehensive array of the highest level healthcare services to approximately 400,000 people in central and western Maine. Our experienced and collegial hospitalist group cares for over half of the inpatient population and is proud of our high retention rate and professionalism.

**The Opportunity:**
Nocturnist and staff positions: We are seeking BC/BE IM or FM physicians to work in a team environment with NP and PA providers.

Nocturnists are supported by physician and NP/PA swing shift staff, full-time hours are reduced and compensation is highly incented. We also offer:
- The opportunity to expand your professional interests in areas such as our nationally recognized Palliative Care team and award-winning Quality Improvement initiatives.
- Encouragement of innovation and career growth at all stages starting with mentoring for early hospitalists, and progressing to leadership training and opportunities.
- The only Hospital Medicine Fellowship in northern New England with active roles in fellow, resident and medical student education.

**What we can do for you:**
Welcome you to a motivated, highly engaged, outstanding group that offers a competitive compensation package with moving expense reimbursement, student loan assistance and generous sign-on bonus.

We also value your time outside of work, to enjoy the abundance of outdoor and cultural opportunities that are found in our family-friendly state. Check out our website: [www.cmmc.org](http://www.cmmc.org). And, for more information, contact Julia Lauver, CMMC Medical Staff Recruitment at JLauver@cmhc.org, #800/445-7431 or 207/755-5854 (fax).
www.shmcareercenter.org
IM HOSPITALIST OPPORTUNITIES

Greenville Health System (GHS), the largest healthcare provider in South Carolina, seeks BC/BE Internal Medicine Physicians interested in opportunities as Hospitalists. These positions are located at Baptist Easley Hospital in Easley, SC. Surrounded by the Blue Ridge Mountains and many beautiful lakes, Easley is a quick 20-minute drive to downtown Greenville, SC, two hours to Charlotte and Atlanta, and less than 4 hours to the coast.

Qualified candidates should submit a letter of interest and CV to Sr. In-House Physician Recruiter, Kendra Hall, kbhall@ghs.org, 800-772-6987.

Highlights of the position:
• 8 physician team
• 7 on/off block schedule
• Competitive salary, incentive bonuses and premium pay for Nocturnists
• Additional shifts paid at a premium based on location and shift
• Minimal call schedule and rounding
• Ideal candidates are comfortable managing critically ill patients and are trained in IM procedures

Baptist Easley has been part of the upstate South Carolina community since 1958. As the primary healthcare service provider in Pickens County, our 109-bed general acute care facility provides services such as surgery, lithotripsy, MRI, CT Scan, and emergency and outpatient care, as well as cardiopulmonary services.

THE HOSPITALIST

So is the difference you can make.

Hospitalists

Minnesota and Wisconsin

Be part of something bigger at HealthPartners, where we focus on health as it could be, affordability as it must be, and relationships built on trust. HealthPartners Medical Group (HPMG) is a large, nationally recognized multi-specialty physician practice, based at clinics and hospitals throughout metropolitan Minneapolis/St. Paul, central Minnesota and western Wisconsin.

Our Hospital Medicine Department is seeking BC/BE IM or FM physicians to work in our high functioning, multi-disciplinary team environment. Whether you seek an urban, suburban, semi-rural or rural community practice, HPMG has a variety of opportunities within thriving family-oriented communities with top school systems, healthy economies, sports and theatre and bountiful lakes and outdoor recreation.

• Regions Hospital is our tertiary hospital and regional referral center in St. Paul. We are a major teaching affiliate for the University of Minnesota with a dedicated Hospital Medicine Pathway in their residency program.
• We are nocturnist-supported and have additional nocturnist opportunities available with pay differentials.
• We have a strong Advanced Practice Provider (APP) team and a dedicated APP fellowship training program.
• We have ample opportunities to expand your professional interests in palliative care, community hospital medicine, surgical co-management, telemedicine, research, quality improvement and medical education.
• Our hospital locations in western Wisconsin’s beautiful St. Croix River Valley offer community-based practices with convenient connections to metro area support.
• Our scheduling system offers flexibility, allowing for travel, CME and a good work-life balance.
• We offer a generous, competitive compensation and benefits package and an exciting practice within a prestigious, respected healthcare organization.

