Managing hospital- and ventilator-associated pneumonia

Recommendations updated from IDSA and ATS

By Joseph A. Hippensteel, MD, and Jeffrey M. Sippel, MD, MPH

Background
Hospital-acquired pneumonia (HAP) is defined as pneumonia that develops 48 hours or more after admission and that was not present on admission. Ventilator-associated pneumonia (VAP) is pneumonia that develops 48 hours or more after endotracheal intubation.

HAP and VAP are common afflictions in hospitalized patients, accounting for nearly one-quarter of all hospital-acquired infections. They confer mortality rates of 24%-50%, increasing to nearly 75% if caused by resistant organisms.1,2 Given the high prevalence and significant mortality associated with these types of pneumonia, diagnosis and treatment are essential. Treatment must be balanced against potential unintended consequences of antibiotic use including Clostridium difficile infections and the promotion of resistant bacteria caused by poor antibiotic stewardship.

Given the frequency with which HAP and VAP occur, and the need for equipoise with antibiotic use, it is essential that all practicing clinicians have an evidence-based construct for the diagnosis and treatment of HAP and VAP.
Immigration reforms: Repercussions for hospitalists and the health care industry

By Venkatrao Medarametla, MD, and Mohan Ramkumar Pamerla, MD

International medical graduates (IMGs) have been playing a crucial role in clinician staffing needs for U.S. hospitals, especially in hospital medicine and internal medicine. According to a study, IMGs compose 25% of the total U.S. physician workforce and 36% of internists.1 According to data from the 2008 survey of the Hospitalist Compensation & Career Survey, 32% of practicing hospitalists are IMGs.3 Many IMGs come to work in the United States via one of three paths. Just like all roads lead to Rome, all visas lead to a permanent residency pathway, eventually based on the country of origin and number of years waiting. The first path is a green card – cases where IMGs were on a visa and within a certain amount of time they received a green card. The second path is the process of H-1B allocation more efficient and ensure the beneficiaries of the program are the best and the brightest.” and also suggesting "extreme vetting.” Congress set the current annual cap for the H-1B visa category at 85,000. The majority (79%) of H-1B visas will go to technology, engineering, and computer-related occupations. Medicine and health-related H-1B applications are only 5% of total H-1B visas approved.2 Most of the H-1B reforms are aimed at the technology industry, but hospitalists happen to be in the same candidate pool, and this might be a good time to consider whether hospitalists and other clinicians should be separated from this pool.

The Department of Homeland Security has considered creating another visa pathway for the technology industry, whereby an alien graduating from a U.S. university with an advanced degree in a STEM discipline would receive a new visa and pathway to permanent residency. This step would be able to work in different hospitals. They would also be able to move to remote places, or “doctor deserts,” and offer their services, helping to ensure the quality and safety of patient care to which all Americans are entitled.

With an expedited pathway to a green card, hospitalists would be able to work in different hospitals. They would also be able to move to remote places, or “doctor deserts,” and offer their services, helping to ensure the quality and safety of patient care to which all Americans are entitled.

J-1 visa waivers for physicians who trained in the United States under a J-1 Visa. Typically, physicians on J-1 Visa waivers need to provide their services for a minimum of 3 years working in underserved areas – where there’s a shortage of health professionals – before they can apply for permanent residency.

The third and most popular path is the H-1B visa, which hospitalists traditionally use as a springboard to apply for permanent residency. Studies have shown that IMGs are more likely to practice medicine in rural and underserved areas. In many instances, physicians end up working in these areas for long periods of time.4 There has been an ongoing national debate on immigration reform and revamping the H-1B visa process since President Trump first issued an executive order directing the Secretary of Homeland Security to consider ways to "make

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The third and most popular path is the H-1B visa, which hospitalists traditionally use as a springboard to apply for permanent residency. This step benefits both the U.S. health care system and hospitalists in many ways. It increases hospitalists’ portability and flexibility with schedules. With a traditional H-1B visa, hospitalists are bound to work with the one hospital/system that sponsors the H-1B, and would not be able to work at any other hospital without another extension/addendum to current visa status, even in cases where a physician had time off and would like to offer services at another facility. It is a well-known fact that hospitalist teams are understaffed and try to bring on per-diem staff to fill holes in schedules.

The majority of hospitals are working week-on-week-off schedules, and with an expedited pathway to a green card, they would be able to work in different hospitals.
Crossing the Personal Quality Chasm: QI enthusiast to QI leader
An early interest in finding solutions shapes a prosperous career in QI and research

By Claudia Stahl

Editor’s Note: This ongoing series highlights the professional pathways of quality improvement leaders. This month features the story of Luci Leykum, MD, division chief, general and hospital medicine at the University of Texas Health Science Center, San Antonio.

Luci Leykum, MD, MBA, MSc, FACP, SFHM, became familiar with inpatient medicine at age 9 years, when her grandfather contracted non-AB hepatitis from a postoperative blood transfusion. In the ensuing years, Dr. Leykum visited her grandfather during hospitalizations, keeping a close watch on the physicians charged with his care.

“When it was HIV and what we now think is hep C were just emerging, and there was a lot to figure out,” Dr. Leykum reflected on her experiences. Her keen observations led to a life-changing, “how did we get here?” moment.

“I was amazed at how things in the hospital system could work so well and so poorly at the same time and [at] how many [processes] weren’t useful to clinicians or patients,” said Dr. Leykum, “and how decisions were made around standards and metrics for the system as a whole and for its multiple individual hospital facilities.”

In 2004, 2 years out of residency, Dr. Leykum relocated to San Antonio to accept a clinician investigator position with the South Texas Veterans Health Care System/University of Texas Health Science Center San Antonio (UTHSCSA). Research, she said, has allowed her to delve deeper into the underlying mechanisms that impact systems of health care. She sees the complementary sides of quality improvement and research.

“Through our quality improvement initiatives, we can evaluate and improve specific aspects of care, in specific contexts or systems,” Dr. Leykum explained. “In our research projects, we look for new insights that can be more broadly applied across contexts. With funding, you are able to look at things with a scope, depth, or time horizon beyond what you typically have with a QI project.”

Since joining the UTHSCSA/VA system, Dr. Leykum has participated in more than 15 externally funded studies, 6 as principal investigator. She joined SHM’s research committee in 2009, serving as chair for 6 years, and is currently working with the committee to implement the Improving Hospital Outcomes Through Patient Engagement (i-HOPE) Study. i-HOPE, funded through the Patient-Centered Outcomes Research Institute, is a project to develop a patient- and stakeholder-partnered research agenda to improve the care of hospitalized patients. Dr. Leykum is also involved in implementing a collaborative care model at University Health System, a patient-partnered, interprofessional model that “focuses on improving interconnections, relationships, and sense making,” in the hospital system, she explained. “It was motivated strongly by our desire to improve our partnerships with patients and other providers in the hospital as a strategy to improve care.”

In addition to the many professional responsibilities she manages as division chief of general and hospital medicine at UTHSCSA – a position she has held for hospital medicine since 2006 and for the combined division since 2016 – Dr. Leykum continues to play an integral role in multiple academic and research initiatives for SHM.

She encourages anyone considering a concentration in QI and research to seek opportunities to actively learn these skills and, more importantly, let other people know their interests.

“The value of talking with colleagues at other places is so high,” she said. “When you actively reach out, you find that most people are happy to share their knowledge. Networking is one of the best parts of the SHM annual meeting for me. There’s an energy and excitement in learning about what others are doing. Wander into the poster and special interest sessions and see what people are working on, get email addresses, and participate on committees.”

“I was amazed at how things in the hospital system could work so well and so poorly at the same time and [at] how many [processes] weren’t useful to clinicians or patients.”

– Luci Leykum, MD

Ms. Stahl is content manager at the Society of Hospital Medicine.
Future Hospitalist:
Top 10 tips for carrying out a successful quality improvement project

By Maria Anaizza Aurora Reyna, MD, FHIM; Alfred Burger, MD, FACP, SFHM; and Hyung J Cho, MD, FACP

Editor’s Note: This volume is a quarterly feature written by members of the Physicians in Training Committee. It aims to encourage and educate students, residents, and early-career hospitalists.

One of the biggest challenges early-career hospitalists, residents, and medical students face in launching their first quality improvement (QI) project is knowing how and where to get started. QI can be highly rewarding, but it can also take valuable time and resources without any guarantees of sustainable improvement. In this article, we outline 10 key factors that you should take into consideration when starting a new project.

1. Frame your project so that it aligns with your hospital’s current goals

When choosing a project, keep your hospital’s goals in mind. Securing resources such as health IT, financial, or staffing support will prove difficult unless you get buy-in from hospital leadership. If your project does not directly address hospital goals, frame the purpose to demonstrate that it still fits with leadership priorities. For example, though improving handoffs from daytime to nighttime providers may not be a specific goal, leadership should appreciate that this project is expected to improve patient safety.

2. Be SMART about goals

Many QI projects fail because the scope of the initial project is too large, unrealistic, or vague. Creating a clear and focused aim statement and keeping it “SMART” (Specific, Measurable, Achievable, Realistic, and Timely) will bring structure to the project.1 We will reduce Congestive Heart Failure readmissions on five medicine units at our hospital by 2.5% in 6 months2 is an example of a SMART aim statement.

3. Involve the right people from the start

QI project disasters often start because team members were poorly chosen. Select members based on who is needed and not on who is available. It is critical to include representatives or “champions” from each area that will be affected. People will buy into a new methodology much more quickly if they are engaged in its development or if they know that respected members in their area are involved.

4. Use a simple, systematic approach to guide improvement work

Various QI models exist, and each offers a systematic approach for assessing and improving care services. The Model for Improvement developed by the Associates in Process Improvement is a simple and powerful framework for quality improvement that asks three questions:3

1. What are we trying to accomplish with this service? (2) How will we know a change is an improvement, rather than a setback? (3) What changes can we make that will result in further improvement?

