Reducing harm: When doing less is enough

Choosing Wisely shifts focus to implementation

By Suzanne Bopp

Launched in April 2012 – the same year an article in the Journal of the American Medical Association estimated the U.S. health care system was wasting between $600 billion and $1 trillion annually because of issues such as overtreatment – Choosing Wisely continues to change both conversations and practices across the medical field.1

In creating Choosing Wisely, the ABIM Foundation sought to establish a framework for physicians to think about managing resources and to talk to patients about which medical tests and procedures might be unnecessary – or even harmful.

“What we’re trying to do is avoid harm,” said Daniel Wolfson, executive vice president and chief operating officer of ABIM. “That harm can be clinical, physical, psychological, and financial. That’s what we’re trying to reduce.”

Today, more than 75 medical specialties have their own “five things” lists: procedures that practitioners should question before ordering. Hospitalists have a total of 10 procedures – 5 for adults and 5 for pediatrics – and hospitalists play a pivotal role in Choosing Wisely’s implementation, with crucial control over service lines.

“Hospitalists are on the front line of patient care,” said Moises Auron, MD, FAAP, FACP, SFHM, a hospitalist at the Cleveland Clinic. “We are actually the frontline workers in the hospital.”

Choosing Wisely’s successes

In terms of its initial goal – starting...
McNeill Jr. Award for Outstanding Physician Leadership in 2014, as voted by his peers.

Joahd Toure, MD, recently was hired by Adirondack Health (Saranac Lake, N.Y.) as its new chief medical officer. He started his new position in late June 2017.

Dr. Toure will oversee quality care for Adirondack Medical Center, as well as its subsidiaries, including four health centers, a women’s health center, a nursing home, a dental practice, and more.

A Massachusetts native, Dr. Toure most recently worked as chief of hospitalist medicine with AdvantageCare Physicians in New York City. There, he helped manage care for patients in the system’s 16 hospitals in the New York metro area. Previously, he was regional medical director for Essex Inpatient Physicians (Boxford, Mass.) and a staff hospitalist at South Shore Hospital (South Weymouth, Mass.).

Longtime employee Emily Chapman, MD, has been promoted to chief medical officer and vice president of medical affairs at Children’s Minnesota Hospital (Minneapolis). The former vice CMO took on her new role on July 5, 2017.

A 10-year veteran at Children’s Minnesota, Dr. Chapman will lead, direct, and oversee all clinical initiatives in the Children’s system, focusing on improved performance, safety of patients, education, and research. She will be part of Children’s strategy operation, as well.

Previously, Dr. Chapman served Children’s as its hospitalist program director, and as director of graduate medical education. She is an American Academy of Pediatrics Fellow.

Mark Sockell, MD, is the new chief medical officer at Meritage Medical Network in Novato, Calif. Meritage is a physician-run network that includes more than 700 board-certified physicians in both primary care and specialist fields.

SOCIETY PAGES | News and information about SHM

HOSPITALIST MOVERS AND SHAKERS

By Matt Pesyna

Pediatric hospitalist Patrick Conway, MD, has been named president and chief executive officer of Blue Cross and Blue Shield of North Carolina. Dr. Conway will take over for the retiring Brad Wilson on Oct. 1.

Dr. Conway is currently the deputy administrator for Innovation and Quality, and the director of the Center for Medicare & Medicaid Innovation for the Centers for Medicare and Medicaid Services (CMS). Previously, he was chief medical officer at CMS, having served both the Obama and Trump administrations.

Dr. Conway received the high honor of being elected to the National Academy of Medicine in 2014, and he has been selected as a Master of Hospital Medicine by the Society of Hospital Medicine.

Hossam Hafez, MD, recently claimed the role of chief of Hospitalist Service with Health Quest Medical Practice (LaGrangeville, N.Y.). Dr. Hafez will be based out of Health Quest’s Vassar Brothers Medical Center in Poughkeepsie, N.Y., coordinating care in that hospital and throughout the Health Quest system.

Caldwell UNC Healthcare (Lenoir, N.C.) has been named president and chief executive officer of Caldwell HealthCare. Dr. Conway will take over for the departing officer of Blue Cross and Blue Shield of North Carolina. Dr. Conway will take over for the departing Daniel Flood, MD, FHM; Anthony Carola, MD; James S. Lee, MD; Paul Xin, MD; Anthony A. Landolfi, MD; and others.

For all inquiries, please contact FREE Press 312-410-6409 or info@hospitalmedicine.org.

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Inclusion valued by advanced practice providers

Lorraine Britting, ANP, SFHM, encourages nonlinear career development

By Felicia Steele

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

This month, The Hospitalist spotlights Lorraine Britting, ANP, SFHM, clinical director of advanced practice in cardiology medicine at Beth Israel Deaconess Medical Center, Boston. Ms. Britting has been a SHM member for over 10 years, has served on various SHM committees, and was one of the first nurse practitioners to earn the Senior Fellow in Hospital Medicine designation.

How did you become a hospital medicine nurse practitioner, and when did you join SHM?

I was a nurse working in a coronary care unit and medical intensive care unit for 19 years when I graduated from a master’s program as a nurse practitioner (NP) in adult care. I thought I was going to work in the outpatient side after graduation, but my experience was much more suited to hospital medicine. My first job in 2004 was as a hospitalist in a very small community hospital affiliated with Beth Israel Deaconess Medical Center. I was the first NP to work as an inpatient provider there, which was challenging, but I had the opportunity to wear many hats and be involved with numerous quality initiatives that helped me grow as a provider and a leader.

I was working as the clinical manager of three hospitalist programs under the director by the time I left. I now work in inpatient cardiology and am the director of advanced practice providers (APPs) for cardiology medicine. I joined SHM in 2005 when it was a small but rapidly growing society, and I started work on the NP/IPA Committee. I was also involved in the Hospital Quality and Patient Safety Committee for 6 years and worked as a peer reviewer for the Journal of Hospital Medicine.

Describe your role on the Membership Committee. What is the committee currently working on?

I am finishing my 3rd year on the committee. In the last few months, we have been focusing on member engagement. We have collected information on why members choose to join SHM and what deters potential members from joining SHM, and we are developing strategies to build and retain our membership. The Membership Committee also reviews Fellows applications and discusses modifications of requirements each year.

As an NP, I have unique insight into motivations for why other APPs would join SHM and which membership benefits are most valuable. I find that many APPs join SHM because they feel that SHM treats them as equals, not junior members, as in some other physician organizations.

What does the Senior Fellow in Hospital Medicine designation mean to you?

I am grateful that SHM allows all members to be a part of the Fellows program, and I was honored to be one of the first NPs to become a Senior Fellow. Many medical societies allow APPs to join but do not offer the opportunity to become Fellows.

As a nurse practitioner, which SHM resources do you find most valuable?

As a special NIP, it’s easy for me to be current in cardiology but harder to keep current in general medicine. I find the clinical information very helpful to keep me up to date on hospital medicine. The Journal of Hospital Medicine and the Hospitalist are must reads, and the Annual Conference is, of course, very informative. I also enjoy the conversations on the Hospital Medicine Exchange and feel that the Choosing Wisely campaign is an excellent contribution to the goal of cost containment in everyday practice.

One of the best features of SHM is that I can meet other clinicians from around the country and around the world who have innovations or novel ideas that I can bring back to my institution.

What advice do you have for nurse practitioners as their role in hospital medicine continues to evolve?

I say to my staff that they should always say yes. Yes to continuing education, yes to opportunities for growth and advancement, yes to promotions, yes to research, etc. Careers develop in nonlinear ways, and you have to follow the opportunities as they come.

Ms. Steele is the marketing communications specialist at the Society of Hospital Medicine.

Get the latest news about upcoming events, new programs, and SHM initiatives

By Brett Radler

Recognizing American Diabetes Month, COPD Month, and CDC’s Get Smart Week with QI Solutions

> There’s no better time than during American Diabetes Month to learn more about SHM’s Glycemic Control programs. Find out how your institution can submit point-of-care data to SHM’s Data Center, generate monthly reports, and be included in the national glucometrics benchmark report. Be one of the 100-plus hospitals nationwide that are supported by SHM’s respected Glycemic Control Programs. Contact Sara Platt for a free demo at splatt@hospitalmedicine.org or by phone at 267-702-2672. For additional information, visit hospitalmedicine.org/gc.

> November marks Chronic Obstructive Pulmonary Disease (COPD) Month, and it is critical that hospitals begin to direct QI resources to improving care for COPD patients. SHM developed a free guide to help you make changes to COPD care at both the individual patient and the institutional levels. Visit hospitalmedicine.org/COPD to download the guide.

> And, in conjunction with the Centers for Disease Control & Prevention’s Get Smart Week, SHM is committed to promoting improved antibiotic prescrib- ing behaviors among U.S. hospitalists. Through the Fight the Resistance campaign, SHM has developed many antimicrobial stewardship resources, including an implementation guide, four educational modules, and posters to hang in your hospital. Learn more at hospitalmedicine.org/abs.

Present your abstract in front of a national audience at HM18

> SHM is accepting submissions for the Research, Innovations, and Clinical Vignettes (RIV) Competition at Hospital Medicine 2018 (HM18). Based on past experience, the RIV Competition is likely to be one of the most popular events at HM18.

The competition features more than 1,700 applicants vying for approximately 900 poster spots.

Plenary and oral sessions are chosen from the pool of abstracts prior to the conference, and authors are invited to present on site at HM18 in front of a national audience.

Many of the cutting-edge abstracts that are first presented at SHM’s RIV sessions go on to be published in highly respected medical journals. The competition also includes a special Trainee Award category for resident and student authors.

SHM is excited to launch the Resident Travel Grant for 10 residents to receive funding to help cover the costs of travel and accommodations to attend SHM’s annual conference. See full details on how to apply and the selection process at shmannualconference.org/riv.

The submission deadline is Sunday, Dec. 3, 2017.

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Swarm and suspicion leadership

Articulating a mission that others can rally around and follow

By Leonard J. Marcus, PhD

During your career, you serve as staff or leader to many different professional groups. Some are collaborative, collegial, and supportive. Others are competitive, antagonistic, or even combative. What are the benefits and downsides of each of these cultures and what can you do, as a hospitalist leader, to influence the character of your workplace?

There are arguments favoring each option. For people who prefer a warm, encouraging workplace environment, there is the pleasure and satisfaction that comes with the camaraderie of a friendly atmosphere. It boosts morale, reduces turnover, and improves patient care. Others argue that a “kumbaya” tone encourages sloppy practices and wastes time in social interaction and on decisions that favor personal favoritism over the whole of the response. This is an individual with organizational authority and subject-matter expertise appropriate to the situation at hand. In Boston, however, there were so many different jurisdictions—federal, state, and local—and so many different agencies, that no one leader stood above the others. They worked in a remarkably collaborative fashion. While the bombings themselves were tragic, the response itself was a success: All who survived the initial blasts lived, a function of remarkable emergency care, distribution to hospitals, and good medical care. The perpetrators were caught in 102 hours, and “Boston Strong” reflected a genuine city resilience.

These leaders worked together in ways that we had rarely seen before. What did we discover was a phenomenon we call “swarm leadership,” inspired by the ways ants, bees, and termites engage in collective work and decision making. These creatures have clear lines of communication and structures for judgment calls, often about food sources, nest locations, and threats. There are five principles of swarm leadership:

• **Unity of mission**—In Boston, that was to “save lives,” and it motivated and activated the whole of the response.

• **Generosity of spirit and action**—Across the community, people were eager to assist in the response.

• **Everyone stayed in their own lanes of responsibility and helped others succeed in theirs**—There were law enforcement, medical, and resilience activities and the theme across the leaders was “how can I help you make a success?”

• **No ego and no blame**—There was a level of emotional intelligence and maturity among the leaders.

• **A foundation of trusting relations**—These leaders had known one another for years and, though the decisions were tough, they were confident in the motives and actions of the others.