Apply online at healthpartners.com/careers or email your CV, letter and references directly to lori.m.fake@healthpartners.com. For more details, contact: Department Chair Jerome Sty, M.D., SFHM or Lori Fake at 800-472-4695, x1. H-1B visa eligible, EOE
HOSPITALIST OPPORTUNITY
Southwest Ohio

UC Health Hospitalist Group at West Chester Hospital seeking a board certified/prepared Internal Medicine or Family Medicine physician to join our growing Hospitalist group. West Chester Hospital is a community hospital, located just north of Cincinnati OH, with academic affiliation to the University of Cincinnati Health System.

Seeking candidates for a dedicated nocturnist position, 7p to 7a. Position is supported by 24hr Critical Care Services. The contractual obligation is for 12 shifts per month with opportunities/ incentives for additional shifts if desired. Excellent benefits and retirement packages through the UC Health and the UC College of Medicine. Faculty appointed position at UC College of Medicine with hire. Qualified candidate must be ACLS certified.

CONTACT:  Dr. Brad Evans, Director
UC Health Hospitalist Group
513-298-7325
evansb7@ucmail.uc.edu

Physicians, you’re just one click away from your next job with the new SHM Career Center
You’ve never had a more powerful ally in making your next career move. The new SHM Career Center is designed for busy doctors. Now you can:
• Create job alerts
• Save your jobs
• Quickly search for jobs on your smartphone — works seamlessly!
Create a candidate profile and get matched to your ideal job

To learn more, visit www.the-hospitalist.org and click “Advertise” or contact
Heather Gonroski • 973.290.8259 • hgonroski@frontlinemedcom.com or Linda Wilson • 973.290.8243 • lwilson@frontlinemedcom.com

Visit www.shmcareers.org
Find your next job today.
The University of Missouri-Columbia, Division of Hospital Medicine is seeking individuals who are committed to this goal and our core campus values of respect, responsibility, discovery and excellence. The University of Missouri is fully committed to achieving the goal of a diverse and inclusive academic community of faculty, staff and students. We also offer a low cost of living and excellent schools. This is a comprehensive hospital academic health system. We seek applicants who have exemplary clinical skills and a strong interest in teaching. This position comes with a competitive salary, benefits, and work hours. We seek applicants whom areavailable in Cardiology, Cancer Care and Orthopedics. It is the intent of the Department of Internal Medicine that faculty in Hospital Medicine will set the standard for teaching in patient care. Both day and nocturnist interest welcomed. Highlights of the position include:

- Salaries which are competitive with private hospitalist groups in Dallas and exceed academic programs elsewhere
- Faculty appointment at a top 20 medical school and research center that is home to 5 Nobel Prize winners
- Relocation allowance
- 403 (b), 457 and state-matched retirement accounts
- Team based approach with individual dedicated support
- Dedicated advanced practice providers, pharmacists and discharge planners

Qualified applicants should submit a cover letter, curriculum vitae, three (3) letters of reference, and a summary of professional goals to:
Jonathan Weissler, M.D.
c/o Larry Hughes
UT Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, TX 75390-9175
larry.hughes@utsouthwestern.edu

The University of Missouri is An Equal Opportunity/Access/Affirmative Action/Minorities/Di enabled & Veteran Employer. To request ADA accommodations, please contact Syed Naqvi, Director, Division of Hospital Medicine (hospitalist@health.missouri.edu) or for more information visit our web-site at www.bassett.org