The model incorporates Plan-Do-Study-Act (PDSA) cycles to test changes on a small scale.

5. Start with good background data for good projects

As with patient care, you must gather baseline information before prescribing any solutions, in order to improve a service’s “health status.” Anecdotal information helps, but, to accurately assess baseline performance, you need details and data. Data will determine the need for improvement, as well as the scope of your project. Use QI tools, such as process mapping or a fishbone diagram, to identify potential causes of error in a new or ongoing project.3

6. Choose interventions that are high impact, low effort

People will more easily change if the change itself is easy. So consider the question: “Does this intervention add significant work?” The best interventions change a process without causing undue burden to the clinicians and staff involved.

7. Can’t you improve it if you can’t measure it?

After implementation, collect enough data to know whether or not the changes made improved the process. Study outcome, process, and balancing measures. If possible, use data that are already being collected by your institution. While it is critical to have quantitative measures, qualitative data, such as surveys and observations, can also enrich understanding.

For example, your hospital wants to improve early discharge rates in a medical unit. Outcome measure: This is the desired outcome that the project aims to improve.

“May be the percentage of discharges before noon (DBN) or the average discharge time. Process measure: This is a measure of a specific change made to improve the outcome metric. The discharge orders may need to be placed earlier in the electronic medical record to improve DBN. This average discharge order time is an example of a process measure. Balance measure: This metric evaluates whether the intended outcome is leading to unintended consequences. For example, tracking the readmission rate is an important balance measure that allows you to assess whether improved DBN is associated with rushed discharges and possible unsafe transitions.

8. Communicate project goals and progress

Progress and changes need to be communicated effectively and repeatedly—do not assume that team members are all on the same page. Celebrate the achievement of intermediate goals and small successes to ensure the engagement and commitment of the team. Feedback and reminders help develop the momentum that is crucial for completing any long-term project.

9. Manage resistance to change

“People responsible for planning and implementing change often forget that, while the first task of change management is to understand the destination and how to get there, the first task of transition management is to convince people to leave home,” according to William Bridges.

Inertia is powerful. We may consider meaningful change. Inertia is powerful. We may consider meaningful change.

10. Make the work count twice

Consider QI as a scholarly initiative from the start, so as to bring rigor to the project at all phases. Describe the project in an abstract or manuscript once improvements have been made. Publication is a great way to boost team morale and help make a business case for future improvement work. The Standards for Quality Improvement Reporting Excellence (SQUIRE) guidelines provide an excellent framework for designing and writing up an improvement project for publication.4 The guidelines focus on why the project was started, what was done, what was found, and what the findings mean.

Driving change is challenging, and it is tempting to jump ahead to “fixing the problem.” But, implementing a successful QI project requires intelligent direction, strategic planning, and skillful execution. It is our hope that following the above tips will help you develop the best possible ideas and approach implementation in a systematic way, ultimately leading to meaningful change.

References
What I say and do

I find a way to connect with my patients to express sincere appreciation. A recent “Everything We Say and Do” column focused on an important element of high-impact physician-patient communication: closing the encounter by thanking the patient. Evidence suggests that patients feel more valued by their providers when appropriate thanks are offered. However, it is not always easy to find a genuine and sincere way to incorporate a “thank you” at the end of a visit.

WHY I DO IT

The physician-patient relationship is an inherently hierarchical one. Recognizing that the encounter represents a meeting of two people who equally stand to gain from the interaction goes a long way toward improving rapport, improving clinical evaluation, and enhancing the therapeutic effect.

HOW I DO IT

I don’t mean to imply that this task is easy for me; it’s not. I’m an introvert at heart who does not gravitate toward niceties and small talk – I don’t feel comfortable saying something if it is not genuine. But with a little effort and introspection, we can channel motivation for a meaningful appreciation of the many things our patients offer. Breaking out of the traditional mindset that the therapeutic relationship is a one-way street coming from the physician to patient as part of a professional duty, is the first step. Opening our eyes to the ways our patients also serve us helps draw the motivation for gratitude.

Many who don’t regularly experience serious illness firsthand take good health for granted. I appreciate my patients for reminding me to cherish my own good health. My patients offer me glimpses of hope as I watch them and their families rally through the trials that serious illness brings; in addition, they provide me inspiration and ideas for how I will handle these issues myself someday.

Some in other fields feel unfulfilled with their work as they contemplate their professional legacy. On the contrary, our patients validate our sense of purpose and strengthen our empathy for the greater human condition and enhance our personal relationships. Recalibrating my perspective makes it easier to have a genuine and sincere gratitude to patients, and enhances my ability to connect on a deeper level with those I serve.  

Dr. Seymann is clinical professor and vice chief for academic affairs, UCSD Division of Hospital Medicine.

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By Greg Seymann, 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.’”

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**IDSA/ATS guidelines**

**Guideline updates**

In 2016, the Infectious Diseases Society of America (IDSA) and the American Thoracic Society (ATS) reconvened after 11 years to update their recommendations for the treatment of HAP and VAP. The decision to update their recommendations was based on the availability of new evidence regarding the diagnosis and treatment of these conditions. Notably, these new guidelines have completely removed the entity of health care–associated pneumonia (HCAP), as these patients are not necessarily at high risk for resistant organisms, and most will present with their illness directly from the community. This update alone significantly changes the scope of these guidelines. HCAP likely will be addressed in future guidelines for community-acquired pneumonia. Included in this review are guideline updates on methods for diagnosis, initial antibiotic choice, and duration of therapy. The guidelines also have recommendations for pathogen-specific therapy and the role of inhalaed antibiotics and pharmacokinetic optimization of antibiotic dosing, which will not be reviewed here.

**Methods for Diagnosis:** The use of semiquantitative, noninvasive sampling of respiratory cultures is preferred for HAP and VAP, rather than empiric treatment or quantitative cultures (i.e., bronchoalveolar lavage, protected-specimen brush, and blind bronchial sampling).

**Initial antibiotic choice:** For HAP and VAP, clinicians should include therapy targeting Staphylococcus aureus, Pseudomonas aeruginosa, and other gram-negative bacilli. Therapy for methicillin-resistant S. aureus should be included if patients are at high risk for death (i.e., septic shock or ventilated patients) or if local drug-resistant prevalence is greater than 10%-20%. Similarly, two antipseudomonal antibiotics should be used with empiric therapy only if the patient is at high risk for mortality or local drug-resistant prevalence is greater than 10%.

**Duration of therapy:** HAP and VAP should be treated for 7 days with regimens that are tailored to culture data when available, assuming there has been appropriate clinical response. Procalcitonin may be paired with clinical judgment when considering antibiotic discontinuation.

**Guideline analysis:** There are several notable differences between the 2016 IDSA/ATS guidelines and the 2005 guidelines. The earlier guidelines recommended strong consideration of invasive respiratory cultures such as bronchoalveolar lavage or protected-specimen brush sampling for HAP/VAP. It is now recommended that only noninvasive cultures be performed in most clinical scenarios. Regarding Pseudomonas infections, the previous guidelines recommended consideration of an aminoglycoside combined with a beta-lactam antibiotic. The new guidelines recommend against the use of aminoglycosides because of their poor lung penetration, risk of ototoxic- and nephrotoxicity, and potential clinical inferiority when compared to nonaminoglycoside-containing regimens. In addition, a 14-day course of antibiotics had been recommended for the treatment of pseudomonal pneumonia, which has been changed to 7 days in the most recent guidelines. Lastly, the updated guidelines recommend dual therapy for potential or documented Pseudomonas infection only for patients at high risk for mortality or in hospitals with a high prevalence of antibiotic resistance; previously, dual-antipseudomonal therapy was recommended for all cases of HAP and VAP, based upon the risk of developing resistant strains with monotherapy. Since 2005, several organizations have released guidelines addressing the management of HAP and VAP. These are largely in keeping with the current version released by the IDSA/ATS. Across all guidelines, there is a focus on the importance of local antibiograms for appropriate and effective treatment, and the use of noninvasive culture data to guide therapy. Also, all groups recommend a short-course (7-8 days) of antibiotics for both HAP and VAP, assuming there has been an appropriate clinical response. The recent Canadian guidelines have one unique recommendation, which is to avoid the use of ceftazidime for suspected P. aeruginosa pneumonia, based upon inferior outcomes when compared to alternative regimens.

**Takeaways**

When considering the diagnosis of HAP and VAP, clinicians should be aware that the category of HCAP has been removed from current guidelines, and methods for microbiological diagnosis have been simplified. In addition, initial antibiotic selection should rely on institution-specific antibiograms and local resistance patterns when available. Recommended duration of therapy has been shortened, and should not include aminoglycosides. Finally, antibiotic stewardship is the responsibility of each clinician and de-escalation of therapy for HAP and VAP should be guided by available respiratory cultures.

Dr. Hippenstein is a pulmonologist in Aurora, Colo. Dr. Sippel is visiting associate professor of clinical practice, medicine-pulmonary sciences & critical care at the University of Colorado School of Medicine.

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Deadline for submissions is October 2, 2017.
METHODS: We interviewed a broad sample of patients during hospitalization and post discharge to elicit patient perspectives on breakdowns in care. Through an iterative process, we developed a categorization of patient-perceived breakdowns called the Patient Experience Coding Tool.

RESULTS: Of 979 interviewees, 386 (39.4%) believed they had experienced at least one breakdown in care. The most common reported breakdowns involved information exchange (n = 158; 16.1%), medications (n = 90; 9.2%), team communication (n = 65; 6.6%), providers’ manner (n = 62; 6.3%), and discharge (n = 56; 5.7%).

Of the 386 interviewees who reported a breakdown, 140 (36.3%) perceived associated harm. Patient-perceived harms included physical (e.g., pain), emotional (e.g., distress, worry), damage to relationship with providers, need for additional care or prolonged hospital stay, and life disruption.