While the discovery emerged from our crisis research, the findings equally apply to other, more routine work and interactions. Conduct your own assessment. Have you worked in groups in which these principles of swarm leadership characterized the experience? People were focused on a shared mission: They were available to assist one another; accomplished their work in ways that were respectful and supportive of their different responsibilities; did not claim undue credit or swipe at each another; and knew one another well enough to trust the others’ actions and motives.

The flip side of this continuum of collaboration and competition we term “suspicion leadership.” This is characterized by selfish ambitions; narcissistic actions; grabs for authority and resources; credit taking for the good and accusations for the bad; and an environment of mistrust and back stabbing.

Leaders influence the tone and tenor of their own group’s interactions as well as interactions among different working groups. As role models, if they articulate and demonstrate a mission that others can rally around, they forge that critical unity of mission. By contrast, suspicion leaders make it clear that “it is all about me and my priorities.” There is much work to be done, and swarm leaders ensure that people have the resources, autonomy, and support necessary to get the job done. On the other end, the work environment is burdened by the uncertainties about who does what and who is responsible. Swarm leaders are focused on “we” and suspicion leaders are caught up on “me.” There is no trust when people are suspicious of one another. Much can be accomplished when people believe in themselves, their colleagues, and the reasons that bring them together.

As a hospitalist leader, you influence where on this continuum your group will lie. It is your choice to be a role model for the principles of swarm, encouraging the same among others. When those principles become the beliefs by which you work and relate, you will find an environment that inspires people to be and to do their best.

In the next column, how to build trust within your teams.
ARE YOU READY TO TAKE THE LEAP?

We’re here to propel you forward.

Being every patient’s superhero can be a rewarding and challenging career. CEP America has the tools to support your joy in medicine.
The Hospital Leader blog
Less job security, fewer employer-paid benefits than in previous generations

By Leslie Flores, MHA, SFHM

What we expect and what we get from work
Are American workers becoming happier with less? An interesting article in the Wall Street Journal reported on the findings of a recent survey of U.S. workers by the Conference Board, a research organization. Although the survey wasn’t specific to health care, much less to hospitalists, I see some parallels that might cause many of us to stop and think more carefully about what we expect from our work.

The Conference Board’s findings highlight how American workers’ employment relationships are evolving and how that is affecting what Americans think of as a “good” job. The biggest shift has come in the nature of the implied compact between workers and their employers: unlike a generation or two ago, U.S. workers no longer expect to receive generous benefits and lifelong employment in exchange for hard work and loyalty. In fact, I suspect many younger workers today would face the prospect of lifelong employment with a single company with distaste, if not outright horror.

American workers today tend to have less job security and fewer employer-paid benefits than they did in previous generations. A companion graphic in the WSJ reported that, while in 1973 only 6% of Americans said they worked too many hours and 7% said they had trouble completing their work in the time allotted, by 2016 26% said they often worked more than 48 hours a week and half said they work during their free time at least periodically. Two-thirds of Americans now say they need to spend at least half of their day working at high speeds or meeting tight deadlines.

Yet, despite these trends, the Conference Board found that, overall, U.S. workers are more satisfied with their jobs than they have been in the past. The WSJ article posits that workers are happier at work because they have adjusted to lower expectations of the employer-employee relationship. In addition, workers have more flexibility today to change jobs or companies to find the right fit or pursue advancement, and often have more influence over when, where, and how they do their jobs than ever before. Many are working as temps or independent contractors, or in similar “contingent” arrangements. Finally, more employers are offering a wider array of tools to aid with work-life balance, such as paid medical and family leave.

So what does all this have to do with hospitalists? Read the full post at hospitalleader.org.
Dabigatran, rivaroxaban linked to slight increase in GI bleeding risk

By Amy Karon
Frontline Medical News
FROM CLINICAL GASTROENTEROLOGY AND HEPATOLOGY

Compared with conventional anticoagulants, both dabigatran and rivaroxaban conferred small but statistically significant increases in the risk of major gastrointestinal bleeding in a systematic review and meta-analysis of randomized trials reported in the November issue of Clinical Gastroenterology and Hepatology (doi: 10.1016/j.cgh.2017.04.031).

But other novel oral anticoagulants (NOACs) showed no such effect compared with warfarin, aspirin, or placebo, reported Corey S. Miller, MD, of McGill University, Montreal, and his associates. “The potentially increased risk of GI bleeding associated with dabigatran and rivaroxaban observed in some of our subgroup analyses merits further consideration,” they wrote.

The NOACs (also known as non–vitamin K antagonist oral anticoagulants) help prevent stroke in patients with atrial fibrillation and prevent and treat venous thromboembolism. However, large AF trials have linked all except apixaban to an increased risk of major GI bleeding compared with warfarin. Dabigatran currently is the only NOAC with an approved reversal agent, “making the question of GI bleeding risk even more consequential,” the authors wrote.

They searched the MEDLINE, EMBASE, Cochrane, and ISI Web of Knowledge databases for reports of randomized trials of NOACs for approved indications published between 1980 and January 2016, which identified 43 trials of 166,289 patients. Most used warfarin as the comparator, but one study compared apixaban with aspirin and six studies compared apixaban, rivaroxaban, or dabigatran with placebo. Fifteen trials failed to specify bleeding sources and therefore could not be evaluated for the primary endpoint, the reviewers noted.

In the remaining 28 trials, 1.5% of NOAC recipients developed major GI bleeding, compared with 1.3% of recipients of conventional anticoagulants (odds ratio, 0.98; 95% confidence interval, 0.80-1.21). Five trials of dabigatran showed a 2% risk of major GI bleeding, compared with 1.4% with conventional anticoagulation, a slight but significant increase (OR, 1.27; 95% CI, 1.04-1.53). Eight trials of rivaroxaban showed a similar trend (bleeding risk, 1.7% vs. 1.3%; OR, 1.40; 95% CI, 1.15-1.70). In contrast, subgroup analyses of apixaban and edoxaban found no difference in risk of major GI bleeding versus conventional treatment.

Subgroup analyses by region found no differences except in Asia, where NOACs were associated with a significantly lower odds of major GI bleeding (0.5% and 1.2%, respectively; OR, 0.45; 95% CI, 0.22-0.91).

Most studies did not report minor or nonsevere bleeds or specify bleeding location within the GI tract, the reviewers noted. Given those caveats, NOACs and conventional anticoagulants conferred similar risks of clinically relevant nonmajor bleeding (0.6% and 0.6%, respectively), upper GI bleeding (1.5% and 1.6%), and lower GI bleeding (1.0% and 1.0%).

A post-hoc analysis using a random-effects model found no significant difference in risk of major GI bleeding between either rivaroxaban or dabigatran and conventional therapy, the reviewers said. In addition, the increased risk of bleeding with dabigatran was confined to the RELY and ROCKET trials of AF, both of which exposed patients to longer treatment periods. Dabigatran is coated with tarteric acid, which might have a “direct caustic effect on the intestinal lumen,” they wrote. Also, NOACs are incompletely absorbed across the GI mucosa and therefore have some anticoagulant activity in the GI lumen, unlike warfarin or parenteral anticoagulants.

The reviewers disclosed no funding sources. Dr. Miller and another author reported having no conflicts of interest. One author received research grants and speaker honoraria from Boehringer Ingelheim Canada, Bayer Canada, Daiichi Sankyo, Bristol-Myers Squibb, and Pfizer Canada; another author disclosed serving as a consultant to Pendopharm, Boston Scientific, and Cook.
Emphasizing an entrepreneurial spirit: Raman Palabindala, MD, SFHM

Dr. Palabindala joins The Hospitalist Editorial Advisory Board

By Eli Zimmerman

Venkatraraman “Raman” Palabindala, MD, FACP, SFHM, was destined to be a doctor since his first breath. Born in India, his father decided Dr. Palabindala would take the mantle as the doctor of the family, while his siblings took to other professions like engineering.

Eager to be in the thick of things, Dr. Palabindala has voraciously pursued leadership positions, leading to his current role as chief of the Division of Hospital Medicine at the University of Mississippi Medical Center, Jackson.

Over the course of his career, Dr. Palabindala has become engrossed with both the medical and business sides of medicine, hoping to break down some of the stigmas that each hold for the other. In India, Dr. Palabindala used writing to help educate rural populations on safe medical practices. Dr. Palabindala is enthusiastic about his role as one of the eight new members of The Hospitalist editorial advisory board, and took time to tell us more about himself in a recent interview.

Q: How did you get into medicine?
A: It’s all because of my dad’s motivation. My father believed in education, so when I was born, he said, “He’s going to be a doctor,” and as I grew up, I just worked toward being a physician and nothing else. I didn’t even have an option of choosing anything else. My dad said that I would be a doctor, and I am a doctor. I feel like that was the best thing that happened to me, though; it worked out well.

Q: What experience with SHM has made the most lasting impact on you?
A: I would say the best impression was from the Academic Hospitalist Academy meeting I attended in Denver. I think that was helpful, because it was like a boot camp where you have only a limited number of attendees with a dedicated mentor. That was amazing, and I learned a lot. It helped me in redesigning my approach to where I would like to be both short- and long-term. I implemented at least 50% of what I learned at that meeting.

Q: What is the worst advice you’ve received?
A: I don’t know if this is the “worst” advice, but in my second year, I was trying to take some leadership positions and was told I should wait, that leadership skills come with experience. I do think that’s a bad piece of advice. It’s all about learning how hard you work and then how fast you learn, and then how fast you implement. People who work, learn, and implement quickly can make a difference.

Q: What is one of the biggest challenges in hospital medicine?
A: I think talking about the business aspect of medicine, because it is like a taboo. We don’t really want to talk about whether the patient is covered or not covered by insurance, how much we are billing, and why we must discuss business issues while we are trying to focus on patient care, but these things are going to indirectly affect patient care, too. If you didn’t note the patient status accurately, they are going to get an inappropriate bill.

Q: What is the best advice you have received that you try to pass on to your students?
A: Do the rounds at the bedside. We have the tendency of doing everything outside and then going in the room and just telling the patient what we are going to do. Instead, I encourage everyone to be at the bedside. Even without students, I go and sit at the bedside and then review the data in terms the patient can understand, and then explain the care plan, so they actually feel like we are at the bedside for a longer time. We are with the patient for at least 10-15 minutes, but at the same time, we are getting things done. I encourage my students and residents to do this.

Q: Outside of patient care, what other career interests do you have?
A: I’m interested in smart clinics, and I actually have a patent for smart clinic chains. I’m a big fan of primary care, because, like hospitalists revolutionized inpatient care, I think we can revolutionize the outpatient care experience as well. I don’t think we are being very efficient with outpatient care.

Q: What is the best book that you’ve read recently and why was it the best?
A: Being Mortal by Atul Gawande. It’s a really beautiful book...

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Venkatraraman “Raman” Palabindala, MD, SFHM
Medical malpractice and the hospitalist: Reasons for optimism

Risk for hospitalists of facing a claim is relatively low

Fear of malpractice litigation weighs on many physicians, including hospitalists. Specific concerns that physicians have about facing a malpractice claim include stigmatization, loss of confidence in one’s own clinical skills, and a possible personal financial toll if an award exceeds the limit of one’s malpractice insurance. Physicists worry about malpractice are increasingly being raised during discussions of burnout, with a recent National Academy of Medicine discussion paper listing malpractice concerns as a possible factor that could contribute to physician burnout.1

In addition to physician concerns about malpractice-related stigma, payment of a malpractice claim triggers reporting requirements for organizations to which paid malpractice claims must be reported is the National Practitioner Data Bank, which is a government-run database of all malpractice payments made on behalf of individual physicians that can be queried by health care organizations as part of the credentialing process. Although the information in the National Practitioner Data Bank is not accessible to patients, a number of government agencies and state or federal agencies maintain websites providing publicly available information on individual physicians’ malpractice history.