Debra Ferrari, Manager, Medical Staff Recruitment
bassetthealthcare@bassett.org

University Hospitals, is seeking physicians to join a thriving academic hospital medicine program at the new William J. Clements University Hospital. This state of the art facility is the flagship of UT Southwestern’s clinical and educational programs in dynamic and cosmopolitan Dallas, Texas. Applicants must have an M.D. degree, or equivalent, from an approved LCME medical school and satisfactory completion of an Internal Medicine residency program from an ACGME accredited program. Level of appointment will be commensurate with experience. Candidate must be eligible for Texas medical licensure and be board certified in Internal Medicine. Hospitalists will play a vital role in teaching medical students and house officers, as well as serving on non-teaching inpatient services. It is the intent of the Department of Internal Medicine that faculty in Hospital Medicine will set the standard for scholarship in patient care. The University of Texas Southwestern Medical Center, Department of Internal Medicine, Division of Hospital Medicine, University Hospitals, is seeking physicians to join a thriving academic hospital medicine program at the new William J. Clements University Hospital. This state of the art facility is the flagship of UT Southwestern’s clinical and educational programs in dynamic and cosmopolitan Dallas, Texas. Applicants must have an M.D. degree, or equivalent, from an approved LCME medical school and satisfactory completion of an Internal Medicine residency program from an ACGME accredited program. Level of appointment will be commensurate with experience. Candidate must be eligible for Texas medical licensure and be board certified in Internal Medicine. Hospitalists will play a vital role in teaching medical students and house officers, as well as serving on non-teaching inpatient services. It is the intent of the Department of Internal Medicine that faculty in Hospital Medicine will set the standard for scholarship in patient care.

For confidential consideration, please contact Debra Ferrari, Manager, Medical Staff Recruitment bassetthealthcare@bassett.org or for more information visit our web-site at www.bassett.org

To apply for this position, please visit the MU web site at hrs.missouri.edu/Find-a-job/academic/ For additional information about the position, please contact Syed Naqvi, Director, Division of Hospital Medicine (hospitalist@health.missouri.edu) or for more information visit our web-site at www.bassett.org

Find your next job today! Visit www.shmcareers.org

Mount Auburn Hospital is searching for a physician to serve as a NOCTURNIST academic hospitalist. The selected candidate will provide clinical care and teaching of medical students and medical residents in a busy community teaching hospital, both on the inpatient medical floors and the step down unit. There will be opportunity for leadership of some aspect of the teaching program such as the inpatient medical consult rotation for medical residents. The selected candidate will receive a Harvard Medical School faculty appointment commensurate with their experience. We are an Equal Opportunity Employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law. We strongly encourage both women and minorities to apply.

Applicants should send CV and a brief cover letter to: searchco@mah.harvard.edu, or fax to: 617-499-5620.

UNIVERSITY OF MISSOURI

Academic Hospitalists

The University of Missouri-Columbia, Division of Hospital Medicine is seeking full-time academic Hospitalists to join our well-established program. Our rapidly growing hospitalist group provides inpatient support for a multi-specialty hospital. We seek applicants who have exemplary clinical skills and a strong interest in teaching. The University of Missouri is consistently rated a top place to live by Forbes, NY Times and Money magazine. Columbia is rated by Forbes as an “A+” best small place for business and careers in America and is consistently rated a top place to live by Money magazine. Columbia also offers a low cost of living and excellent schools. This is a comprehensive, department, offering a full complement of fellowship programs.

The University of Missouri is fully committed to achieving the goal of a diverse and inclusive academic community of faculty, staff and students. We seek individuals who are committed to this goal and our core campus values of respect, responsibility, discovery and excellence. To apply for this position, please visit the MU web site at hrs.missouri.edu/Find-a-job/academic/. For additional information about the position, please contact Syed Naqvi, Director, Division of Hospital Medicine (hospitalist@health.missouri.edu) or for more information visit our web-site at www.bassett.org

To apply for this position, please visit the MU web site at hrs.missouri.edu/Find-a-job/academic/. For additional information about the position, please contact Syed Naqvi, Director, Division of Hospital Medicine (hospitalist@health.missouri.edu) or for more information visit our web-site at www.bassett.org

Mount Auburn Hospital is searching for a physician to serve as a NOCTURNIST academic hospitalist. The selected candidate will provide clinical care and teaching of medical students and medical residents in a busy community teaching hospital, both on the inpatient medical floors and the step down unit. There will be opportunity for leadership of some aspect of the teaching program such as the inpatient medical consult rotation for medical residents. The selected candidate will receive a Harvard Medical School faculty appointment commensurate with their experience. We are an Equal Opportunity Employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law. We strongly encourage both women and minorities to apply.