We found higher rates of reporting breakdowns among younger (< 60 years old) patients (45.4% vs. 34.5%; P < .001), those with at least some college education (46.8% vs 32.7%; P less than .001), and those with another person (family or friend) present during the interview or interviewed in lieu of the patient (53.4% vs 57.8%; P = .002).

CONCLUSIONS: When asked directly, almost 4 out of 10 hospitalized patients reported a breakdown in their care. Patient-perceived breakdowns in care are frequently associated with perceived harm, illustrating the importance of detecting and addressing these events.

ALSO IN JHM THIS MONTH

Excess readmission vs. excess penalties: Maximum readmission penalties as a function of socioeconomic geography

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NEWS & NOTES

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

By Brett Radler

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Mr. Radler is communications specialist at the Society of Hospital Medicine.
In an effort to improve communication among clinicians and patients, the Cleveland Clinic’s Center for Excellence in Healthcare Communication (CEHC) created the Relationship Establishment, Development and Engagement (REDE) model. Vicente J. Velez, MD, FACP, FHM, a hospitalist who serves as the director of faculty enrichment for the leadership team of CEHC, said the model is based on decades of studies on health care communication. “It places a special focus on empathy in relationships, and in our case, the provider-patient relationship rather than patient-centered care. The former acknowledges that the thoughts and feelings in both sides of a relationship are important. We know that clinicians, too, can suffer as a result of the care they provide,” Dr. Velez wrote in “Communication the Cleveland Way.”

“Healthy relationships are based on balance and mutual respect,” Dr Velez said. “Courses made a strong point to practice empathy in order to teach empathy. Clinician participants were gifted with a safe space, an opportunity to share their own experiences.”

## Key skills for optimal patient communications

### Core principles: active listening, body language, empathy

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<tr>
<th>Key communication</th>
<th>Purpose</th>
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<tr>
<td><strong>The introduction:</strong> Establish rapport and trust through courtesy, diligence, and explanations</td>
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<tr>
<td>Knock and acknowledge patient by name</td>
<td>Shows courtesy and verifies identity of patient</td>
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<tr>
<td>Introduce yourself to patient and others in room</td>
<td>Shows respect for friends/family</td>
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<tr>
<td>Solicit patient’s preferred name</td>
<td>Shows commitment to patient-centered communication; engages patient</td>
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<tr>
<td>Sit down/be at eye level</td>
<td>Patient sees you are committed to listening carefully</td>
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<tr>
<td>Explain hospitalist role</td>
<td>Patient understands why you are caring for him or her</td>
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<tr>
<td>Explain connection to primary care physician</td>
<td>Assures patient that primary care physician will be kept informed</td>
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<tr>
<td>Inform patient you have reviewed chart/familiar with diagnosis</td>
<td>Shows that you are engaged in the patient’s care</td>
</tr>
<tr>
<td>Solicit patient/family goals for the visit/day</td>
<td>Shows commitment to patient-centered care</td>
</tr>
</tbody>
</table>

### The care: Solidify trust by being present, confirming understanding, and answering questions

<table>
<thead>
<tr>
<th>Key communication</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask permission to examine patient/share exam findings</td>
<td>Shows courtesy and respect/part of explanation</td>
</tr>
<tr>
<td>Clearly explain diagnoses and care plan in plain terms</td>
<td>Patient understands illness and your treatment</td>
</tr>
<tr>
<td>Confirm understanding using teach-back method</td>
<td>Allows you to address patient uncertainty and clarify plan</td>
</tr>
<tr>
<td>Confirm acceptance and agreement with care plan</td>
<td>Shows commitment to patient-centered care and patient autonomy</td>
</tr>
<tr>
<td>Set expectations for tests/results (timing/duration/delays)</td>
<td>Manages expectations regarding test timing and sharing of results</td>
</tr>
<tr>
<td>Set expectation for anticipated discharge/next site of care</td>
<td>Patient/family can begin to anticipate progress beyond hospital stay</td>
</tr>
<tr>
<td>Ask patient/family about other concerns</td>
<td>Opens door for patient/family to share questions, concerns, confusion</td>
</tr>
</tbody>
</table>

### The goodbye: Maintain trust by confirming your availability and intent to return

<table>
<thead>
<tr>
<th>Key communication</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set expectation for return visit</td>
<td>Patient knows when you will return</td>
</tr>
<tr>
<td>Use team brochure/business card (if patient is new to you)</td>
<td>Shows confidence in role and comfort with accountability</td>
</tr>
<tr>
<td>Accountability statement, such as, “It’s important to me that you get great care while you’re here”</td>
<td>Patient knows you are concerned about quality of care and are accountable for it</td>
</tr>
<tr>
<td>Encourage patient to have nurse call if questions</td>
<td>Patient knows that you are available if he or she needs help</td>
</tr>
<tr>
<td>Endorse care team members (team, nurses, consultants, other dept.)</td>
<td>Builds patient confidence in care team, facility</td>
</tr>
<tr>
<td>Ask patient/family/nurse what other concerns/needs</td>
<td>Allows patient to voice any other needs</td>
</tr>
</tbody>
</table>

Source: SHM’s Patient Experience Committee
skills and expertise, and a chance to be appreciated for what they already do effec-
tively. Most of all, activities were designed to be fun and engaging.” For example, CEHC encouraged and fostered an atti-
dude of exploration, experimentation, and adventure. Various warm-up activities effectively helped the participants enter a more playful space and get into character portrayal.

Dr. Velez credits the CEHC model’s sustainability and success to the early reali-
zation that an appreciative approach is effective. In a study about the strategy, hospital-
employed attending physicians participated in the 8-hour experiential communication skills training course on REDE. The study compared approximately 1,500 “interven-
tion” physicians who attended and 1,900 “nonintervention” physicians who did not attend.

Following the course, scores for physician communication and respect were higher for intervention physicians. Furthermore, physicians showed significant improvement in self-perceptions of empathy and burnout. Out of these gains were sustained for at least 3 months. “This is especially impor-
tant because in the current health care climate, physicians experience increased burnout,” Dr. Velez notes.

**How it works**

Because a provider’s connection with a patient occurs when a relationship is established, the REDE course focuses on the beginning of the conversation. “It’s important for clinicians to exhibit value and respect through words and actions when welcoming patients,” Dr. Velez said. “Further, instead of guiding the medi-
cation, physicians are observed, by asking the patient what they wish to share their own experiences, is quite ther-
apeutic,” Dr. Velez said. “We can extend the same communication strategies to team building, interpersonal interactions, and challenging encounters.”

**Study focuses on comportment and communication**

An effort to define optimal care in hospi-
tal medicine, a team from Johns Hopkins Health System set out to establish a metric that would comprehensively assess hospi-
talists’ comportment (which includes behavior as well as general demeanor) and communication to establish norms and expectations when they saw patients at the bedside.

To perform the study, chefs of hospit-
als medicine divisions at five independent hospitals located in Baltimore and Wash-
ington identified their most clinically excellent hospitalists. Then, an investi-
gator observed each hospitalist during a routine clinical shift and recorded behaviors believed to be associated with excellent behavior and communication using the hospital medicine comport-
ment and communication evaluation tool (HMCCOT), said Susrutha Kotwal, MD, assistant professor of medicine at Johns Hopkins University School of Medicine, Baltimore, and leaders. The investigators collected basic demographic information while observing hospitalists for an average of 280 minutes; 26 physi-
cians were observed for 181 separate clin-
ical encounters. Each provider’s mean HMCCOT score was compared with patient satisfaction surveys such as Press Ganey (PG) scores.

The most frequently observed behav-
iors were physicians washing their hands after leaving the patient’s room (94% of the encounters and smil-
ing (83%)), according to the study’s results. Behaviors that were observed were the least regularly included using an empathic statement (26% of encounters), and employing teach back (13% of encounters). “Teach back” refers to asking patients what they have learned during their visit. They use their own words to explain what they should know about their health, or what they need to do to get better. A common method of demonstrat-
ing interest in the patient as a person, seen in 41% of encounters, involved physicians asking about patients’ personal histories and their interests.

Noteworthy is the fact that the distri-
bution of HMCCOT scores were similar when analyzed by age, gender, race, amount of clinical experience, the hospitalist’s clinical workload, hospital, or time spent observing the hospitalist. But the distribu-
tion of HMCCOT scores was quite differ-
ent in new patient encounters, compared with follow-ups (68.1% versus 39.7%). Encounters with patients that generated HMCCOT scores above versus below the mean were longer (13 minutes versus 8.7 minutes). The physicians’ HMCCOT scores were also associated with their PG scores. These findings suggest that improved bedside communication and comportment with patients might also translate into enhanced patient satisfaction.

As a result of the study, a comportment and communication tool was established and validated by following clinically excel-

tent hospitalists at the bedside. “Even among clinically respected hospitalists, the results reveal that there is wide variability in behaviors and communication practices at the bedside,” Dr. Kotwal said.

**Employing the tool**

Hospitalists can choose whether to perform behaviors in the HMCCOT themselves, or watch the videos and watch other hospitalists to give them feedback tied to specific behaviors. “These simple behav-
iors are intimately linked to excellent communication and comportment, which can serve as the foundation for delivering patient-centered care,” Dr. Kotwal said.

A positive correlation was found between spending more time with patients and higher HMCCOT scores. “Patients are more likely to follow instructions and have better engagement,” Dr. Velez noted. “If a clini-
cian is a discrete set of skills that can be taught in a safe and validating environ-
ment and if principles of adult learning are followed, improvement can be opti-
mized and sustained.”

**CONTINUED FROM PREVIOUS PAGE**
New telehealth legislation would provide for testing, expansion

A
bipartisan bill introduced in the U.S. Senate in late 2017 would authorize the Center for Medicare & Medicaid Innovation (CMMI) to test expanded telehealth services provided to Medicare beneficiaries.