Malpractice fears also influence physician behavior generally, leading to defensive medicine, though the actual costs of defensive medicine are debated. A national survey of physicians by Bishop and colleagues found that 91% felt that physicians order more tests and procedures than patients require in order to try to avoid malpractice claims.2 A survey of 1,020 hospitalists asked what testing they would undergo when provided clinical vignettes involving preoperative evaluation and syncope.4 Overuse of testing was common among hospitalists, and most hospitalists who overused testing specified that a desire to reassure either themselves or the patient or patient’s family was the reason for ordering the unnecessary testing.

The extent to which this overuse was driven by liability fears specifically is not clear. Overuse of testing was less common among physicians associated with Veterans Affairs Hospitals, who generally are not subject to personal medical malpractice liability. But a history of a prior malpractice claim was not associated with significantly greater overuse in the survey.

Hospitalists’ concerns about medical liability notwithstanding, data on the absolute malpractice risk of hospitalists and current trends in medical liability are both encouraging. An important source of misunderstanding about the national medical malpractice landscape is CRICO Strategies National Comparative Benchmarking System (CBS), which includes the malpractice experience from multiple insurers and represents 400 hospitals and 165,000 physicians. A December 2014 analysis of cases involving hospitalists from the CBS database showed that the malpractice claims rate for hospitalists was lower than those for other comparable groups of physicians.3 Hospitalists (in internal medicine) had a claims rate of 0.52 claims per 100 physician coverage-years, which was significantly lower than the claims rate for nonhospitalist internal medicine physicians (with a rate of 1.91 claims per 100 physician coverage-years) and for emergency medicine physicians (with a rate of 3.50 claims per 100 physician coverage-years). The most common types of malpractice allegations made against hospitalists were related to medical treatment, diagnosis, and medications. Medication-related allegations made up almost 10% of claims against hospitalists, and a recent CRICO Benchmarking Report on medication-related malpractice claims found that the most common classes of medications involved in claims against hospitalists were anti coagulants, analgesics, and antibiotics.5 Payment was made in about one-third of hospitalist cases, which is similar to other specialties. Among hospitalist cases in which a payment was made, the mean payment was $384,617, which is comparable to other inpatient paid claims, though significantly higher than the average payment on outpatient claims.

A remarkable national trend in medical malpractice, based on an analysis of data supplied by the National Practitioner Data Bank, is that the overall rate of paid claims is decreasing. From 1992 to 2014, the overall rate of paid claims dropped 55.7%.6 To varying degrees, the drop in paid claims has occurred across all specialties, with internal medicine in particular dropping varying degrees, the drop in paid claims was associated with significantly lower claims rate for nonhospitalist internal medicine physicians (with a rate of 1.91 claims per 100 physician coverage-years) and for emergency medicine physicians (with a rate of 3.50 claims per 100 physician coverage-years). The most common types of malpractice allegations made against hospitalists were related to medical treatment, diagnosis, and medications. Medication-related allegations made up almost 10% of claims against hospitalists, and a recent CRICO Benchmarking Report on medication-related malpractice claims found that the most common classes of medications involved in claims against hospitalists were anticoagulants, analgesics, and antibiotics. Payment was made in about one-third of hospitalist cases, which is similar to other specialties. Among hospitalist cases in which a payment was made, the mean payment was $384,617, which is comparable to other inpatient paid claims, though significantly higher than the average payment on outpatient claims.

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One of the most prominent communication and resolution programs exists at the University of Michigan, and published experience from this program shows that, after implementation of the program, significant drop were seen in the number of malpractice lawsuits, the time it took to resolve malpractice claims, the amount paid in patient compensation on malpractice claims, and the costs involved with litigating malpractice claims.8 One of the goals of communication and resolution programs is to utilize the information from the investigations of whether medical errors occurred to find areas where patient safety systems can be improved, thereby using the medical malpractice system to promote patient safety. Although the University of Michigan’s experience with its communication and resolution program is very encouraging, it remains to be seen how widely such programs will be adopted. Medical malpractice is primarily governed at the state level, and the liability laws of some states are more conducive than others to the implementation of these programs.

Hospitalists concerns about medical malpractice are likely to persist, as being named in a malpractice lawsuit is stressful, regardless of the outcome of the case. Contributing to the stress of facing a malpractice claim, cases typically take 3-5 years to be resolved. However, the risk for hospitalists facing a medical malpractice claim is relatively low. Moreover, given national trends, hospitalists’ liability risk would be expected to remain low or decrease moving forward.9

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The opioid epidemic and its impact on the health care system

Hospitalists a part of multifaceted approach to the crisis

The United States is in the midst of a public health crisis. Every day, 91 Americans die from opioid overdoses.° Opioid addiction has a tremendous negative effect on parents and children by destroying lives and breaking up families. When used appropriately, these drugs, such as morphine, hydrocodone, oxycodone, and fentanyl, provide much needed pain relief to patients, especially after a surgical procedure or during treatment for cancer. Unfortunately, opioids also have qualities that make them addictive and prone to overdose and abuse.

Heroin and other opioid drugs are affecting social, health, and economic welfare in communities throughout the United States. Opioid addiction does not discriminate among occupations, socioeconomic statuses, or ethnicities. Once addicted, users find it difficult to fight and overcome the habit. In this context, hospitalists who develop and use opioid policies and tactics are better equipped to deal with the increasing prevalence of opioid addiction and overdoses seen in the medical center environment.

Overview of opioid addiction

Opioids are more prevalent and easily available today in part because of the intense marketing campaigns by pharmaceutical companies. In fact, according to the 2014 National Survey on Drug Use and Health, almost 2 million Americans were dependent on or abused prescription opioids.° Opioids create artificial endorphins in the brain, amplifying positive feelings and euphoria. Once they become dependent, patients feel sick and become depressed when they aren’t using narcotics. They experience uncontrollable cravings, relieved only by increasing opioid use. Personal relationships and finances are severely affected because patients will do whatever they can to acquire more opioids. Some resort to doctor shopping to obtain more opioids, while others will engage in drug trafficking to purchase and sell narcotics. Most new heroin users report that they started with nonmedical use of opioid pain relievers.° Unfortunately, in 2015, there were more than 20,000 prescription opioid overdose deaths and almost 15,000 overdose deaths related to heroin. In addition to addiction and death, overdose of narcotics can cause many medical issues, including dizziness, constipation, depression, and immune dysfunction.

As with any addiction, there are many problems related to opiate withdrawal. Some of these include anxiety, rtheta, lacrimation, piloerection, mydriasis, nausea, vomiting, abdominal pain, diarrhea, tachycardia, and hypertension. Methadone, buprenorphine, and extended-release naltrexone typically are used to help alleviate cravings and the symptoms of withdrawal. With more than 1,000 patients treated daily by emergency departments for misuse of prescription opioids, it’s imperative for the medical community to address this health care crisis.

Impact on first responders and hospitalists

The impact of this epidemic on the medical community is dramatic. Emergency system resources, already on overload, are further taxed and drained by the increased 911 calls for overdose incidents. This means that, instead of responding to heart attacks, strokes, or other emergencies, first responders are spending time stabilizing overdose patients and taking them to hospitals. This resource drain spreads to emergency rooms and hospitals as they treat these patients. Eventually, the epidemic results in higher insurance costs to cover the impact on medical resources.

Strategies for hospitalists

A multifaceted approach is required to combat this crisis, and hospitalists are one component of that solution. Here are strategies hospitalists can employ to combat the growing use and abuse of narcotics.

• Screen for high-risk conditions. Before prescribing opioids, screen patients for conditions that may be exacerbated by opioid use, such as sleep apnea, obesity, chronic obstructive pulmonary disease, and heart failure, as well as whether they are using medications that cause sedation and respiratory depression.

• Develop and follow pain management clinical pathway protocols. For example, start with nonopioid analgesics, such as acetaminophen, ibuprofen, and naproxen, for patients with mild pain. If the patient is in moderate pain, or if the mild pain was unresolved by the first type of medicine, continue with opioid analgesics including codeine, oxycodone, hydrocodone, or morphine. Finally, if the patient is experiencing severe pain, or if the mild to moderate pain was unresolved by previous medications, prescribe higher doses of morphine, fentanyl, or hydromorphone or use a patient-controlled analgesia delivery of an intravenous opioid.

• Discuss other treatment options. Instead of prescribing narcotics, assess whether other treatment options are available. These include physical and occupational therapy, steroid shots, massage, local nerve blocks, and muscle relaxers.

• Evaluate the reason(s) for current use of prescribed narcotics. It’s crucial to determine why patients are using opioids. The medical condition for which they were prescribed these medications may have resolved. If patients are using opioids without a medically indicated reason, offer alternative medications, such as methadone or naltrexone, and provide education to help them slowly taper off the drugs. Do not cease opioid use altogether unless the use is contraindicated because of other medical conditions or unvaluable signs (for example, blood pressure).

• Train nurses on opioid use and addiction. Educate nurses about opioid addiction risk factors and symptoms of addiction. Instruct them on managing the Ramsay Sedation Scale and using an opioid sedation scale with patients receiving narcotics.

• Educate families on opioid use and addiction. Counsel patients and their families on the long-term effects of opioid use and what the warning signs of addiction. Teach them alternatives to doctor shopping to obtain more opioids.

• Offer referrals to specialized clinics. Work with social workers, case managers, and local mental health professionals to refer patients to behavioral counseling, patient and family support groups, and monitored detoxification clinics qualified to treat opioid addiction.

Socioeconomic impact

The effects of the opioid epidemic are felt in all areas of the United States, especially in the health care industry. Emergency department visits are mounting while billions of dollars are spent on medical care for those addicted to opioids. Additionally, the socioeconomic effects of this crisis contribute to increasing depression, anxiety, missed days of work or school, unemployment, drop-out rates, and loss of productivity among those addicted to opioids. Also, the epidemic is adversely affecting families, leading to increased divorce rates, single-parent families, and child abuse and neglect. By creating strategies and protocols for medical staff, patients, and families affected by opioid use, addiction, or overdose, hospitalists can have a positive influence on patients’ lives and ultimately the opioid epidemic.

References


This advertisement is not available for the digital edition.
Who doesn’t like alphabet soup? Those noodles shaped as letters floating in a delicious hot broth serve as an educational way for young children to play with their food. Of course, this commentary is not about warm food suitable for a cold day but, instead, about another notion of alphabet soup—a metaphor for physicians’ failure to optimally utilize our alphabet soup of venous thromboembolism studies.

The medical literature that has studied the incidence, prevalence, diagnosis, and management of acute pulmonary embolism (PE) is vast. Yes, we have our own PE “alphabet soup”—a “hodgepodge especially of initials,” according to the Merriam-Webster Dictionary. ICOPER (International Cooperative Pulmonary Embolism Registry) and RIETE (Computerized Registry of Patients With Venous Thromboembolism) help estimate prevalence of the disease and indicate high-risk groups. PESI (Pulmonary Embolism Severity Index) and PERC (Pulmonary Embolism Rule-Out Criteria) provide useful predictive information prior to proceeding with diagnostic testing for PE.
nary Embolism Thrombolysis), MOPETT (Moderate Pulmonary Embolism Treated With Thrombolysis), and PERFECT (Pulmonary Embolism Response to Fragmentation, Embolectomy, and Catheter Thrombolysis) studies help to guide the decision to administer fibrinolytic therapy, particularly in the cases of so-called submassive or intermediate-risk PE.

We have no shortage of registries, scoring criteria, and clinical studies standing by to guide us in the management of acute PE. With this plethora of acronyms in scholarly publications, it would seem that health professionals should be well informed and better prepared to manage acute PE than ever.

And yet, in a study published in Hospital Practice (2017 Aug 30. doi: 10.1080/21548351.2017.1372033), my colleagues and I showed that, to a large extent, physicians admitting patients to the hospital between 2011 and 2013 for acute PE failed to order or perform even the most basic noninvasive testing on their patients, despite strong recommendations for such testing from both the 2011 American Heart Association (AHA) and the 2014 European Society of Cardiology as part of the risk assessment of acute PE.