Applicants should send CV and a brief cover letter to: searchco@mah.harvard.edu, or fax to: 617-499-5620.
**Hospitalist or Nocturnist**  
Montgomery County, PA

Now is a great time to join Einstein Physicians, part of Einstein Healthcare Network! We are a patient-centric and physician-led multispecialty practice of more than 500 physicians with a very broad scope of services and striving to be the premier practice in Philadelphia. We are offering the opportunity for you to become part of our team and build a successful, meaningful career alongside an extraordinary group of physicians and staff.

Einstein Medical Center Montgomery (EMCM) seeks candidates for Hospitalist and Nocturnist positions. EMCM is located on 87 acres along Germantown Pike in East Norriton, PA, and was built from the ground up around patient comfort, safety and the demands of evolving medical technology.

Candidates must be physicians who are board-certified/board-eligible in Internal Medicine and who wish to join our practice on a full-time basis. We offer H-1B/Green Card sponsorship if requested, and some of our practices qualify for J-1 waivers.

If you are a dedicated, energetic and ambitious Hospitalist, learn more by sending your CV to hannanki@einstein.edu or by calling Kimberly Hannan at (267) 421-7435.

---

**Self Medical Group**

**Hospitalist & Nocturnist**  
Beautiful Greenwood, SC

Based in Greenwood, SC, Self Medical Group is multi-practice, multi-specialty group is seeking a BE/BC Hospitalist and BE/BC Nocturnist for an expanding practice. Self Regional Healthcare is a 300 bed non-for-profit, DNV accredited facility providing a wide range of specialty services to our surrounding communities.

- Work a 7on/7off, 12 hour schedule with no call
- Excellent work-life balance with comfortable patient volumes
- Intensivist provides majority ICU care
- EPIC EMR 2018
- Competitive salary package and benefits including sign on bonus and student loan repayment
- Self Regional, a nine-time Gallup Great Workplace Award recipient (2008-2016)

**About Greenwood, S.C.:**  
Just an hour from Columbia and Greenville, Greenwood, or as it is called the “Emerald City,” offers a temperate climate, year-round golf and recreation and lakeside living at pristine Lake Greenwood. It is also home to the S.C. Festival of Flowers, a celebration of flora that features larger-than-life size topiaries during the month of June.

Please contact Twyla Camp, Physician Recruiter at 864-725-7029 or tcamp@selfregional.org

---

**US Acute Care Solutions**

A mouthwatering offer for every HM physician.  
A slice of ownership.

When you’re an owner in the group you practice with, life is delicious. We’re all physician owners in the group we call home: US Acute Care Solutions. Our house stretches coast to coast, and it’s filled with HM and EM physicians who are working together to provide the best care to patients, and the best solutions to our hospital partners. By giving every full-time USACS physician ownership in our group, we all share in the fruits of our labor—and that’s good for our patients, partners, and our future. Discover one of the largest, fastest growing acute care providers in the country, and learn how you can get a slice of the pie at USACS.com/HMjobs.

Visit usacs.com/HMjobs
or call us at 1-844-863-6797. usacs@usacs.com

---

**Physicians,** you’re just one click away from your next job with the new SHM Career Center

You’ve never had a more powerful ally in making your next career move. The new SHM Career Center is designed for busy doctors. Now you can:
- Create job alerts
- Save your jobs
- Quickly search for jobs on your smartphone — works seamlessly!

Create a candidate profile and get matched to your ideal job

To learn more, visit www.the-hospitalist.org and click “Advertise” or contact Heather Gonzoski • 973-290-8289 • hgonroski@frontlinemedcom.com or Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

---

Make your next smart move. Visit [www.shmcareercenter.org](http://www.shmcareercenter.org)

---

Visit [www.the-hospitalist.org](http://www.the-hospitalist.org) and click “Advertise” or contact Heather Gonzoski • 973-290-8289 • hgonroski@frontlinemedcom.com or Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com
A case for building our leadership skills

Let me ask you a question: When was the last time you used the Krebs cycle in the hospital? Now another question: When did you last have to persuade your boss to give you additional resources? My guess is that your need for additional resources comes up more frequently than the Krebs cycle. It's interesting that we spent so much time in our training focused on biochemical pathways and next to nothing on leadership skills, such as ways to motivate our health care teams or the most effective way to provide feedback—skills that we use on a regular basis. Yet, these skills are just as critical as understanding the science behind our daily work.