The Telehealth Innovation and Improvement Act (S.787), currently in the Senate Finance Committee, was introduced by Sens. Gary Peters (D-Mich.) and Sen. Cory Gardner (R-Colo.). A similar bill they introduced in 2015 was never enacted.

However, there are physicians hoping to see this bill or others like it granted consideration. Currently, the Centers for Medicare & Medicaid Services reimburses for certain telemedicine services provided only in rural or underserved geographic areas, but the new bill would apply in suburban and urban areas, based on pilot testing of models and evaluating them for cost, quality, and effectiveness.

Successful models would be covered by Medicare.

“Medicare has made some provisions for specific rural sites and for urban sites in other states, so that’s where we’re prescribed for. Within the virtual world, Medicare is looking at delivering care from a hospitalist in Cincinnati to a physician in or from Wisconsin,” said Talbot McCormick, MD, or “Dr. Mac,” is a hospitalist and CEO of Eagle Telemedicine in Atlanta, a physician group whose employees provide a variety of telehealth services to hospitals around the country, from 3-bed critical access facilities to larger, urban hospitals with 300-400 beds.

At present, the company contracts with hospitals and compensates its physicians based on their level of experience, availability, hours worked, and the services they provide each hospital. Eagle’s business model relies on the additional value it provides hospitals that may not have another hospitalist to assign. “Dr. Mac believes it is inconsistent that, in many circumstances, physicians providing services via telemedicine technology are not reimbursed by Medicare and other payers.”

“The expansion and ability to provide care in more unique ways—more specialties and in more environments—has expanded more quickly than the systems of reimbursement for professional fees have and it really is a bit of a hodgepodge now,” he said. “We certainly are pleased that this is getting attention and that we have leaders pushing for this in Congress. We don’t know for sure how the final legislation (on this bill) will look but hopefully there will be some form of this that will work to fruition.”

Whether telemedicine can reduce costs while improving outcomes, or improve outcomes without increasing costs, remains unsettled. A study published in Health Affairs in March 2017 indicates that, while telehealth can improve access to care, it results in greater utilization, thereby increasing costs.

The study relied on claims data for more than 300,000 patients in the California Public Employees’ Retirement System during 2011-2013. It looked at utilization of direct-to-consumer telehealth and spending for acute respiratory illness, one of the most common reasons patients seek telehealth services. While, per episode, telehealth visits cost 50% less than did an outpatient visit and less than 5% of an emergency department visit, annual spending per individual for acute respiratory illness went up $455 because, as the authors estimated, 88% of direct-to-consumer telehealth visits represented new utilization.

Whether this would be the case for hospitalist patients remains to be tested.

“It gets back to whether or not you’re adding a new service or substituting a less expensive one for more expensive one,” said Dr. Flansbaum. “Are physicians providing a needed service or adding unnecessary visits to the system?”

Jayne Lee, MD, has been a hospitalist with Eagle for nearly a decade. Before making a transition from an in-hospital physician to one treating patients from behind a robot—with assistance at the point of service from a nurse—she was working 10 shifts in a row at her home in the United States before traveling to her home in Paris. Dr. Mac offered her the opportunity to practice full time as a telehospitalist from overseas. Today, she is also the company’s chief medical officer and estimates she’s had more than 7,000 patient encounters using telemedicine technology.

“I was skeptical at first,” she said, “but the more I worked in telemedicine, the more I liked it, and I found that working remotely was pretty similar to working on the ground. The physical exam is different, but given technology, we have easily been able to listen to the heart and lungs as easily as at the bedside.”

Dr. Lee is licensed in multiple states—a barrier that plagues many would-be telehealth providers, but which Eagle has solved with its licensing and credentialing staff—and because she is often providing services at night to urban and rural areas, she finds a broad range of patients.

“We see things from coronary artery disease, COPD [chronic obstructive pulmonary disease] exacerbations, and diabetes-related conditions to drug overdoses and alcohol abuse,” she said. “I enjoy seeing the variety of patients I encounter every night.”

Dr. Lee has to navigate each health system’s electronic medical records and triage systems but, she says, patient care has remained the same. And she’s providing services to hospitals that may not have another hospitalist to assign.

“Our practices keep growing, a sign that hospitals are needing our services more than ever, given that there is a physician shortage and given the financial constraints we’re seeing in the healthcare system,” she said.

References
all of these cycles, the collaborative rounding strategy continued.

Because Hospital Consumer Assessments of Healthcare Providers and Systems (HCAHPS) survey scores yielded low response rates for the singular test unit and service, the investigators used a validated patient satisfaction instrument and surveyed patients from the intervention group and patients on the same unit who did not experience this collaborative rounding on their day of discharge. The intervention group had higher satisfaction scores at most of the time points. The unit-based HCAHPS scores (not just study patients) improved during this time period.

“We think the strategy of collaborative rounding yielded positive results for obvious reasons – the entire team was on the same page and the information given to the patient was consistent,” said Dr. Seymour, who notes that the study’s findings weren’t published and the project was completed for an internal quality program. “Doctors had an increased understanding about nursing concerns and the nursing staff expressed improved understanding of ‘patients’ care plans.’

Certainly, face time with the patient was extended because much of the academic discussion occurred at the bedside instead of at another physical location without patient awareness, Dr. Seymour said. She believes the strategy boosted patient satisfaction because it was patient centered. “While this rounding strategy is not the most convenient rounding strategy for nurses or doctors, it consolidates the discussion about the patient’s clinical condition and the plan for the day. The patient experiences a strong sense of being cared for by a unified team and receives consistent messaging,” she said.

Also noteworthy is that job satisfaction for residents and nurses improved on the unit over the study time period because of the expected collaboration that was built into the workflow. Although the facility is no longer using this communication strategy to the same degree, teaching attendings have seen the value of true bedside rounding and continue to teach this skill to learners. “We have had some challenges with geographic cohorting at our institution, which is essential for this type of team-based strategy,” Dr. Seymour said. “Sustainability requires constant encouragement, oversight, and auditing from team leaders which is also challenging and fluctuates with competing demands.”

The results of this study, and others, show that employing tools to improve communication can also result in improved patient satisfaction and experience.

Ms. Appold is a medical writer in Pennsylvania.

References

Why empathy is preferred over patient-centered care

The Cleveland Clinic intentionally puts a focus on relationship-centered care. “When there’s an emphasis on patient-centered care, some physicians have a hard time figuring out what to do when the patient wants something that the physician doesn’t feel is appropriate,” said Katie Neuendorf, MD, director for the Center for Excellence in Healthcare Communication. “Patient-centered care implies that the patient is always right and that their opinion should win out over the physician’s opinion. In that same scenario, relationship-centered care implies that the relationship should be prioritized, even when there’s disagreement in the plan of care. I can tell my patients that I hear what they are saying, that I empathize with their struggles, that I care about the way the illness is affecting their lives, and that I am here to support them. I can do all of that and still not prescribe a treatment that I feel is inappropriate just because it happens to be what the patient wants.”

The development of a relationship between the patient and the physician has benefits for the physician, such as decreased rates of burnout, as well as better health outcomes for the patient, according to the results of several studies.6-8 Given these benefits, in 2014, two physicians advocated for a Quadruple Aim to replace the standard Triple Aim.9-10 “The Quadruple Aim recognizes that improving health care providers’ work life is imperative in keeping health care functioning,” Dr. Neuendorf said.

The Cleveland Clinic’s Relationship Establishment, Development and Engagement (REDE) course helps clinicians to see the individual that exists beyond a diagnosis. “Having empathy, or putting yourself in the other person’s shoes, is a key step in that process,” Dr. Neuendorf said. “Once a physician understands the patient’s perspective, the treatment for the diagnosis is more meaningful to both the patient and physician. Finding meaning in their work addresses the Quadruple Aim.”
How to manage submassive pulmonary embolism

When to consider thrombolysis and inferior vena cava filter placement

By Elizabeth Wenqian Wang, MD, FACP, Deepak Vedamurthy, MD, and Haiyun Wang, MD

The case
A 49-year-old morbidly obese woman presented to the emergency department with shortness of breath and abdominal distention. On presentation, her blood pressure was 100/60 mm Hg with a heart rate of 110, respiratory rate of 24, and a pulse oxygen saturation (SpO2) of 86% on room air. Troponin T was elevated at 0.3 ng/mL. Computed tomography (CT) of the chest with intravenous contrast showed saddle pulmonary embolism (PE) with dilated right ventricle (RV). CT abdomen/pelvis revealed a very large uterine mass with diffuse lymphadenopathy. Heparin infusion was started promptly. Echocardiogram demonstrated RV strain. Findings on duplex ultrasound of the lower extremities were consistent with acute deep vein thromboses (DVT) involving the left common femoral vein and the right popliteal vein. Biopsy of a supraclavicular lymph node showed high-grade undifferentiated carcinoma most likely of uterine origin.

Clinical questions
What, if any, therapeutic options should be considered beyond standard systemic anticoagulation? Is there a role for:

1. Systemic thrombolysis?
2. Catheter-directed thrombolysis (CDT)?
3. Inferior vena cava (IVC) filter placement?

What is the appropriate management of “submassive” PE?
In the case of massive PE, where the thrombus is located in the central pulmonary vasculature and associated with hypotension due to impaired cardiac output, systemic thrombolysis, embolectomy, and CDT are indicated as potentially lifesaving measures. However, the evidence is less clear when the PE is large and has led to RV strain, but without overt hemodynamic instability. This is commonly known as an intermediate risk or “submassive” PE. Submassive PE based on American Heart Association (AHA) guidelines is:1

An acute PE without systemic hypotension (systolic blood pressure less than 90 mm Hg) but with either RV dysfunction or myocardial necrosis. RV dysfunction is defined by the presence of at least one of the following:

- RV dilation (apical 4-chamber RV diameter divided by LV diameter greater than 0.9) or RV systolic dysfunction on echocardiography;
- RV dilation on CT, elevation of BNP (greater than 90 pg/mL), elevation of N-terminal pro-BNP (greater than 500 pg/mL);
- Electrocardiographic changes (new complete or incomplete right bundle branch block, anteroseptal ST elevation or depression, or anteroseptal T-wave inversion).