At the time of the patients’ PE admissions, the 2011 AHA statement already had been published, and it was recognized that medical and interventional therapies needed to be appropriate to the characteristics of the patient with PE. Specifically, in order to determine a prognosis, assessment of right heart strain with an echocardiogram, ECG, and brain natriuretic peptide testing was recommended. For similar reasons, a serum troponin test was recommended to evaluate any myocardial necrosis.

While the 2011 AHA statement was based on a preponderance of evidence-based medicine, our research suggests that physicians may be doing a suboptimal job of collecting the necessary data to manage our acute PE patients. In defense of those physicians we evaluated, these data were collected just before the European Society of Cardiology disseminated their recommendations for risk stratification in 2014. The PEITHO, MOPETT, and PERFECT findings – though already presented at medical meetings in part – were not published in scientific journals in full until 2013 or thereafter.

Nevertheless, I believe these findings illustrate the merits of the Pulmonary Embolism Response Team (PERT) concept. As the data we studied suggest, not only might hospital-based physicians inadequately assess the severity of patients’ PE, but they also may fail to ask for consultations from the specialists who could be most useful in assisting in the proper evaluation and management of these patients. PERTs ensure that every patient admitted to the hospital with the diagnosis of PE will be assessed by a team of physicians with the expertise and professional interest in best managing these patients.

The expectation is that, with the institution of a PERT at each hospital, a more comprehensive evaluation of patients’ PE may lead to optimal management and, thereby, to improved short- and long-term outcomes. Also, we should not assume that a greater degree of expertise and imaging capabilities at an academic university hospital translates to a more comprehensive evaluation of PE; our research shows that this is not necessarily the case. PERTs may help mobilize resources that are underutilized even at academic university hospitals. Those interested in learning more about PERTs may contact the National PERT Consortium via email at contact@pertconsortium.org or go online to www.pertconsortium.org.

Rather than wallow in an alphabet soup of acronyms, let us place our acronymic clinical PE trials to good use. Gather the appropriate clinical data, consult experts in pulmonary embolism, and stratify patients admitted to the hospital with acute PE so that we can manage the expectations of short- and long-term outcomes.

When he became president in 1933, Franklin D. Roosevelt sought to lift the United States from the Great Depression, in part with a New Deal “alphabet soup” of programs. Like FDR, let us put our own alphabet soup – of PE studies and position statements – to good use: to work for the good of people hospitalized with acute pulmonary embolism.
I see that as the next big thing: statewide efforts that pair delivery systems with multistakeholder groups, regional health collaborators, and physician organizations, all working to reduce use.

—Daniel Wolfson, executive vice president and chief operating officer of ABIM

The road ahead

The time it takes to have these conversations is more than a sticking point for Choosing Wisely, it’s an underlying challenge in our health care system.

“For example, it takes more time to have a discussion about what the alternatives are to alleviate pain — other than taking an opioid,” Dr. Bulger said. “The easiest thing to do is to write the script for the opioid — which is part of the reason why we got where we are with opioids — or to write the script for an antibiotic — which is part of the reason why we got here with drug resistance. We haven’t done a great deal to address those underlying drivers. Without doing that, you can only go so far with a campaign like Choosing Wisely.”

Issues around costs fall into a similar category: an underlying issue that demands a broader conversation. “It’s just so elusive,” Dr. Cho said. “There are so many different versions of cost, and from a hospital medicine standpoint, that process is so prolonged. We may not touch base with that patient when they get their bill, so far for us to have a conversation about exactly how much this would cost can be difficult. It’s so complex; I would love for that to be tackled so that it’s a little more straightforward.”

Perhaps these additional conversations will start to happen as value becomes a more defined career path in hospital medicine and as the ideas behind Choosing Wisely continue to move to the forefront.

“There are people involved in career paths in education, quality and safety, research, and administration, but there are very few people actually focused on value — and then finding the resources and the mobilization to do that,” Dr. Cho said. “I think it would really be helpful moving forward to find more people doing this and getting more support from their organizations.”

In one step toward that goal, a value track will be added to the Society of Hospital Medicine annual meeting.

“I think you’re going to see more emphasis on this, especially with younger hospitalists that are really pushing the value theme,” Dr. Bulger said. “I think those are really the lessons learned in what we started with Choosing Wisely.”

References


How hospitalists can focus on health equity

Achieving health equity requires removing the ‘obstacles to health’

By Kelly April Tyrrell

A decade ago, most hospitalists and hospital leaders were not thinking about health equity, let alone discussing it.

“It used to be we could say, ‘We saved your life but everything else is beyond our control,’” said Nick Fitterman, MD, FACP, SFHM, vice chair of Hospital Medicine at Northwell Health in New York, and associate professor of medicine at Hofstra Northwell School of Medicine and Long Island Jewish Medical Center.

But today?

“We have a better understanding of that which affects the health of most of our patients is what happens outside the four walls of the hospital,” he said. “Now, we can work with case managers and community-based organizations to help address housing and food. We can at least steer our patients to resources and help them with the social determinants of their health.”

That’s because the social determinants of health – diet, inactivity, substance abuse, poverty, and more – “account for nearly 75% of disease,” said Kevin Smothers, MD, FACEP, vice president and chief medical officer at Adventist HealthCare Shady Grove Medical Center in Rockville, Md. “Health care providers are only able to fix about 15% of the causes of poor health.”

A report recently published by the University of California, San Francisco, and the Robert Wood Johnson Foundation (RWJF) takes on the definition of health equity: “Clarity is particularly important because pursuing equity often involves engaging diverse audiences and stakeholders, each with their own constituencies, beliefs, and agendas. And in an era of data, a sound definition is crucial to shape the benchmarks against which progress can be measured.”

Measurement is an unavoidable aspect of the practice of medicine in the 21st century and both Dr. Fitterman and Dr. Smothers say hospitals must start focusing on the nonmedical factors that influence health to find success.

“Payment reform is forcing delivery reform,” Dr. Fitterman said.

A report from the National Academies of Sciences, Engineering, and Medicine estimates that racial health disparities alone – not including other marginalized groups – could cost health insurers as much as $337 billion between 2009 and 2018. “Hospitals and hospitalists have to focus on health disparities in order to address the multitude of chronic medical conditions they treat,” said Dr. Smothers.

For the purposes of measurement, the authors of the RWJF report conclude that “health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.” The report attempts to define health equity as a means of specifically addressing it.

“Population health means taking care of the wider population, in terms of health and cost,” said Dr. Fitterman. “But if you’re just looking at the average health of a population you could still be missing pockets of disparity, since there will be pockets that excel and pockets of disparity but the average looks good. If we’re not careful how we measure it, we may leave some groups behind.”

Achieving health equity, the RWJF report says, requires removing the ‘obstacles to health such as poverty, discrimination, and their consequences, including powerless and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.” Health equity means that everyone must have “a fair and just opportunity to be as healthy as possible.”

It lays out four “key steps” to achieve health equity: 1. Identify important health disparities; 2. Change and implement policies, laws, systems, environments, and practices to reduce inequities in the opportunities and resources needed to be healthier; 3. Evaluate and monitor efforts using short- and long-term measures; and 4. Reassess strategies in light of process and outcomes, plan next steps.

Everyone can be a part of the solutions to address health disparities, Dr. Fitterman said. He was not involved in the report. For hospitalists interested in addressing health equity, Dr. Braveman had two recommendations:

• Choose to practice at a hospital that serves large numbers of socially disadvantaged people;
• Put particular effort into helping the most socially disadvantaged patients in their hospitals.

This should include understanding the conditions that bring disadvantaged people to the hospital in disproportionate numbers, Dr. Braveman said, and getting involved in initiatives intended to address them. For example, after observing that disproportionate numbers of poor kids are hospitalized with asthma, hospitalists might connect with community groups that can help address pest abatement in low-income housing.

Health equity efforts should not just focus on socioeconomically or racially disadvantaged groups either, Dr. Braveman and Dr. Fitterman argue. They must also address others who are marginalized, like patients who are disabled, elderly, obese, non-English speaking, or gender nonconforming.

Dr. Fitterman said his hospital leadership has made health equity a priority and help redirect patients to more appropriate, less costly services, such as primary care, urgent care, home care, and subacute care, when it is in the patient’s best interest.

Not only are Adventist’s hospitalists aware of community resources available to their patients, they are also culturally diverse. Dr. Smothers said, noting that they are “well equipped to manage our diverse patient population, including those who lack adequate health care.”

Additionally, Dr. Smothers said: “We engage our hospitalists in care coordination, encouraging them to make recommendations on alternative treatment locations and/or options at the point of entry.” And all admitted patients with chronic conditions are provided with a month’s supply of medication and schedule transportation for their follow-up appointment upon discharge.

“We need to inquire about social determinants that may prohibit our success with our patients,” said Dr. Fitterman. “You are not always going to be able to fix it, but it doesn’t mean you shouldn’t try.”

References
Innovations | Quality, patient safety, and technology initiatives | By Suzanne Bopp

QUALITY

New curriculum teaches value-based health care

Hospitalist-developed content is applicable to ‘our day-to-day world.’

While value has become an imperative in both training and health care delivery, few tools exist to teach hospitalists and other providers the basic concepts of value. “Hospitalists are on the front lines of health care value delivery, and it is critical that we understand and embrace the concepts of value; however, we also need to be able to deliver upon these ideals,” said Christopher Moriates, MD, assistant dean for health care value at the University of Texas at Austin.

Dr. Moriates developed a free online core curriculum called ‘Discovering Value-Based Health Care.’ “We built ‘Discovering Value-Based Health Care’ to serve as an adaptive learning resource for clinicians at all levels – from medical school through practicing physicians,” he said. The first module, “There’s a Better Way,” is available now.

“As a hospitalist, I ensured that the content would be specifically applicable to our day-to-day world and experience,” Dr. Moriates said. “Using the modules, hospitalists can better understand how emerging tools, such as the University of Utah’s Value-Drive Outcome tool, can be used by hospitalists to improve value. The modules also dig into thorny subjects like understanding health care costs – for example, what really is the difference between costs and charges?”

The course is adaptive and interactive, using the latest in instructional technology, he said. Hospitalists can take the course independently and earn free CME credits; those who complete all three modules in this first collection will receive a certificate of completion and CME credit.

The goal is to release 10 modules over the course of this academic year, Dr. Moriates said. Future collections will cover ‘value-based health care delivery,’ ‘how to deliver high-value care at the bedside,’ and ‘how to deliver high-value care in systems.’

“As value-based health care is increasingly taught in medical schools and residency training, it is important for hospitalists – especially any of us that work with trainees – to be able to speak the same language and understand what our trainees now will know,” he said.  

Consider ‘impactibility’ to prevent hospital readmissions

Link predictive models to actionable opportunities for improving care

With the goal of reducing 28-day or 30-day readmissions, some health care teams are turning to predictive models to identify patients at high risk for readmission and to efficiently focus resource-intensive prevention strategies. Recently, there’s been a rapid multiplying of these models. Many of these models do accurately predict readmission risk, according to a recent BMJ editorial. “Among the 14 published models that target all unplanned readmissions (rather than readmissions for specific patient groups), the ‘C statistic’ ranges from 0.55 to 0.80, meaning that, when presented with two patients, these models correctly identify the higher risk individual between 55% and 80% of the time,” the authors wrote.

But, the authors suggested, the real value is not in simply making predictions but in using predictive models in ways that improve outcomes for patients.

“This will require linking predictive models to actionable opportunities for improving care,” they wrote. “Such linkages will most likely be identified through close collaboration between analytical teams, health care practitioners, and patients.” Being at high risk of readmission is not the only consideration; the patient must also be able to benefit from interventions being considered – they must be “impactible.”