I'll give you an example. I've been involved in quality improvement and operational work for a decade, so I often find myself in front of groups of health care professionals convincing them to implement new pathways and protocols. In the past, I would present my case in the following way:

1. Highlight the importance of the ask.
2. Leverage data to prove the point.
3. Illustrate large-scale implications of the ask.
4. Make the ask.

I'll use a project to increase deep vein thrombosis prophylaxis (DVT) rates to illustrate this point:

1. Highlight the importance of DVT prophylaxis: I would focus on statistics that would surprise the audience, such as "Worldwide, only 40%-60% of patients requiring DVT prophylaxis actually receive it in the hospital." Our performance leaves tremendous room for improvement—"we're currently at 68%.
2. Leverage data to prove the point: "Worldwide, only 40%-60% of patients requiring DVT prophylaxis actually receive it in the hospital." Our performance leaves tremendous room for improvement—"we're currently at 68%.
3. Illustrate large-scale implications of the ask: "If we do this, it enhances our reputation as a group, and it will improve hospital revenues." Connect with the audience in a genuine way: Instead of highlighting the importance of the ask with statistics, use an attention getter to connect with the group. Highlighting the fact that the group is "quality-minded" and has surmounted challenging obstacles in the past reinforces the providers' sense of identity. This helps the group think more openly about the proposal.

Make the ask: Now that you've captured their attention, make your ask, clearly and concisely, upfront. Remember, in today's health care settings, we have short attention spans. You're minutes away from someone getting paged away from the meeting or people checking their emails or the latest Facebook post. Don't schedule the protocol review as the last item on the agenda.

Leverage data to prove your point: Data are powerful, but only if presented in the right way. Use questions to keep your audience engaged ("What do you think our numbers are?"), particularly around data, where most people decide to switch their attention to their smartphones. Based on your access to data sources, find another unit or institution with a higher performance than yours. State that upfront. It anchors the group to a higher number, so, when you reveal your current performance, the gap is highlighted.

In the first case, when the lower national average of 40%-60% is presented initially, the group will be happy that their performance is in fact better at 68%.

Illustrate large-scale implications of the ask: There are two concepts at work here: First, loss aversion. We tend to experience greater psychological burden with losses versus gains. Changing the framing from the fact that the hospital will lose money, versus making money in the first case, changes how we perceive the information. Second, active choice. Emphasizing that a decision has to be made today, and giving the group a choice around it, increases the likelihood of walking out of the meeting with a decision.

With some simple, yet thoughtful, modifications, the message takes on more effective tone, and, based on my experience, it is significantly more impactful.

So, while I'm a fan of biochemical pathways that enable us to generate energy, I also hope we can integrate leadership lessons into our day-to-day learning and life.

References

5. Ilyaf/Thinkstock
Will artificial intelligence make us better doctors?

Gating factors: Data availability, signal, noise.

Given the amount of time physicians spend entering data, clicking through screens, navigating pages, and logging into computers, one would have hoped that substantial near-term payback for such efforts would have materialized. Many of us believed this would take the form of health information exchange—the ability to easily access clinical information from hospitals or clinics other than our own, creating a more comprehensive picture of the patient before us. To our disappointment, true information exchange has yet to materialize. (We won’t debate here whether politics or technology is culpable.) We are left to look elsewhere for the benefits of the digitization of the medical records and other sources of health care knowledge.

Lately, there has been a lot of talk about the promise of machine learning and artificial intelligence (AI) in health care. Much of the resurgence of interest in AI can be traced to IBM’s appearance as a contestant on Jeopardy in 2011. Watson, a natural language supercomputer with enough power to process the equivalent of a million books per second, had access to 200 million pages of content, including the full text of Wikipedia, for Jeopardy. Watson handily outperformed its human opponents—two Jeopardy savants who were also the most successful contestants in game show history—taking the $1 million first prize but struggling in categories with clues containing only a few words.