Myocardial necrosis is defined as elevated troponin I (greater than 0.4 ng/mL) or elevated troponin T (greater than 0.1 ng/mL).

Why is submassive PE of clinical significance?
In 1999, analysis of the International Cooperative Pulmonary Embolism Registry (ICOPER) revealed that RV dysfunction in PE patients was associated with a near doubling of the 3-month mortality risk (hazard ratio, 2.0; 95% confidence interval, 1.3-2.9). Given this increased risk, one could draw the logical conclusion that we need to treat submassive PE more aggressively than PE without RV strain. But will this necessarily result in a better outcome for the patient given the 3% risk of intracranial hemorrhage associated with thrombolytic therapy?

In the clinical scenario above, the patient did meet the definition of submassive PE. While the patient did not experience systemic hypotension, she did have RV dilation on CT and RV systolic dysfunction on echo, as well as an elevated troponin T level. In addition to starting anticoagulant therapy, what more should be done to increase her probability of a good outcome?

The AHA recommends that systemic thrombolysis and CDT be considered for patients with acute submassive PE if they have clinical evidence of adverse prognosis, including worsening respiratory failure, severe RV dysfunction, or major myocardial necrosis and low risk of bleeding complications (Class IIb; Level of Evidence C). The 2016 American College of Chest Physicians (CHEST) guidelines update4 recommends systemically administered thrombolytic therapy over no therapy in selected patients with acute PE who deteriorate after starting anticoagulant therapy but have yet to develop hypotension and who have a low bleeding risk (Grade 2C recommendation).

Systemic thrombolysis
Systemic thrombolysis is administered as an intravenous thrombolytic infusion delivered over a period of time. The Food and Drug Administration–approved thrombolytic drugs currently include tissue plasminogen activator (tPA)/alteplase, streptokinase, and urokinase. In the 2002 randomized, double-blind Pulmonary Embolism-3 Trial,2 Konstan- tinides and colleagues compared heparin plus tPA versus heparin plus placebo in 256 patients with submassive PE. The primary clinical endpoint of death or in-hospital escalation of care was 11.6% in the tPA group versus 24.6% in the placebo group (P = .006); the difference was driven largely by the escalation of care, defined as use of vasopressors, rescue thrombolysis, mechanical...
ventilation, cardiac arrest, and requirement of surgical embolectomy. Perhaps surprisingly, there were no cases of hemorrhagic stroke in either of these groups. The trial demonstrated that systemic thrombolysis in submassive PE was associated with a lower risk of death and treatment escalation.

Efficacy of low-dose thrombolysis was studied in MOPPETT 2013, a single-center, prospective, randomized, open-label study, in which 126 patients were found to have submassive PE based on symptoms and CT angiographic or ventilation/perfusion scan data. Low-dose tPA was given at 1.6 mg/kg over 8 hours. The primary efficacy outcome was the chest CT–measured RV/LV ratio difference from baseline compared to 48 hours after the start of the procedure. The pre- and postprocedure ratio was 1.07 versus 1.16, respectively (P < .05), indicating a significant difference in average pulmonary pressure changes, average thrombolytic doses, or average infusion times. A prospective single-arm multicenter trial, SEATTLE II 2015, evaluated the efficacy of EKOS in a sample of 159 patients. Patients with both massive and submassive PE received approximately 24 mg tPA as a single dose or a carveratol or placebo as a control. The primary efficacy outcome was the chest CT–measured RV/LV ratio difference from baseline compared to 48 hours after the start of the procedure. The pre- and postprocedure ratio was 1.55 versus 1.13, respectively (P < .05), indicating that EKOS decreased RV dilatation. No intracranial hemorrhage was observed and the investigators did not comment on long-term outcomes such as mortality or quality of life. The study was limited by the lack of a comparison group, such as anticoagulation with heparin as monotherapy, or systemic thrombolysis or standard CDT.

Catheter-directed thrombolysis CDT was originally developed to treat arterial, dialysis graft and deep vein thromboses, but is now approved by the FDA for the treatment of acute submassive or massive PE. A wire is passed through the embolus to place a multihole infusion catheter is placed, through which a thrombolytic drug is infused over 12–24 hours. The direct delivery of the drug into the thrombus is thought to be as effective as systemic therapy but with a lower risk of bleeding. If more rapid thrombus removal is indicated, the catheter is replaced with a high-pressure catheter, which is cleared of the clot. These mechanical techniques carry the risk of pulmonary artery injury, and therefore should be used only as a last resort. An ultrasound-emitting wire can be added to the multihole infusion catheter to expedite thrombolysis by ultrasonically disrupting the thrombus, a technique known as ultrasound-enhanced thrombolysis (EKOS). 1,2

The ULTIMA 2014 trial, 3 a small, randomized, open-label study of Ultrasound-Assisted Catheter Directed Thrombolysis (USAT), the term can be used interchangeably with EKOS versus heparin anticoagulation alone in 59 patients, was designed to study if the former strategy was better at improving the primary outcome measure of RV/LV for PE patients. The mean reduction in RV/LV ratio was 0.30 ± 0.20 in the USAT group compared to 0.05 ± 0.16 in the heparin group (P < .001). However, no significant difference in mortality or bleeding was observed in the groups at 90-day follow-up. The PERFECT 2015 Trial, 4 a multicenter registry-based study, prospectively enrolled 101 patients who received CDT as first-line therapy for massive and submassive PE. Among patients with submassive PE, 97.3% were found to have “clinical success” with this treatment, defined as stabilization of hemodynamics, improvement in pulmonary hypertension and right heart strain, and survival to hospital discharge. There was no major bleeding or intracranial hemorrhage. Subgroup analyses in this study comparing USAT against standard CDT did not reveal significant differences in average pulmonary pressure changes, average thrombolytic doses, or average infusion times. A prospective single-arm multicenter trial, SEATTLE II 2015, evaluated the efficacy of EKOS in a sample of 159 patients. Patients with both massive and submassive PE received approximately 24 mg tPA as a single dose or a carveratol or placebo as a control. The primary efficacy outcome was the chest CT–measured RV/LV ratio difference from baseline compared to 48 hours after the start of the procedure. The pre- and postprocedure ratio was 1.55 versus 1.13, respectively (P < .05), indicating that EKOS decreased RV dilatation. No intracranial hemorrhage was observed and the investigations did not comment on long-term outcomes such as mortality or quality of life. The study was limited by the lack of a comparison group, such as anticoagulation with heparin as monotherapy, or systemic thrombolysis or standard CDT.

Treatment of submassive PE varies between different institutions. There simply are not adequate data comparing low-dose systemic thrombolysis, CDT, EKOS, and standard heparin anticoagulation to make firm recommendations. Some investigators feel low-dose systemic thrombolysis is probably as good as the expensive catheter-based thrombolytic therapies. 1,2,7-14 Low-dose thrombolytic therapy can be followed by use of oral direct factor Xa inhibitors for maintenance of antithrombotic activity. 15

Bottom line

In our institution, the interventional radiology team screens patients who meet criteria for submassive PE on a case-by-case basis. We use pulmonary angiographic data (nature and extent of the thrombus), clinical stability, and analysis of other comorbid conditions to decide the best treatment modality for an individual patient. Our team prefers EKOS for submassive PE patients as well as for massive PE patients and as a rescue procedure for patients who have failed systemic thrombolysis. Until more data are available to support firm guidelines, we feel establishing multidisciplinary teams composed of interventional radiologists, intensivists, cardiologists, and vascular surgeons is prudent in order to make individualized patient decisions and to achieve the best outcomes for our patients. 14

IVC filter

Since the patient in this case already has a submassive PE, can she tolerate additional clot burden should her remaining DVT embolize again? Is there a role for IVC filter?
SYNOPSIS: From data on 1,548,945 adults (aged 18-64 years) showed that 21.1% of adults received a prescription for short-term corticosteroids. Previous epidemiologic studies have been smaller with less clinical information available and without steroid usage rates. Of patients aged 18 or older, 26,429 were included with a primary or secondary discharge diagnosis of meningitis or encephalitis from 2011 to 2014. Encephalitis was the most common cause of adult meningoencephalitis, and patients with pneumococcal meningitis who received steroids had decreased mortality.


Dr. Hall is an assistant professor in the University of Kentucky division of hospital medicine and pediatrics.

By Adam Gray, MD

2 Even short-term steroids can be problematic

CLINICAL QUESTION: What is the frequency of short-term corticosteroid prescriptions and adverse events associated with their use?

BACKGROUND: Long-term corticosteroid use is usually avoided given risks of complications. Less is known about the risk and frequency of short-term corticosteroid use.

STUDY DESIGN: Retrospective cohort study and self-controlled case series.

SETTING: National U.S. dataset of private insurance claims.

SYNOPSIS: Data from 1,548,945 adults (aged 18-64 years) showed that 21.1% of adults received a prescription for short-term corticosteroids, incident rate ratios (IRR) were increased for sepsis (5.3; 95% confidence interval, 3.8-7.4), venous thromboembolism (3.3; 95% CI, 2.78-3.99), and fracture (1.87; 95% CI, 1.69-2.07).

Short-term corticosteroids were frequently prescribed for indications with little evidence of benefit, such as upper respiratory conditions, spinal conditions, and allergies. For these conditions, patients should be educated about the risks of short-term corticosteroid use and alternative treatments should be considered. This study only evaluated for these indications and adverse reactions and excluded the elderly, so these findings likely underestimate the adverse effects of short-term corticosteroids.