“The distinction between predictive risk and impactibility might explain why practitioners tend to identify quite different patients for intervention than predictive risk models,” the authors wrote.

But together, predictive models and clinicians might produce more effective decisions than either does alone. “One of the strengths of predictive models is that they produce objective and consistent judgments regarding readmission risk, whereas clinical judgment can be affected by personal attitudes or attentiveness. Predictive risk models can also be operationalized across whole populations, and might therefore identify needs that would otherwise be missed by clinical teams (e.g., among more socioeconomically deprived neighbourhoods or groups with inadequate primary care).” On the other hand, clinicians have access to a much wider range of information regarding patients than predictive risk models, which is essential to judge impactibility.”

The authors conclude, “The predictive modelling enterprise would benefit enormously from such collaboration because the real goal of this activity lies not in predicting the risk of readmission but in identifying patients at risk for preventable readmissions and ‘impactible’ by available interventions.”

Reference


Quick Byte

Take a seat: Enhancing patient satisfaction

A survey of 305 inpatients showed that patients who reported that at least one provider sat down while caring for them were more likely to feel that their provider spent appropriate time with them and that their provider kept them well informed. The authors concluded that sitting down at a patient’s bedside improves some aspects of patients’ and families’ experience of their hospital care, and should be included in hospital efforts to improve the patient experience.

Reference


Health care workers creating innovations by applying “design thinking” – a human-centered approach to innovation “that comes from the business world – is a growing trend, according to a recent New York Times article.

“With design thinking, the innovations come from those who actually work there, providing feedback to designers to improve the final product,” wrote author Amitha Kalachandran, MD, MHS.

“Health providers... are uniquely positioned to come up with fresh solutions to health care problems,” Dr. Kalachandran wrote. An example at her own hospital: The leader of the trauma team now wears an orange vest, clearly identifying who’s in charge in a potentially chaotic situation. It was an idea created by a hospital nurse.

“A 2016 report that looked at ways in which a health system can implement design thinking identified three principles behind the approach: empathy for the user, in this case a patient, doctor or other health care provider; the involvement of an interdisciplinary team; and rapid prototyping of the idea,” she wrote. “To develop a truly useful product, a comprehensive understanding of the problem the innovation aims to solve is paramount.”

In design thinking, described as creative, multidisciplinary thinking around a problem, groups naturally coalesce to find such solutions. The article cites examples such as Clinicians for Design, an international group of providers focused on improving hospital layouts, and Health Design by Us, a collaborative group that supports health care innovations such as a mobile system for diabetes management, designed by a patient.

Reference

For many patients, paying for medication presents a serious challenge. Studies show that up to 45% of Americans do not fill prescriptions secondary to cost, and medication nonadherence leads to morbidity and mortality, with costs from $100 billion to $300 billion annually. One way to address the problem is by empowering clinicians to reduce patient outpatient medication costs — the goal described in a recent abstract.

The researchers partnered with GoodRx to provide prescription pricing and discount information. “We used this data to create a novel proprietary algorithm-based tool to further reduce prescription cost,” wrote lead author Alan A. Kubey, MD. “Leveraging a combination of therapeutic interchange and analysis of medication dose, formulation, quantity, pharmacy, and available discounts, we are able to identify the most high-value therapeutic choice for a particular patient.”

Initial testing was promising. One patient, admitted for the fourth time in 14 months for hypertriglyceridemia-induced pancreatitis secondary to medication nonadherence, was able to reduce 90-day outpatient medication cost by 95%, from $1,287.00 to $61.79. By reducing his readmissions, the institution saved more than $20,000 a year.

The researchers secured internal grant funding to develop an automated version of the tool. “We currently have technology that can dramatically reduce the cost of many medications with early promising results for patient outcomes, readmissions rates and overall systemic cost,” Dr. Kubey said. “We are working rapidly to further develop and study our tool and, if prospective results confirm our initial findings, we will seek to provide this tool to clinicians broadly.”

Such tools are a true win-win. Hospitalists using them help ensure that discharged patients are able to afford the often life-saving medications that will keep them healthy and out of the hospital, improve readmission rates, patient satisfaction metrics, total system cost, and, most important, do right by our patients in need for whom we are charged to care, Dr. Kubey said.

“Hospitalists first must be aware that savings of 90% or more are possible for many medications and that medication nonadherence because of cost is a serious issue affecting nearly half the patients we see,” he said. “The first step is simply asking patients if medication cost is proving troublesome — we cannot address what we do not see. The second step is to use current discount tools such as GoodRx, Needy-Meds, and the like — and, we hope, in the not too distant future, our tool, which we plan to integrate into EHR prescribing to make it easy and nearly instantaneous for hospitalists to prescribe the most high-value, low-cost medication regimen for each individual patient at discharge.”

Reference
KEY POINTS

• The classic symptom for PAD is claudication. In contrast, symptoms of CVI present more variably.
• Other than cases of critical limb ischemia, the main objective of identifying PAD or CVI is to arrange testing and follow-up after discharge.

1 In addition to an infection, could there also be underlying peripheral arterial or venous disease?

Patients with peripheral edema and vascular disease are predisposed to recurrent lower extremity SSTIs. For assessment of vascular disease, it is important to consider PAD and CVI separately.

CVI refers to the spectrum of syndromes caused by venous valvular incompetency, venous obstruction, or decreased muscle contraction. Veins cannot maximally deliver venous blood back to the heart resulting in venous pooling in the lower extremities. The exact mechanism of the skin changes that accompany venous insufficiency is unknown but may be related to cytokine cascades that result in perivascular inflammation and a weakening of the dermal barrier. Over time, this can develop into spontaneous ulceration of the skin.3,5

PAD refers to atherosclerosis of the noncerebral, noncoronary arteries, which leads to ischemic symptoms and atrophy of the supplied territory. Ulceration usually results from mild trauma due to poor wound healing.3,4 A thorough history, assessment of risk factors, and physical exam are essential to identifying these two potential diagnoses in patients admitted with SSTIs.

First, the provider should assess risk factors for underlying vascular disease. For PAD, these include risk factors similar to those of coronary artery disease (CAD): hyperension, hyperlipidemia, history of smoking, and poorly controlled diabetes. Chronic kidney disease and family history are also associated with PAD. Since PAD and CAD share similar risk factors, it is often common for patients with CAD (as well as patients with cerebrovascular disease) to have PAD. Risk factors for CVI include obesity, chronic sedentary lifestyle, multiple pregnancies, family history, and prior superficial or deep venous thrombosis.2,4

Next, the provider should ask the patient about symptoms experienced prior to the onset of the current SSTI. Patients with either arterial or venous disease will typically report lower extremity symptoms that have been occurring for months to years, long before the acute SSTI. The classic symptom for PAD is claudication – leg pain or cramping that occurs on exertion and improves with rest. This is due to decreased arterial blood flow to the affected limb, felt most acutely during exercise. Other symptoms include numbness, a cool lower extremity, and lower extremity hair loss. As PAD progresses, a patient may also have rest pain, which may indicate more critical ischemia, as well as nonhealing wounds after mild trauma.

In contrast, symptoms of CVI present more variably. CVI can be associated with heaviness, cramping, and pain that are usually worse in the dependent position and relieved with elevation. Patients may also report dry skin, edema, pruritus, scaling, skin tightness, and indolent ulcers at advanced stages.2,5

The physical exam can help the provider distinguish between venous and arterial disease. Patients with PAD often have diminished or nonpalpable distal pulses, bruises in proximal arteries, pallor, hair loss, nail thickening, decreased capillary refill time, and ulceration of the toes. CVI shares some common characteristics but can be distinguished by evidence of various venous, telangiectasia, edema (which spares the foot), lipodermatosclerosis, and atrophic blanche (white scarring around the ankle). Patients with venous disease tend to have warm lower extremities and palpable pulses. Often, there is hyperpigmentation, especially around the ankles, and associated eczematous changes with scaling, erythema, and weeping. CVI can also present with ulcers. In addition, if the SSTI is not responding to appropriate antibiotics in the typical time frame, this may be a clue that there is an underlying vascular issue.2,6

Ulcers, whether arterial or venous, comprise a break in the skin’s protective barrier and give bacteria a point of entry. Thus, ulcers often get superinfected, leading to an SSTI rather than SSTIs causing ulcers. The anatomic location can help differentiate between venous and arterial ulcers. Arterial ulcers tend to occur on the toes, heels, and lateral and medial malleoli. Venous ulcers are classically present above the medial malleolus but can occur anywhere from the tip of the toes to the third of the leg. Venous ulcers are more superficial and have an irregular shape, while arterial ulcers are deeper and have smoother edges. Both arterial and venous ulcers can be exudative though venous ulcers are rarely necrotic. Both arterial and venous ulcers can be painful.7,9
In an inpatient with risk factors for PAD and claudication symptoms, referral for outpatient ABIs with subsequent follow-up by a primary care physician (PCP) should be arranged. If a diagnosis of PAD is made via ABI, the PCP should reinforce risk factor modification (tobacco cessation, diet, exercise, and aggressive lipid, blood pressure, and glucose control) and start medical management with a single antiplatelet agent to reduce the risk of MI, stroke, or “vascular death.” The most recent ACC guidelines recommend either aspirin or clopidogrel as an acceptable antiplatelet agent (grade 1A).7 Clopidogrel may be considered if claudication symptoms are significantly interfering with lifestyle. If this management fails, the patient may be referred to a vascular specialist for consideration of revascularization.

**Infected ulcer with PAD features**

Unlike cellulitis, arterial ulcers are a direct sequela of arterial insufficiency and represent the far end of the spectrum of disease severity and in certain cases treatment failure. Patients who present with advanced ischemic and/or diabetic foot ulcers may have never been evaluated for PAD as an outpatient. Promont work-up and management is required given the high degree of mortality associated with arterial ulcers. Whether an urgent inpatient evaluation is indicated depends on the clinical evaluation.

The first step to determine the depth of the ulceration. Critical limb ischemia may be present if the ulcer is deep, gangrenous, overlies a bony prominence, or is associated with systemic signs of sepsis. A physical exam should include an assessment of the pulses including femoral, popliteal, IP, and DP preferably with bedside Doppler ultrasound. If pulses are absent, urgent vascular surgery evaluation is warranted to prevent loss of limb; the work-up generally involves imaging such as computed tomography angiography (CTA) or magnetic resonance angiography (MRA) to identify culprit lesions, or if sufficiently suspicious, immediate angiographic angiong with the potential for endovascular intervention. While palpable pulses can be reassuring and raise the possibility of a nonarterial etiology such as a microvascular, neutrophic, or venous disease – it is important to remember that pulse exams are often unreliable and provider dependent. The absence of pulses does not effectively exclude severe PAD or critical limb ischemia in patients with a high pretest probability.14 Thus, in cases of deep, complex lower extremity and foot ulcers, it is prudent to obtain urgent evaluation by a surgical wound specialist, which depending on the institution may be podiatry, vascular surgery, or wound care. This may lead to a better clinical assessment of the wound and clearer recommendations regarding the need for additional testing, such as imaging, to rule out osteomyelitis, surgical debridement, or amputation.

Inpatient ABIs in this situation may be diabetic and quantify the severity of PAD. Newer classification schemes such as the Society of Vascular Surgery WbI score (Wound Ischemia Foot Infection) take into account clinical findings as well as ABI scores to better prognosticate limb loss and select patients for intervention.13 If the clinical picture is deemed sufficiently suspicious for critical limb ischemia, the patient may be taken directly for invasive testing with possible intervention.

If an infected ulcer is superficial, shows no signs of gangrene, and has been present for less than 30 days, further work-up for suspected PAD can generally be deferred to an outpatient setting after resolution of the acute infection. Management of the wound is highly institution dependent. When available, a wound care specialist (nurse) or a plastic surgeon can be consulted as an inpatient to give specific recommendations that can range anywhere from enzymatic debridement to simple dressing. If this service is unavailable, we recommend dressing the wound with moist nonocclusive dressings with frequent changes. Referrals for ABI testing and follow-up in podiatry, wound care, or vascular clinic should be arranged. Finally, educating the patient on what to expect can increase compliance with the outpatient treatment plan.