MD Anderson and Watson: Dashed hopes follow initial promise

As a result of growing recognition of AI’s potential in health care, IBM began collaborations with a number of health care organizations to deploy Watson.

In 2013, MD Anderson Cancer Center and IBM began a pilot to develop an oncology clinical decision support technology powered by Watson to aid MD Anderson in its mission to eradicate cancer. Recently, it was announced that the project—which cost the cancer center $62 million—has been put on hold, and MD Anderson is looking for other contractors to replace IBM.

While administrative problems are at least partly responsible for the project’s challenges, the undertaking has raised issues with the quality and quantity of data in health care that call into question the ability of AI to work as well in health care as it did on Jeopardy, at least in the short term.

Health care: Not as data rich as you might think

“We are not ‘Big Data’ in health care, yet.”—Dale Sanders, Health Catalyst

In its quest for Jeopardy victory, Watson accessed a massive data storehouse subsuming a vast array of knowledge assembled over the course of human history. Conversely, for health care, Watson is limited to a few decades of scientific journals (that may not contribute to diagnosis and treatment as much as one might think), claims data geared to billing without much clinical information like outcomes, and clinical data from progress notes (plagued by inaccuracies, serial “copy and paste,” and nonstandardized language and numeric representations), and variable-format reports from lab, radiology, pathology, and other disciplines.

To articulate how data-poor health care is, Dale Sanders, executive vice president for software at Health Catalyst, notes that a Boeing 787 generates 500 GB of data in a 6 hour flight while one patient may generate just 100 MB of data in an entire year. He said that AI platforms like Watson currently do not have enough data substrate to impact health care as many hoped it would. Over the longer term, he says, if health care can develop a coherent, standard approach to data content, AI may fulfill its promise.

What can AI and related technologies achieve in the near-term?

“AI seems to have replaced Uber as the most talked about in AI in health care, yet.”—Reporter Stephanie Bau, paraphrasing from an interview with Bob Kocher, Venrock Partners.

My observations tell me that we have already made some progress and are likely to make more strides in the coming years, thanks to AI, machine learning, and natural language processing. A few areas of potential gain are:

Clinical documentation

Technology that can derive meaning from words or groups of words can help with more accurate clinical documentation. For example, if a patient has a documented UTI but also has in the record an 11 on the Glasgow Coma Scale, a systolic BP of 90, and a respiratory rate of 24, technology can alert the physician to document sepsis.

Quality measurement and reporting

Similarly, if technology can recognize words and numbers, it may be able to extract and report quality measures (for example, an ejection fraction of 35% in a heart failure patient) from progress notes without having a nurse-abstractor manually enter such data into structured fields for reporting, as is currently the case.

Predicting readmissions, mortality, other events

While machine learning has had mixed results in predicting future clinical events, this is likely to change as data integrity and algorithms improve. Best-of-breed technology will probably use both clinical and machine learning tools for predictive purposes in the future.

In 2015, I met Vinod Khosla, cofounder of SUN Microsystems and venture capitalist, who predicts that computers will largely supplant physicians in the future, at least in domains relying on access to data. As he puts it, “the core functions necessary for complex diagnoses, treatments, and monitoring will be driven by machine judgment instead of human judgment.”

While the benefits of technology, especially in health care, are often overstated, I believe AI and related technologies will some day play a large role alongside physicians in the care of patients. However, for AI to deliver, we must first figure out how to collect and organize health care data so that computers are able to ingest, digest, and use it in a purposeful way.

Disclosures: Dr. Whitcomb is founder and adviser to Zato Health, which uses natural language processing and discovery technology in health care.

References

DO YOU KNOW A LEADER WHEN YOU SEE ONE?

We do too.

Leaders challenge convention and turn ideas into action.

Whether your leadership goals are large or small, CEP America will be there with you every step of your journey.

DOWNLOAD YOUR OWN LEADERSHIP GROWTH GUIDE AT: go.cep.com/YourJourney