BOTTOM LINE: Corticosteroids are frequently prescribed for short courses and were associated with increased rates of sepsis, venous thromboembolism, and fracture.


Dr. Gray is assistant professor in the University of Kentucky division of hospital medicine and the Lexington VA Medical Center.

By Arthur Gray, MD, FACCP

1 Epidemiology of meningitis and encephalitis in the United States

CLINICAL QUESTION: What is the epidemiology of meningitis and encephalitis in adults in the United States?

BACKGROUND: Previous epidemiologic studies have been smaller with less clinical information available and without steroid usage rates.

STUDY DESIGN: A retrospective database review.

SETTING: The Premier HealthCare Database, including hospitals of all types and sizes.

SYNOPSIS: Of patients aged 18 or older, 26,429 were included with a primary or secondary discharge diagnosis of meningitis or encephalitis from 2011 to 2014. Encephalitis was the most common cause of adult meningoencephalitis, and patients with pneumococcal meningitis who received steroids had decreased mortality.


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SETTING: National U.S. dataset of private insurance claims.

SYNOPSIS: Data from 1,548,945 adults (aged 18-64 years) showed that 21.1% of adults received a prescription for short-term corticosteroids, incident rate ratios (IRR) were increased for sepsis (5.3; 95% confidence interval, 3.8-7.4), venous thromboembolism (3.3; 95% CI, 2.78-3.99), and fracture (1.87; 95% CI, 1.69-2.07).

Short-term corticosteroids were frequently prescribed for indications with little evidence of benefit, such as upper respiratory conditions, spinal conditions, and allergies. For these conditions, patients should be educated about the risks of short-term corticosteroid use and alternative treatments should be considered. This study only evaluated for these indications and adverse reactions and excluded the elderly, so these findings likely underestimate the adverse effects of short-term corticosteroids.

BOTTOM LINE: Corticosteroids are frequently prescribed for short courses and were associated with increased rates of sepsis, venous thromboembolism, and fracture.


Dr. Gray is assistant professor in the University of Kentucky division of hospital medicine and the Lexington VA Medical Center.
May 16;166(10):715-24.

Dr. Dogra is clinical instructor of medicine in the University of Kentucky division of hospital medicine.

By Rebecca Helfrich, MD

**Rapid AMI rule out**

**CLINICAL QUESTION:** Can a single high-sensitivity cardiac troponin-T (hs-cTnT) reliably rule-out acute myocardial infarction (AMI) to safely enable earlier discharge?

**BACKGROUND:** Current practice includes serial measures of hs-cTnT to rule out AMI.

**STUDY DESIGN:** A meta-analysis of 11 prospective cohorts at various international locations

**SETTING:** Patients presenting to emergency departments with chest pain.

**SYNOPSIS:** Of 9,241, a total of 2,825 patients were classified as low risk with a single negative hs-cTnT and nonischemic EKG. The primary outcome was AMI during initial hospitalization. Of low-risk patients, 14 (0.5%) had AMI. Pooled estimated sensitivity was 98.7% and pooled negative predictive value was 99.3%. For the secondary outcome of 30-day major adverse cardiac events, pooled sensitivity was 98%. Limitations include a small number of studies, high statistical heterogeneity, variation in troponin assays, and variable prevalence of AMI across studies.

**BOTTOM LINE:** A single negative hs-cTnT and nonischemic EKG after 3 hours of chest pain can reliably rule out AMI. Further research is, however, required to validate the unequivocal use of this early rule-out strategy.


**Simplified HOSPITAL score predicts 30-day readmissions**

**CLINICAL QUESTION:** Will a simplified HOSPITAL score accurately predict 30-day readmissions?

**BACKGROUND:** Hospital readmissions stress patients and health care systems. Interventions to prevent avoidable readmissions are complex and expensive. The HOSPITAL score predicts 30-day readmissions which may help direct resources toward high-risk patients.

**STUDY DESIGN:** A retrospective study.

**SETTING:** Nine hospitals in four countries.

**SYNOPSIS:** The HOSPITAL score was simplified by removing the procedure variable, expanding the oncology criteria to include a diagnosis of cancer, and dividing patients into high- and low-risk groups. The simplified HOSPITAL score was used to predict avoidable readmissions of 117,065 patients from nine hospitals. Readmission rates predicted by the simplified HOSPITAL score matched observed outcomes with a sensitivity of 94% and specificity of 73%. Its discriminatory power was comparable with the original HOSPITAL score.

**BOTTOM LINE:** The simplified HOSPITAL score accurately predicts avoidable 30-day readmission rates.

**CITATION:** Aubert CE, Schnipper JL, Williams MV, et al. Simplification of the HOSPITAL score for predicting 30-day readmissions. BMJ Qual Saf. Published online first. 17 Apr 2017. doi: 10.1136/bmjqs-2016-006239.

**SHORT TAKES**

**Hospitalized-patient one-year mortality risk (HOMR) score an excellent prognostic tool**

The HOMR score, derived from administrative data, accurately predicts mortality. This study derived the score from medical records which providers can access and found it still accurately determines 1-year mortality.


**New drug for C. difficile recurrence**

Bezlotoxumab is now approved to reduce recurrence of *Clostridium difficile*. This is an injectable human monoclonal antibody to *C. difficile* toxin and must be used in conjunction with antibiotics.

This advertisement is not available for the digital edition.
5 HERDOO2 may guide duration of treatment for unprovoked VTE

CLINICAL QUESTION: Can HERDOO2 guide anticoagulation cessation in women with unprovoked venous thromboembolism (VTE)?

BACKGROUND: Patients with unprovoked VTE have increased recurrence rates after stopping anticoagulation, but no tools have been validated to identify low-risk patients.

STUDY DESIGN: A prospective cohort study.

SETTING: A selection of 49 referral centers in seven countries.

SYNOPSIS: Of patients with unprovoked, symptomatic VTE, 2,747 were evaluated after receiving anticoagulation for 5-12 months. HERDOO2 was used to classify women as low (0-1 points) or high (equal to or greater than 2 points) risk categories. Men were considered high-risk. Anticoagulation was stopped for low-risk patients. Treatment of high-risk patients was left to physician choice.

Overall, high-risk patients who continued anticoagulation had a 1.6% recurrence rate per patient year, but postmenopausal women aged 50 years or older had a rate of 5.7%. High-risk patients who stopped anticoagulation had a 3% recurrence rate. This study included multiple sites, but only 44% of participants were women. HERDOO2 should be used cautiously in postmenopausal women aged 50 years or older and in white women.

BOTTOM LINE: HERDOO2 may help guide the decision to stop anticoagulation in select low-risk women with unprovoked VTE.


6 VIP services linked to unnecessary care

CLINICAL QUESTION: Does “very important person” (VIP) status impact physician decision making and lead to unnecessary care?

BACKGROUND: In many centers, VIP patients avail VIP services, which involve extra services beyond the standard of care. No prior studies assess the impact of such VIP services on these patients.

STUDY DESIGN: A qualitative multi-site case study.

SETTING: Centers associated with the Hospital Medicine Reengineering Network (HOMEReN).

SYNOPSIS: Of the 160 hospitalists across eight centers who felt that VIP services were present at their hospital. These patients often had personal ties with the hospital. The majority of hospitalists (78%) felt VIP patients received similar medical care, compared with non-VIP patients. However, 63% felt pressured by VIP patients or families to order unnecessary tests. Moreover, 36% perceived pressure from hospital administration to comply with VIP patient wishes. Most hospitalists felt being more likely to comply with requests from VIP patients than from other patients.

The survey questions were not validated, and the responses might not reflect actual perceptions of hospitalists. These results are purely qualitative, so the burden of unnecessary care cannot be quantified.

BOTTOM LINE: Most hospitalists perceive VIP services to lead to pressure to deliver unnecessary care.


7 Prediction tool for mortality after respiratory compromise

CLINICAL QUESTION: Can we predict in-hospital mortality of initial survivors of acute respiratory compromise (ARC)?

BACKGROUND: Scoring systems exist to predict outcomes following cardiac arrest. There is currently no reliable model to predict outcome of patients with chest compression ongoing after receiving anticoagulation for 5-12 months.

SYNOPSIS: Of patients with unprovoked, symptomatic VTE, 2,747 were evaluated after receiving anticoagulation for 5-12 months. HERDOO2 was used to classify women as low (0-1 points) or high (equal to or greater than 2 points) risk categories. Men were considered high-risk. Anticoagulation was stopped for low-risk patients. Treatment of high-risk patients was left to physician choice.

Overall, high-risk patients who continued anticoagulation had a 1.6% recurrence rate per patient year, but postmenopausal women aged 50 years or older had a rate of 5.7%. High-risk patients who stopped anticoagulation had a 3% recurrence rate. This study included multiple sites, but only 44% of participants were women. HERDOO2 should be used cautiously in postmenopausal women aged 50 years or older and in white women.

BOTTOM LINE: HERDOO2 may help guide the decision to stop anticoagulation in select low-risk women with unprovoked VTE.


8 HEART score can safely identify low-risk chest pain

CLINICAL QUESTION: Can the HEART score stratify emergency department patients with chest pain?

BACKGROUND: Many patients with chest pain are subjected to unnecessary admission and testing. The HEART (History, Electrocardiogram, Age, Risk factors, and initial Troponin) score can accurately predict outcomes in chest pain patients, though large-scale validation has been limited. The greatest predictors of a poor outcome were high-risk chest pain, although these likely affect mortality.

SYNOPSIS: All sites started by providing usual care, then sequentially switched over to use of the HEART score to guide treatment. HEART care recommended early discharge if low risk (HEART score, 0-3), admission and further testing if intermediate risk (4-6), and early invasive testing if high risk (7-10).