Mild to moderate CVI symptoms with superimposed cellulitis but no ulceration

Chronic venous insufficiency is a syndrome that has variable presentations based on the location and degree of valvulitis incompetence in the superficial or, less commonly, the deep venous systems. For a patient with cellulitis and CVI, the clinical exam findings may be associated with venous hyper- tension – in which case one can expect an axial reflux and possible obstruction – and could also represent complex varicose disease which is usually caused by superficial reflux of the greater saphenous vein.15 The lack of advanced skin changes and ulceration raises the suspicion of mild to moderate CVI.

Guidelines from the American Venous Forum and the Society for Vascular Surgery recommend that all patients with suspected CVI, regardless of severity, undergo venous duplex ultrasound scanning as a first diagnostic test (grade 1A) to accurately classify the disease according to the CEAP (Clinical Epidemiological Anatomical Pathophysiology) system (Table 1).16

This test is different from the routine lower extremity ultrasound used to diagnose venous thrombosis between 20 and 30 mm Hg.18 The patient should also be encouraged to complete the outpatient duplex ultrasound testing prior to the PCP visit if they do not already have this service performed by a vascular specialist appropriately.

Table 1. CEAP classification of chronic venous disease

<table>
<thead>
<tr>
<th>CEAP</th>
<th>Anatomical Classification (A)</th>
<th>Pathophysiologic Classification (P)</th>
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</thead>
<tbody>
<tr>
<td><strong>C</strong></td>
<td>A</td>
<td>P</td>
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<tr>
<td><strong>E</strong></td>
<td>Subtype</td>
<td>Reflux</td>
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<tr>
<td><strong>A</strong></td>
<td>Asymptomatic</td>
<td>Obstruction</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>Symptomatic</td>
<td>Reflux and obstruction</td>
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Though duplex ultrasound can estimate the severity of CVI with scores of equal or greater than 4; based on physical exam alone, this patient’s active venous ulcer yields the highest possible score of 6.2. If not previously done, this patient with advanced CVI ulceration should be referred for an outpatient venous duplex ultrasound as well as urgent follow-up with a vascular specialist soon after discharge.

There is significant consensus in the literature that multilayer compression therapy between 30 and 40 mm Hg is the first-line treatment in patients with venous ulcers as it has been shown to promote ulcer healing and prevent recurrence.20,21 In addition, superficial venous surgery, including minimally invasive ablation, can reduce the recurrence of ulcers if used as adjunctive therapy in selected patients.22,23 However, compressive therapy should not generally be prescribed in patients with venous ulcers until PAD has been ruled out.

In ABI results are available, the clinician can consider compression at 30-40 mm Hg for ABI values greater than or equal to 0.8 and reduced compression at 20-30 mm Hg for values of 0.5-0.8; compression is contraindicated if the ABI is less than 0.5. Prompt follow-up with a vascular specialist can help direct compressive and/or surgical therapy. Wound care consultation as an inpatient can assist with dressing recommendations,
Though most hospitalists are adept at managing diabetes, blood pressure, and other comorbidities, the ability to recognize and manage peripheral vascular disease can be challenging.

Bottom line
Hospitalists are in a unique position to identify patients with underlying peripheral arterial and venous disease when they are admitted for lower extremity skin and soft tissue infections. A focused history and physical exam can yield significant clinical clues and should prompt either inpatient or outpatient work-up.

In patients with deep ulcers and concern for critical limb ischemia, inpatient consultation should be sought. In patients with superficial venous or arterial ulcers, referral for outpatient ABI, color duplex ultrasound, or both should be made; most of these patients should also be directly referred to a vascular and/or wound specialist. Patients with more benign forms of disease who exhibit chronic symptoms suspicious for mild to moderate PAD or CVI can be seen by a PCP for further management. All patients should be educated about the importance of follow-up as it remains their best chance to curb the progression of disease, reduce the risks for recurrent infection, and improve overall quality of life.

Back to the original case
Our patient’s lower extremity erythema, fever, and leukocytosis improved with 3 days of IV vancomycin treatment. Her wound was kept clean with moist dressings and showed no signs of deep infection; with elevation, her bilateral lower extremity edema also improved. Her physical exam findings and clinical history were highly suspicious for long-standing CVI. She was discharged with oral antibiotics and a referral to wound care for ongoing management of her superficial ulcers. An outpatient venous duplex ultrasound and ABI were scheduled prior to her vascular surgery appointment to effectively rule out PAD before consideration of further therapy for severe CVI.

Dr. Nigalaye is an attending physician in the division of hospital medicine at Mount Sinai Beth Israel Hospital in New York, and assistant professor of medicine at the Icahn School of Medicine at Mount Sinai. Dr. Merrill is an attending physician in the division of hospital medicine at Mount Sinai Beth Israel, and assistant professor of medicine at the Icahn School of Medicine at Mount Sinai.

References
ITL: Physician reviews of HM-related research

By Aparna Kamath, MD, MS; Suchita Shah Sata, MD; Noppon Setji, MD; Snehal Patel, MD; Adam Wachter, MD; and Faye Farber, MD

Duke University Health System, Durham, N.C.

1. Idarucizumab reverses anticoagulation effects of dabigatran

**CLINICAL QUESTION:** Can idarucizumab reverse anticoagulation effects of dabigatran in a timely manner for urgent surgery or in the event of bleeding?

**BACKGROUND:** Reversing the anticoagulant properties of anticoagulants can be important in the event of a life-threatening bleed, or if patients taking these medications need urgent surgery or other interventions. Idarucizumab, a humanized monoclonal antibody fragment, can reverse anticoagulant activity of dabigatran, increasing its acceptance for prescribing physicians as well as patients.

**STUDY DESIGN:** Multicenter prospective single cohort study.

**SETTING:** 173 sites, 39 countries.

**SYNOPSIS:** Among 503 patients (median age, 78 years; indication for dabigatran, stroke prevention in setting of atrial fibrillation for most) who had either uncontrolled bleeding (n = 301) or needing emergent surgery (n = 202), a single 5-g dose of idarucizumab was able to reverse anticoagulation rapidly and completely in more than 98% of these patients independent of age, sex, renal function, and dabigatran concentration at baseline. Specifically in 68% of the patients in the bleeding group (excluding intracranial hemorrhage), median time to the cessation of bleeding was 2.5 hours and median time to the initiation of the procedure in the emergent surgery group was 1.6 hours. Study limited by lack of control group.

**BOTTOM LINE:** Idarucizumab can be effective for dabigatran reversal among patients who have uncontrolled bleeding or need to undergo urgent surgery.


By Aparna Kamath, MD, MS

2. You aren’t (necessarily) a walking petri dish!

**CLINICAL QUESTION:** Does exposure to a patient with a multidrug-resistant organism result in colonization of a healthcare provider?

**BACKGROUND:** Multidrug-resistant organisms (MDROs) are growing threats in our hospitals, particularly vancomycin-resistant enterococci (VRE) and resistant gram-negative bacteria. The role of the health care team in preventing infection transmission is paramount. If a team member who is caring for a patient with an MDRO or handling lab specimens becomes colonized with these bacteria, he or she could potentially transmit them to the next patient.

**STUDY DESIGN:** Observational case control.

**SETTING:** Large academic research hospital.

**SYNOPSIS:** Staff submitted self-collected rectal swabs, which were then cultured for MDROs. 379 health care personnel (which they defined as having had self-reported exposure to MDROs) were compared with 376 staff members in the control group, who reported no exposure to MDROs. There was a nonsignificant difference between growth of multidrug-resistant organisms between the groups (4.0% vs 3.2%).

**BOTTOM LINE:** This study suggests that occupational exposure to an MDRO does not result in subsequent colonization of the health care provider and may not be a major risk factor for nosocomial transmission.


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**IN THE LITERATURE**

1. Idarucizumab reverses anticoagulation effects of dabigatran

2. You aren’t (necessarily) a walking petri dish!
**3 Treat sleep apnea with positive airway pressure, but don’t expect it to prevent heart attacks**

**CLINICAL QUESTION:** In patients with sleep apnea, does using positive airway pressure (PAP) treatment prevent adverse cardiovascular events and death?

**BACKGROUND:** Previous observational studies have suggested that untreated sleep apnea is a factor in cardiopulmonary morbidity as well as hospitalization for unstable angina and all-cause death, among others. They found no association between treatment with positive airway pressure and MACE (acute coronary syndrome, stroke, cardiovascular death) as well as hospitalization for unstable angina and all-cause death, among others. Other studies have reported prevalence of sleep disordered breathing in patients with heart failure, diabetes, hypertension and coronary heart disease.

**SYNOPSIS:** The authors analyzed 10 randomized-controlled trials encompassing 7,266 patients with sleep apnea. They examined instances of major adverse cardiovascular events (MACE; acute coronary syndrome, stroke, cardiovascular death) as well as hospitalization for unstable angina and all-cause death, among others. They found no association between treatment with positive airway pressure and MACE (169 events vs. 187 events, with a relative risk of 0.77; 95% confidence interval, 0.53-1.35) or all-cause death (324 events vs. 289 events, RR 1.13; 95% CI 0.99-1.29).

**BOTTOM LINE:** Positive airway pressure treatment for patients with sleep apnea is not an intervention to prevent cardiovascular morbidity.


Dr. Satal is a medical instructor, Duke University Hospital.

By Noppon Setji, MD

**4 Outcomes of alcohol septal ablation in younger patients with obstructive hypertrophic cardiomyopathy**

**CLINICAL QUESTION:** Is alcohol septal ablation (ASA) safe in younger patients with obstructive hypertrophic cardiomyopathy (HCM)?

**BACKGROUND:** ASA is a class III recommendation for younger patients when myectomy is a viable option. This recommendation was based on the lack of evidence for younger patients whereas myectomy already was proven to be safe and effective.

**STUDY DESIGN:** International multicenter observational cohort design.

**SETTING:** 7 tertiary centers from 4 European countries during 1996-2015.

**SYNOPSIS:** With 1,200 patients, this was the largest ASA cohort to date. The cohort was divided into three groups: young (less than 50 years), middle age (51-65 years), and old (greater than 65 years). During the perioperative period, young patients had better outcomes compared to old patients in regards to complete heart block, cardiac tamponade, and mortality. After 5.4 years of follow-up, young patients had favorable outcomes for long-term survival after ASA and comparable rates of adverse arrhythmic events; 95% of these young patients were functioning in NYHA class I or II at follow-up. These young patients also had half the risk of permanent pacemaker implantation, compared with older patients. In an analysis of very young patients (younger than 35 years), ASA appeared to be safe and effective as well. Additionally, young patients who were treated with more than 2.5 mL ascorbic acid (5.8%), UHR (ultra-high all-cause mortality), were compared with patients who were treated with less than 2.5 mL.

**BOTTOM LINE:** For patients aged 50 years or less with HCM, ASA and surgical myectomy are both safe and effective for relief of symptoms.


**By Snehal Patel, MD**

**5 Use of the dual-antiplatelet therapy score to guide treatment duration after percutaneous coronary intervention**

**CLINICAL QUESTION:** Can the dual-antiplatelet therapy scoring system be used to determine which patients undergoing percutaneous coronary intervention (PCI) would benefit from prolonged (24 months) DAPT?

**BACKGROUND:** Prolonged DAPT therapy has been estimated to prevent 8 myocardial infarctions per 1,000 persons treated for 1 year but at the cost of 6 major bleeding events with no clear mortality benefit. Given these trade-offs, the DAPT score could be used to identify patients who would benefit or would be harmed from prolonged DAPT.

**SYNOPSIS:** In the study, the safety and efficacy of DAPT duration as guided by the DAPT score has not been assessed outside the derivation cohort. This study has applied the DAPT score to the PRODIGY trial patients to evaluate safety and outcomes of DAPT for 24 months versus a less than 6-month regimen.