The study included 3,648 adults presenting with chest pain. The HEART score was noninferior to usual care for the safety outcome of major adverse cardiovascular events (MACE) within 6 months. Only 2.0% of low-risk patients experienced MACE, though 41% of these patients were still admitted or sent for further testing, and in-hospital care cost was minimal.

BOTTOM LINE: The HEART score accurately predicted risk in patients with chest pain, but a significant portion of low-risk patients underwent further testing anyway.


9 Triple therapy reduces exacerbations in patients with symptomatic COPD

CLINICAL QUESTION: Does triple therapy (long-acting beta-2 agonist, long-acting muscarinic antagonist, and inhaled corticosteroid) reduce exacerbations in patients with symptomatic chronic obstructive pulmonary disease (COPD)?

BACKGROUND: Guidelmes from GOLD recommend considering a step-up to triple therapy for patients with refractory COPD symptoms or exacerbations. However, it is unknown if this reduces the long-term risk of exacerbations.

SYNOPSIS: Of the 163 patients with stable COPD, 81 were randomized to the gold standard therapy (containing formoterol, and glycopyrronium), a novel three-agent inhaler (containing sacubitril, significantly reduced hospitalization and mortality. Optimal dose and titration strategies remain unclear. ARBs should not be used in patients with a history of angioedema (IIIC) or within 36 hours of receiving ACE- inhibitor (IIIB). Ixabradine, a selective inhibitor of the L-type calcium channel, if given at a stable node, is recommended to reduce hospitalizations for patients with HFREF with stable symptoms with resting sinus heart rate greater than or equal to 70 despite maximally tolerated beta-blockade (IIa). Intravenous iron replacement is recommended to improve function and quality of life for patients with symptomatic HF and iron deficiency (IIb).

BOTTOM LINE: Updates support use of BNP, ARB-Ns, ivabradine, and IV iron for HFREF.

From *Clostridium difficile* to VTE

**By Leslie M. Martin, MD; William James Frederick III, MD, PhD; Vineet Gupta, MD, FACP, FHM**

Division of Hospital Medicine, Department of Medicine, University of California San Diego

**IN THE LITERATURE**

**CLINICAL QUESTION:** Does the use and timing of probiotics in hospitalized adult patients with *Clostridium difficile* infection (CDI) improve clinical outcomes?

**BACKGROUND:** The incidence of CDI in hospitalized patients has increased significantly over the past years, resulting in significant morbidity and mortality. Improved prevention of CDI could have substantial public health benefits.

**STUDY DESIGN:** Systematic review and metaregression analysis.

**SETTING:** A selection of nineteen studies meeting inclusion criteria.

**SYNOPSIS:** Computerized bibliography databases were searched for randomized controlled trials (RCTs) evaluating probiotic effects on CDI in hospitalized adults taking antibiotics. Compiling 6,261 subjects, 19 RCTs were analyzed. The incidence of CDI was lower in the probiotic cohort than in the control group (1.6% vs. 3.9%; *P* < .001). The pooled relative risk of CDI in probiotic users was 0.42 (95% confidence interval, 0.30–0.57).

Metaregression analysis demonstrated that probiotics were significantly more effective if given closer to the first antibiotic dose, with a decrease in efficacy for every day of delay in starting probiotics (*P* = .04).

Probiotics given within 2 days of antibiotic initiation produced a greater reduction of risk for CDI (RR, 0.32; 95% CI, 0.22–0.48) than did later administration (RR, 0.70; 95% CI, 0.40–1.23; *P* = .02). There was no increased risk for adverse events among patients receiving probiotics.

Limitations included high risk of bias because of missing data, attrition, restricted patient population, lack of placebo, and conflict of interest.

**BOTTOM LINE:** Administration of probiotics soon after the first dose of antibiotic reduces the risk of CDI by more than 50% in hospitalized adults without any increased risk of adverse events.


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

**2 Application of the MASCC and CISNE risk-stratification scores to identify low-risk febrile neutropenic patients in the emergency department**

**CLINICAL QUESTION:** Does the Multinational Association for Supportive Care in Cancer (MASCC) or Clinical Index of Stable Febrile Neutropenia (CISNE) risk-stratification score better predict patient outcomes in patients presenting to emergency departments with febrile neutropenia?

**BACKGROUND:** Risk-stratification metrics such as the MASCC and CISNE identify subsets of relatively low-risk patients with febrile neutropenia after chemotherapy for treatment at home with empiric oral anti-
ICU patients with stable renal function had no significant benefit of using sodium bicarbonate hydration over isotonic sodium chloride for preventing contrast-associated acute kidney injury.

**SYNOPSIS:** 307 consecutive ICU patients with stable renal function who received IV contrast were randomized to either 0.9% sodium chloride (n = 156) or 1.4% sodium bicarbonate (n = 151) hydration. Infusion protocol comprising 3 mL/kg given 1 hour before and 1 mL/kg per hour given for 6 hours after contrast exposure. The study excluded patients with unstable renal function, patients on renal replacement therapy patients unable to tolerate volume expansion, patients who were pregnant, and those with life expectancy of less than 5 days.

The frequency of CA-AKI was similar in both groups: 52 patients (33.3%) in the saline group and 53 patients (35.1%) in the bicarbonate group (absolute risk difference, 1.8%; 95% confidence interval, 12.3%–8.9%; P = .81). The need for renal replacement therapy (3.2% vs 3.9%; P = .77), ICU length of stay (24.7 ± 22.9 vs 23 ± 23.8 days; P = .52), and mortality (16.0% vs 15.9%; P > .99) were also similar between the two groups.

The limitations of this study include study sites in a single country, no blinding to the measurements of urinary pH, and multi-factorial etiology of AKI in critically ill patients affecting attribution to CA-AKI alone.

**BOTTOM LINE:** ICU patients with stable renal function had no significant benefit of using sodium bicarbonate hydration over isotonic sodium chloride for preventing contrast-associated acute kidney injury.


**Recurrence and mortality after first venous thromboembolism in a large population-based cohort**

**CLINICAL QUESTION:** What are the rates of recurrence and mortality after a first venous thromboembolism (VTE) in patients recruited from a large population-based cohort?

**BACKGROUND:** Recurrence and mortality rates after initial VTE have been variably reported. The authors assessed the cumulative incidence of recurrence and mortality after a first VTE by using cases derived from a general population cohort between 1994 and 2012.

**STUDY DESIGN:** Prospective, multicenter, randomized controlled study.

**SETTING:** Hospital and outpatient setting in Tromsø, Norway.

**SYNOPSIS:** Patients (n = 710) with the first lifetime occurrence of objectively confirmed VTE were included. VTE diagnosis was validated by reviewing the hospital discharge registry, the autopsy registry, and the radiology procedure registry.

The mean age of the patients was 68 years (range, 28-102 years), and 166 (23.4%) had cancer at the time of first VTE.

There were 114 VTE recurrences and 335 deaths during a median study period of 7.7 years (range, 0.8 years) from a general population cohort between 1994 and 2012.

The risk of recurrence was highest during the first year. The overall 1-year recurrence rate was 7.8% (95% CI, 5.8-10.6) per 100 person-years (PY), whereas the recurrence rate in the remaining follow-up period (1-18 years) was 3.0% (95% CI, 2.4-3.8) per 100 PY. The overall 1-year all-cause mortality rate was 29.9% (95% confidence interval, 25.7-34.8) per 100 PY, and, in those without cancer, the corresponding rate was 23.6% (95% CI, 1.8-31.3) per 100 PY.

The study was limited by insufficient information on causes of death, lack of information on cancer treatment, retrospective nature, and small study population.

**BOTTOM LINE:** Despite advances in VTE management, the rates of adverse events remained fairly high, particularly in the initial year following a first lifetime VTE.


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**SHORT TAKES**

**Caregiver integration in discharge planning decreases readmissions**

Meta-analysis of 15 randomized controlled trials in older adults showed that integration of care in interdisciplinary discharge planning decreased 90- and 180-day readmission rates by approximately 25%.


**Do not treat subclinical hypothyroidism**

A randomized controlled trial involving 737 elderly adults (older than 65 years) with subclinical hypothyroidism compared levothyroxine to placebo. Levothyroxine provided no benefit in thyroid-related symptoms or any secondary outcomes.

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Interested candidates should contact Julia Lauver, CMMC Physician Recruitment

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email: LauverJu@cmhc.org
call: 800/445-7431   fax: 207/755-5854

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**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.

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For additional information, please contact:
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**Hospitalist/Nocturnist Opportunities in PA Starting Bonus and Loan Repayment**

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**Health Sciences Center**

**Internal Medicine Division: Hospital Medicine**

**Job Title:** Hospitalist

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Inquiries may be directed to John Rush Pierce, MD, Professor, Division of Hospital Medicine, Department of Internal Medicine, University of New Mexico, MSC 10 5550, 1 University of New Mexico, Albuquerque, NM 87131, Attn: (JRPierce@salud.unm.edu).

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HOSPITALIST

The Division of Internal Medicine at Penn State Hershey Medical Center, The Pennsylvania State University College of Medicine, is accepting applications for HOSPITALIST positions. Successful candidates will hold a faculty appointment to Penn State College of Medicine and will be responsible for the care in patients at Penn State Hershey Medical Center. Individuals should have experience in hospital medicine and be comfortable managing patients in a sub-acute care setting. Hospitalists will be part of the post-acute care program and will work in collaboration with advanced practice clinicians, residents, and staff. In addition, the candidate will supervise physicians-in-training, both graduate and undergraduate level, as well as participate in other educational initiatives. The candidate will be encouraged to develop quality improvement projects in transitions of care and other scholarly pursuits around caring for this population. This opportunity has potential for growth into a leadership role as a medical director and/or other leadership roles.