**STUDY DESIGN:** Retrospective analysis of the DAPT score in PRODIGY patients.

**SETTING:** PCI patients in PRODIGY trial.

**SYNOPSIS:** In the original derivation cohort, a low DAPT score of less than 2 identified patients whose bleeding risks outweigh ischemic benefits and a high score above 2 identifies patients for whom ischemic benefits outweigh bleeding risks. When the DAPT score was applied to the 1,970 patients enrolled in PRODIGY, 55% had a low score and 45% had a high score. The primary efficacy outcomes of death, MI, and stroke were evaluated as well as primary safety outcomes of bleeding according to the Bleeding Academic Research Consor- tium definition. The reduction in the primary efficacy outcomes with 24-month vs. 6-month DAPT was greater in patients with a low DAPT score than in the older paciety-eluting stents. Since these stents have mostly fallen out of favor, there are some limitations to the applicability of the study findings. The study also provides support for 6 months of DAPT for patients with a DAPT score of less than 2.

**BOTTOM LINE:** For patients who underwent PCI with a DAPT score of less than 2, the risk for bleeding appears to be higher than the ischemic benefits, while patients who had a high DAPT score of greater than 2 with a first-generation stent, the ischemic benefits of prolonged DAPT seemed to outweigh the bleeding risks.


Dr. Setji is a hospitalist and medical director, Duke University Hospital.

**6 Urgent endoscopy is associated with lower mortality in high-risk patients with acute nonvariceal GI bleeding**

**CLINICAL QUESTION:** Is urgent endoscopy beneficial in reducing mortality in high-risk patients with ANVGIB?

**BACKGROUND:** High-risk ANVGIB patients (Glasgow-Blatchford score greater than 7) are recommended to undergo early endoscopy, within 24 hours of presentation. The impact of urgent endoscopy (less than 6 hours) on patient outcomes is not clear.

**STUDY DESIGN:** Retrospective observational study.

**SETTING:** Single tertiary referral center in South Korea.

**SYNOPSIS:** Investigators retrospectively reviewed 961 high-risk ANVGIB patients, 571 patients underwent urgent endoscopy and 390 patients had elective endoscopy (6-48 hours), to compare clinical features and outcomes. The urgent group was slightly older, had a higher Rockall score, lower blood pressure, and higher incidence of shock on admission. Urgent endoscopy was associated with significantly lower 28-day mortality (1.6% vs. 3.8%). Urgent endoscopy was also associated with higher packed red cell transfusion volume (2.6 U vs. 2.3 U) and greater need for endoscopic intervention (69.5% vs. 53.5%) and embolization (2.8% vs. 0.5%). There was no significant difference in rebleeding rates, need for ICU admission, vasopressor use, and length of hospital stay between the urgent and elective endoscopy groups. The authors conclude that urgent endoscopy was associated with lower mortality rate but not rebleeding in high-risk patients with ANVGIB.

Despite differences between these two groups, based on these retrospective data, it is reasonable to suggest that urgent endoscopy may be beneficial for reducing mortal- ity in high-risk patients with ANVGIB.


Dr. Patel is a hospitalist and an assistant professor of medicine, Duke University Health System.

By Adam Wachter, MD

**7 Isolation precautions are associated with higher costs, longer LOS**

**CLINICAL QUESTION:** What are the effects of isolation precautions on hospital outcomes and cost of care?

**BACKGROUND:** Previous studies have found that isolation precautions negatively affect various aspects of patient care, including frequency of contact with clinicians, adverse events in the hospital, measures of patient well-being, and patient experience scores. It is not known how isolation precautions affect other hospital-based metrics, such as 30-day readmissions, length of stay (LOS), in-hospital mortality, and cost of care.

**STUDY DESIGN:** Multi-site, retrospective, propensity score-matched cohort study.

**SETTING:** Three academic tertiary care hospitals in Toronto.

**SYNOPSIS:** The authors used administrative databases and propensity-score modeling to match isolated patients and nonisolated controls. Researchers included 17,649 control patients, 737 patients isolated for methicillin-resistant Staphylococcus aureus (contact isolation), and 1,502 patients isolated for respiratory illnesses (contact and droplet isolation) in the study. Patients isolated for MRSA had a higher 30-day readmission rate than did controls (19% vs. 14.7%).

For patients who underwent PCI with a DAPT score of less than 2, the risk for bleeding appears to be higher than the ischemic benefits, while patients who had a high DAPT score of greater than 2 with a first-generation stent, the ischemic benefits of prolonged DAPT seemed to outweigh the bleeding risks.
Pediatric acute appendicitis: Is it time for nonoperative treatment (NOT)?

**CLINICAL QUESTION:** What are the differences in rates of treatment failure, duration of hospitalization, and cost between nonoperative treatment (NOT) for acute uncomplicated appendicitis versus urgent appendectomy?

**BACKGROUND:** Acute appendicitis is found in around 5% of children presenting for urgent or emergent evaluation of abdominal pain. It is the most common illness prompting emergency abdominal surgery in children.

Possible complications from appendicitis include perforation, gangrenous changes, peritonitis, and sepsis. To avoid these significant morbidities, surgical teaching for more than a century has recommended urgent removal of the appendix in acute uncomplicated appendicitis. Appendicitis is classified as “complicated” if there is evidence of perforation, abscess, or gangrenous changes, and “uncomplicated” otherwise.

Several trials in adults have shown that urgent surgery may not be necessary, and NOT of uncomplicated appendicitis may be both effective and safe. NOT involves a course of IV antibiotics and careful clinical monitoring while hospitalized, then a course of oral antibiotics after discharge. Regimens vary but include coverage for aerobic and anaerobic gut flora, such as piperacillin-tazobactam followed by amoxicillin-clavulanate. Little is known about the safety and efficacy of NOT in children.

**STUDY DESIGN:** Meta-analysis.

**SEARCH STRATEGY:** PubMed, MEDLINE, EMBASE, and Cochrane Library were searched for relevant studies. This search identified 527 potential articles, of which the authors examined the full text of 68 and ultimately identified 4 prospective cohort trials (1 randomized, controlled trial).

**SYNOPSIS:** A total of 404 patients with uncomplicated appendicitis were seen in all trials: 168 received NOT and 236 received standard surgical care (urgent appendectomy). In the single randomized, controlled trial, patients were assigned NOT or surgical care randomly. In the other trials parental preference directed therapy.

The heterogeneity of the design, populations, definitions of illness, duration of follow-up, and NOT treatment regimens made the meta-analysis challenging. Antibiotic options for NOT varied by center but included a course of IV antibiotics followed by 7-10 days of oral antibiotics. NOT success was defined as no need for surgery within 48 hours and no recurrence of appendicitis within 1 month. Of the 236 patients who received standard surgical care, all had appendicitis and 1 had a complication requiring repeat operation. Of the NOT group, 16 (8.9%) had treatment failures, including 3 with perforated appendicitis, and 45 (27%) went on to have an appendectomy within the following year, yielding a risk ratio of failure versus standard treatment of 8.9 (95% confidence interval, 2.7-29.8). A subgroup analysis of patients with appendicoliths who received NOT found that these patients experienced a substantially increased risk of treatment failure and recurrent appendicitis with the risk ratio versus NOT without appendicolith of 10.4 (95% CI, 1.5-74). Of the 30 patients who experienced treatment failure with NOT, 15 had appendicoliths. NOT lengthened hospital stays by 14.3 hours (95% CI, 7.5-21.1) but led to lower total costs by $1,310 (95% CI, $920-$1,690).

**BOTTOM LINE:** NOT may be a reasonable alternative to standard surgical management for acute uncomplicated appendicitis without appendicolith in children, with a success rate of greater than 90%.

Further larger, randomized prospective studies are required to establish its safety and efficacy.

8 Text paging practices need improvement, standardization

**CLINICAL QUESTION:** What is the content and structure of patient care–related text paging sent in the inpatient setting?

**BACKGROUND:** Text paging has become a common form of communication among members of the inpatient multidisciplinary team, but there are potential risks and downsides of text paging, including disruptive, inefficiency, and potential patient safety issues.

**STUDY DESIGN:** Modified case-study approach.

**SETTING:** The medical inpatient service of an academic tertiary care hospital.

**SYNOPSIS:** 575 text-page messages relating to 217 unique patients were analyzed in the study. The majority of the messages were sent from nonphysicians to physicians. Common themes that were identified included lack of standardization of text, message content and format, lack of indication of the urgency of the message, and lack of clarity within the message. Pertinent information sometimes was missing from the messages, and it was not always clear whether the sender was requesting a response from the recipient.

**BOTTOM LINE:** Text-paging practices may raise patient safety issues that could be addressed by implementation of a standardized, structured approach to this form of communication.


Dr. Wachter is an assistant professor of medicine at Duke University.

By Faye Farber, MD

**9**

**Addition of azithromycin to maintenance therapy is beneficial in adults with uncontrolled asthma**

**CLINICAL QUESTION:** Does azithromycin decrease the frequency of asthma exacerbations in adults with persistent asthma symptoms despite use of inhaled corticosteroid (ICS) and a long-acting beta-agonist (LABA)?

**BACKGROUND:** Asthma is a chronic inflammatory airway disease that is highly prevalent worldwide within a subset of people with asthma who have symptoms that are poorly controlled despite ICS and LABA maintenance therapy. Currently, add-on therapy options include monoclonal antibodies, which are cost prohibitive. The need for additional therapeutic options exists. At the same time, macrolide antibiotics are known to have anti-inflammatory, antiviral, and antibacterial effects and have proven to have beneficial effects on asthma symptoms.

**STUDY DESIGN:** Randomized, double-blind, placebo-controlled trial.

**SETTING:** Multiple sites throughout Australia.

**SYNOPSIS:** The AMAZES trial enrolled 420 adult patients with symptomatic asthma despite current use of ICS and LABA. Patients were randomly assigned to receive azithromycin 500 mg or placebo three times a week for 48 weeks. Patients who had hearing impairment, prolonged QTc interval, or emphysema were excluded.

Azithromycin reduced the frequency of asthma exacerbations, compared with placebo (1.07 vs. 1.86 exacerbations/patient-year; incidence rate ratio 0.59; 95% confidence interval, 0.47-0.74; P < .001). It also significantly improved asthma-related quality of life according to the Asthma Quality of Life Questionnaire (adjusted mean difference, 0.36; 95% CI, 0.21-0.52; P < .001). Diarrhea occurred more commonly in the azithromycin group but did not result in a higher withdrawal rate.

A significant limitation of this study was generalizability, as the median patient age was 60 years and race was not reported. More research is needed to determine the effect of long-term azithromycin use on microbial resistance.

**BOTTOM LINE:** Adding azithromycin to maintenance ICS and LABA therapy in patients with symptomatic asthma decreased the frequency of asthma exacerbations and improved quality of life.


Dr. Farber

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**IN THE LITERATURE**

**SHORT TAKES**

**Early furosemide treatment associated with decrease in hospital mortality for acute heart failure**

This prospective multicenter observational trial showed that if intravenous furosemide was administered at the time of acute heart failure who had prominent congestive symptoms within 60 minutes of their arrival to the emergency department, it was associated with a decrease in hospital mortality (odds ratio, 0.42; 95% confidence interval, 0.24-0.72; P < .001) even after the researchers adjusted for Get With The Guidelines heart failure risk scores.


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**10 Improvements made in safe opioid prescribing practices but crisis far from over**

**CLINICAL QUESTION:** How have national and county-level opioid prescribing practices changed from the years 2006 to 2015?