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- Eligibility to acquire a license to practice in the Commonwealth of Pennsylvania
- Board certification in Internal Medicine
- No J1 visa waiver sponsorships available

For further consideration, please send your CV to:
Brian McClellan, MD – Director, Hospital Medicine
Penn State Milton S. Hershey Medical Center
500 University Drive
Hershey, PA 17033
or email: bmccll@hmc.psu.edu

HOSPITALIST

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A.O. Fox Hospital

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For confidential consideration, please contact:
Debra Ferrari, Manager, Medical Staff Recruitment
Bassett Healthcare Network
phone: 607-547-6982; fax: 607-547-3651 or email: debra.ferrari@bassett.org
or for more information visit our web-site at www.bassett.org

HOSPITALIST

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If you are interested in learning more about our opportunities, please contact Joanne Johnson at 518-897-2706, or e-mail johnson@adirondackhealth.org

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Robert McCann MD
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We are seeking a talented Internal Medicine and Family Medicine trained candidates to join one of our established Hospital Medicine programs in Northern California. We have opportunities located near Napa Valley, where the right candidate would receive a competitive compensation package and other benefits. We are seeking a Nocturnist or a physician who is willing to work a mix of days and nights.

TeamHealth is searching for a full-time hospitalist in Southern California at Barstow Community Hospital. The ideal candidate will demonstrate clinical excellence and superior communication skills while placing the patient above all other considerations. This position offers paid malpractice insurance and productivity and quality bonus. Visa candidates are welcomed to apply!

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The Core Competencies in Hospital Medicine – 2017 revision

Time again to improve, invigorate, and innovate.

“Y ou must be the change you wish to see in the world.” This famous quote from Mahatma Gandhi has inspired many to transform their work and personal space into an eternal quest for improvement. We hospitalists are now well-recognized agents of change in our work environment, improving the quality and safety of inpatient care, striving to create increased value, and promoting the delivery of cost-effective care.

When first published in 2006 by the Society of Hospital Medicine (SHM), the Core Competencies in Hospital Medicine was pivotal in laying the foundation for the then-evolving field of hospital medicine that was growing rapidly. It gave hospitalists common grounding to focus their collective energies to improve, invigorate, and innovate across a variety of domains. Attributes like these set the field apart, such that the American Board of Internal Medicine (ABIM) created a separate certification path for a focused practice in Hospital Medicine in 2009. To recognize it as a unique discipline, the ABIM used the Core Competencies to describe the characteristics of this new field.

Much has changed in the U.S. health care and hospital practice environment over the past decade. The 2017 revision of the Core Competencies seeks to maintain its relevance and value and, more importantly, highlight areas for future growth and innovation.

What does the “Core Competencies” represent and who should use it?

It comprises a set of competency-based learning objectives that present a shared understanding of the knowledge, skills, and attitudes expected of physicians practicing hospital medicine in the United States.

A common misconception is that every hospitalist can be expected to demonstrate proficiency in all topics in the Core Competencies. While every item in the compendium is highly relevant to the field as a whole, its significance for individual hospitalists will vary depending on their practice pattern, leadership role, and local culture.

It also is noteworthy to indicate that it is not a set of practice guidelines that provide recommendations based on the latest scientific evidence, nor does it represent any legal standard of care. Rather, the Core Competencies offer an agenda for curricular training and to broadly influence the direction of the field. It also is important to realize that the Core Competencies is not an all-inclusive list that restricts a hospitalist’s scope of practice. Instead, hospitalists should use the Core Competencies as an educational and professional benchmark with the ultimate goal of providing safe, efficient, and high-value care using interdisciplinary collaboration when necessary.

As a core set of attributes, all hospitalists can use it to reflect on their knowledge, skills, and attitudes, as well as those of their group or practice collectively. The Core Competencies highlights areas within the field that are prime for further research and quality improvement initiatives on a national, regional, and local level. Thus, they also should be of interest to health care administrators and a variety of stakeholders looking to support and fund such efforts in enhancing health care value and quality for all.

It is a framework for the development of curricula for both education and professional development purposes for use by hospitalists, hospital medicine programs, and health care institutions. Core Directors of Continuing Medical Education programs can use the Core Competencies to identify learning objectives that fulfill the goal of the educational program. Similarly, residency and fellowship program directors and medical school clerkship directors can use it to develop course syllabi targeted to the needs of their learner groups.

The 2017 revision of the Core Competencies in Hospital Medicine

The 53 chapters in the 2017 revision are divided into three sections – Clinical Conditions, Procedures, and Healthcare Systems, all integral to the practice of hospital medicine. Each chapter starts with an introductory paragraph that discusses the relevance and importance of the subject. Each competency-based learning objective describes a particular concept coupled with an action verb that specifies an expected level of proficiency.

For example, the action verb “explain” that requires a mere description of a subject denotes a lower competency level, compared with the verb “evaluate,” which implies not only an understanding of the matter but also the ability to assess its value for a particular purpose. These learning objectives are further categorized into knowledge, skills, and attitudes subsections to reflect the cognitive, psychomotor, and affective domains of learning.

Because hospitalists are the experts in complex hospital systems, the clinical and procedural sections have an additional subsection, “System Organization and Improvement.” The objectives in this paragraph emphasize the critical role that hospitalists can play as leaders of multidisciplinary teams to improve the quality of care of all patients with a similar condition or undergoing the same procedure.

Examples of everyday use of the Core Competencies for practicing hospitalists

A hospitalist looking to improve her performance of bedside thoracentesis reviews the chapter on Thoracentesis. She then decides to enhance her skills by attending an educational workshop on the use of point-of-care ultrasonography.

A hospital medicine group interested in improving the rate of common hospital-acquired infections reviews the Urinary Tract Infection, Hospital-Acquired and Healthcare-Associated Pneumonia, and Prevention of Healthcare-Associated Infections and Antimicrobial Resistance chapters to identify possible gaps in practice patterns. The group also goes through the chapters on Quality Improvement, Practice-based Learning and Improvement, and Hospitalist as Educator, to further reflect upon the characteristics of their practice environment. The group then adopts a separate strategy to address identified gaps by finding suitable evidence-based content in a format that best fits their need.

An attending physician leading a team of medical residents and students reviews the chapter on Syncope to identify the teaching objectives for each learner. He decides that the medical student should be able to “define syncope” and “explain the physiologic mechanisms that lead to reflex or neurally mediated syncope.” He determines that the intern on the team should be able to “differentiate syncope from other causes of loss of consciousness,” and the senior resident should be able to “formulate a logical diagnostic plan to determine the cause of syncope while avoiding rarely indicated diagnostic tests.”

New chapters in the 2017 revision

SHM’s Core Competencies Task Force (CCTF) considered several topics as potential new chapters for the 2017 Revision. The SHM Education Committee judged each for its value as a “core” subject by its relevance, intersection with other specialties, and its scope as a stand-alone chapter.

There are two new clinical conditions – hypotension and syncope – mainly chosen because of their clinical importance, the risk of complications, and management inconsistencies that offer hospitalists great opportunities for quality improvement initiatives. The CCTF also identified the use of point-of-care ultrasonography as a notable advancement in the field. A separate task force is working to evaluate best practices and develop a practice guideline that hospitalists can use. The CCTF expects to add more chapters as the field of hospital medicine continues to advance and transform the delivery of health care globally.

The 2017 Revision of the Core Competencies in Hospital Medicine is located online at www.journalofhospitalmedicine.com or using the URL shortener bit.ly/corecomp17.
The impact of the 2016 election
Will it change where we were heading?

Because of the health care policy work I have done over the years, I often get asked about what to expect from Capitol Hill and from federal policy makers in D.C. Since the surprise election results in November, the most common questions revolve around what impact the Trump administration is likely to have on the delivery system reform work done since the passage of the Affordable Care Act (ACA).

Will the ACA get repealed? And if so, what will that mean? Will the movement away from fee for service and toward payment for quality and satisfaction slow down or stop? Will Accountable Care Organizations (ACOs), bundled payments, and the testing of other new payment models all come to a halt, just as we were gaining confidence that this might be the answer to lower health care costs? Will the move toward population health (that we hoped would improve our health care system) stall or evaporate?

While much uncertainty remains, events since the election have given us some clues to answer these and other questions.

Let’s address the ACA. It’s important to recognize that the ACA cannot be repealed completely for at least two reasons. First, it does not exist as it was passed, having undergone several changes, including adjustments and exemptions. Second, parts of the bill would require 60 votes in the Senate to repeal, and those votes are not available to the party seeking repeal.

Yes, parts of the bill could be changed significantly with only Republican votes. However, the reality is that many changes would have occurred even if Hillary Clinton had won the election; there are elements of the current law that are not working and that both sides acknowledge need to be fixed, such as state individual insurance exchanges. There also are parts of the ACA that neither party would like to see rescinded, which are unlikely to be removed in a new law – for example, loss of insurance for preexisting conditions.

From the standpoint of providers, the most notable aspect of the current discussion is that proposed changes have largely been limited to addressing areas of insurance reform. This has potential impact on anyone who is covered under a revised plan. In the meantime, the important work of delivery system reform – the elements of the ACA that providers care the most about (and that will have the most impact on their careers) – have been left untouched. There are strong signs that this will remain the case and that this important work will continue.

What are those signs? First of all, neither the “repeal” bill passed by the House nor any of the bills considered by the Senate made any mention of interrupting any of the important work being done by the Center for Medicare & Medicaid Innovation (CMMI), the part of the Centers for Medicare & Medicaid Services created by the ACA to develop and test alternative payment models (APMs), such as accountable care organizations and bundled payments. If successful, this work will improve quality while lowering the growth of health care costs and may save a health care system that, if unchecked, will create a crushing financial burden that threatens the Medicare Trust Fund. It also is a strong and clear sign that the CMMI continues its work today under the same effective leadership that first created excitement about its potential to improve the delivery system.

But, probably the clearest sign that delivery system reform will continue was the strong bipartisan support shown in the passage of the Medicare Access and CHIP Reauthorization Act.
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