**BACKGROUND:** The opioid epidemic is currently at the forefront of public health crises, with more than 15,000 deaths caused by prescription opioid overdoses in 2015 alone and an estimated 2 million people with an opioid use disorder associated with prescription opioids. The opioid epidemic also has a significant financial burden with the cost of opioid overdose, abuse, and dependence totaling $78.5 billion/year in the United States. As the utilization of opioids to treat noncancer pain quadrupled during 1999-2010, so did the prevalence of opioid misuse disorder and overdose deaths from prescription opioids. This study reviewed prescribing practices at the national and county level during 2006-2015 in hopes of understanding how this affected the opioid crisis.

**STUDY DESIGN:** Review of opioid prescription data.

**SETTING:** The data were summarized from a sample of pharmacies throughout the United States.

**SYNOPSIS:** Data were obtained via the QuintilesIMS Data Warehouse, which estimated the number of opioid prescriptions based on a sample of 59,000 U.S. pharmacies (88% of total prescriptions). The amount of prescriptions peaked in 2010 then decreased yearly through 2015, yet remained about three times as high as prescription rates from 1999. Opioid prescribing practices had significant variation throughout the country, with higher prescription rates associated with smaller cities, larger white population, higher rates of Medicaid and unemployment, and higher prevalence of arthritis and diabetes. Variation in prescribing practices at the county level represents lack of consensus and evidence-based guidelines.

The authors suggest that providers carefully weigh the risks and benefits of opioids and review the Guideline for Prescribing Opioids for Chronic Pain from the Centers for Disease Control and Prevention. At the state and local levels, mandated pain clinic regulations and Physician Drug Monitoring Programs also are needed for continued improvement in opioid-related deaths. Weaknesses of study included lack of clinical outcomes and use of QuintilesIMS to estimate prescriptions that has not been validated.

**BOTTOM LINE:** Although rates of opioid prescriptions have improved since 2010, substantial changes and regulations for prescribing practices are needed at the state and local levels.


Dr. Farber is a medical instructor, Duke University Health System.
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HOSPITALISTS - Sacramento, CA

Full-time and part-time openings are available, as are opportunities for Nocturnists. At our large multi-specialty practice with approximately 400 providers, we strive to offer our patients a full scope of healthcare services throughout the Sacramento area. Our award-winning Hospitalist program has around 70 providers and currently serves 4 major hospitals in the area.

Sacramento offers a wide variety of activities to enjoy, including fine dining, shopping, biking, boating, river rafting, skiing and cultural events. Our physicians utilize leading edge technology, including EMR, and enjoy a comprehensive, excellent compensation and benefits package in a collegial, supportive environment.

For more information, please contact: Physician Recruitment Phone: 888-599-7797 Email: providers@dignityhealth.org www.mercymedgroup.org www.dignityhealth.org/physician-careers

These are not J1 opportunities.

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

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

Competitive salary and benefits among highly qualified, friendly colleagues foster networking opportunities. Excellent schools, affordable cost of living, great family-oriented lifestyle with a multitude of outdoor activities year round.

Relocation assistance, CME funds, Penn State University tuition discount for employees and dependents, LTD and Life insurance, and so much more!

Appropriate candidates must possess an MD, DO, or foreign equivalent; be Board Certified in Internal Medicine and have or be able to acquire a license to practice in the Commonwealth of Pennsylvania. Qualified applicants should upload a letter of interest and CV at: http://tinyurl.com/j29p3z Ref Job ID#4524

For additional information, please contact:
Brian Mc Gellen, MD — Director, Hospitalist Medicine
Penn State Milton S. Hershey Medical Center
c/o Heather Peffley, PHR FASPR – Physician Recruiter
hpoffley@hmc.psu.edu

For more information, please contact: Heather Gonroski • 973.290.8259 • hgonroski@frontlinemedcom.com or Linda Wilson • 973.290.8243 • lwilson@frontlinemedcom.com

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

ACADEMIC NOCTURNIST HOSPITALIST

To advertise in The Hospitalist or the Journal of Hospitalist Medicine

Contact:
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ASSOCIATE MEDICAL DIRECTOR
INTEGRATED ACUTE CARE OPENING
AT SHARON REGIONAL HEALTH SYSTEM

Be an owner in our growing physician-owned and -led group.

We’re looking for an associate medical director to unite with our integrated EM & HM team in western PA. Enjoy all that Sharon, PA has to offer – small town charm with local farm and artisan culture. Sharon is just east of Youngstown, 70 miles north of Pittsburgh, and 80 miles south of Erie.

Sharon Regional Health System consists of a 241-bed hospital with 17 satellite centers and more than 1,750 employees. It is Mercer County’s most comprehensive health system with a full-service and interventional cath lab.

ASSOCIATE MEDICAL DIRECTOR
INTEGRATED ACUTE CARE OPENING
AT INDIANA REGIONAL MEDICAL CENTER

Be an owner in our growing physician-owned and -led group.

We’re looking for an associate medical director to unite with our integrated EM & HM team in western PA. Indiana is a centrally located county seat of Indiana County, 60 miles northeast of Pittsburgh, and is home of Indiana University of Pennsylvania.

Indiana Regional Medical Center is a 164-bed acute care community hospital serving nearly every specialty.

Own your future in Sharon, PA.
Become an owner and get first-rate benefits when you join one of the largest and fastest-growing physician-owned and led groups in the nation. You’ll also get the support you need and the culture you want.

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- Company-funded 401(k) – an additional 10%
- Groundbreaking parental paid leave
- Occurrence based medical malpractice including tail
- Highly competitive compensation package
- Student loan refinancing as low as 2.99%
- CME/BEA (Business Expense Account)
- Short- and long-term disability (own occupation)
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To learn more about this and other exciting opportunities, please contact
TAMMIE ZWICK
USACS Physician Recruiter

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Hospitalist Opportunities
Greater St. Louis Area
Mercy Clinic is seeking Hospitalists to join our established teams throughout the Greater St. Louis Area.

Positions Offer:
• Competitive base salary, quarterly bonus, and incentives
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• No procedures
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• Sponsorship of H1B Visa
• Teaching opportunity
• Comprehensive benefits including health, dental, vacation and CME.
• Relocation assistance and professional liability coverage.

For more information, please contact:
Joan Humphries | Manager, Physician Recruitment
p 314.364.3840 | f 314.364.2597 | Joan.Humphries@mercy.net
AA/EEO/Minorities/Females/Disabled/Veterans

Physician Research Scientist Position in Hospital Outcomes Research
Kaiser Permanente, Northern California’s Division of Research (KPNC DOR) seeks an investigator with strong informatics expertise to develop an independently funded research program, conduct scholarly research, and collaborate with KPNC clinicians and leadership in evaluating or developing interventions to enhance the delivery of evidence-based hospital care. The investigator may be appointed at the assistant professor, associate professor, or professor-equivalent level. This position will be part of an established DOR program, the Systems Research Initiative (SRI), which focuses on the processes and outcomes of hospital care, hospitalization/rehospitalization prevention, and use of advanced analytics (including cloud computing, machine learning, and provision of clinical decision support in real time). The SRI has tight links to KPNC leadership and EMR staff and draws on granular data from KPNC’s 22 hospitals’ > 250,000 annual discharges. The SRI plays an important role in developing new approaches used by KPNC for hospital performance benchmarking. Preferred qualifications include an MD or equivalent plus appropriate research experience (masters, PhD, and/or fellowship) in clinical informatics, health services research, statistics, and/or clinical epidemiology. Opportunities for clinical practice are available, as it is desirable that the successful candidate remain connected with hospital care.

Please email a letter of interest and curriculum vitae to:
Gabriel J. Escobar, MD
Email: gabriel.escobar@kp.org
and please cc: fernando.barreda@kp.org
Regional Director for Hospital Operations Research
Director, Systems Research Initiative
Kaiser Permanente Division of Research

TEAM Health
JOIN OUR HOSPITAL MEDICINE TEAM IN CONNECTICUT!
We are seeking full-time physicians to join our team at Bristol Hospital in Bristol, CT. This established hospital medicine program sees an average census of 12 to 16 patients per physician per day. Enjoy flexible scheduling, CME allowance, excellent compensation, comprehensive benefits, paid P/L with tail coverage and a 401K option. Must be BC/BE in IM or FM with an active CT license. Nocturnists encouraged to apply.
Bristol, in North Central Connecticut is best known as home of ESiPN. A sense of community and history define this diverse, family-friendly area, which has a high quality of life reflected by vast public parks, high-ranked education systems, and aggressive economic development. Residents have access to numerous parks and golf courses as well as the oldest continuously operating amusement park in North America, Lake Compounce.

To learn more about these and other opportunities, contact Kyle Wofford at 713.503.2036 or kyle.wofford@teamhealth.com, or visit www.teamhealth.com/join.

Looking to fill an open position?
to advertise in the Hospitalist or the Journal of Hospital Medicine, contact:
Heather Gonroski • 973.290.8259 • hgonroski@frontlinemedcom.com
OR
Linda Wilson • 973.290.8243 • lwilson@frontlinemedcom.com

To learn more, visit www.the-hospitalist.org and click “Advertise”
Ochsner Health System is seeking physicians to join our hospitalist team. BC/BE Internal Medicine and Family Medicine physicians are welcomed to apply. Highlights of our opportunities are:

- Hospital Medicine was established at Ochsner in 1992. We have a stable 50+ member group
- 7 on 7 off block schedule with flexibility
- Dedicated nocturnists cover nights
- Base plus up to 50 K in incentives
- Average census of 14-18 patients
- E-ICU intensivist support with open ICUs at the community hospitals
- EPIC medical record system with remote access capabilities
- Dedicated RN and Social Work Clinical Care Coordinators
- Community based academic appointment
- The only Louisiana Hospital recognized by US News and World Report Distinguished Hospital for Clinical Excellence award in 4 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

Ochsner Health System is Louisiana’s largest non-profit, academic, healthcare system. Driven by a mission to Serve, Heal, Lead, Educate and Innovate, coordinated clinical and hospital patient care is provided across the region by Ochsner’s 29 owned, managed and affiliated hospitals and more than 80 health centers and urgent care centers. Ochsner is the only Louisiana hospital recognized by U.S. News & World Report as a “Best Hospital” across four specialty categories caring for patients from all 50 states and more than 80 countries worldwide each year. Ochsner employs more than 18,000 employees and over 1,100 physicians in over 90 medical specialties and subspecialties, and conducts more than 600 clinical research studies. For more information, please visit ochsner.org and follow us on Twitter and Facebook.

Interested physicians should email their CV to profrecruiting@ochsner.org or call 800-488-2240 for more information. Reference # SHM2017.

Sorry, no opportunities for J1 applications.

Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law.
Hospitalist Position in Pictoresque Bridgton, Maine: Bridgton Hospital, part of the Central Maine Medical Family, seeks BE/BC Internist to join its well-established Hospitalist program. Candidates may choose part-time (7-8 shifts/month) to full-time (15 shifts/month) position. Located 45 miles west of Portland, Bridgton Hospital is located in the beautiful Lakes Region of Maine and boasts a wide array of outdoor activities including boating, kayaking, fishing, and skiing. Benefits include medical student loan assistance, competitive salary, highly qualified colleagues and excellent quality of life.

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

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

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.

Competitive salary and benefits among highly qualified, friendly colleagues foster networking opportunities. Relocation assistance, CME funds, Penn State University tuition discount for employees and dependents, LTD and Life insurance, and so much more!

Known for home of the Hershey chocolate bar, Hershey, PA is rich in history and offers a diverse culture. Our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Hershey, PA is home to the Hershey Bears hockey team and close to the Harrisburg Senators baseball team. The Susquehanna River, various ski slopes and the Appalachian Trail are in our backyard, offering many outdoor activities for all seasons.

Successful candidates require the following:
• Medical degree - M.D., D.O. or foreign equivalent
• Completion of an accredited Internal Medicine Residency program
• Eligibility to acquire a license to practice in the Commonwealth of Pennsylvania
• Board eligible/certified in Internal Medicine
• No J1 visa waiver sponsorships available

For further consideration, please send your CV to:
Brian McGillick, MD – Director, Hospital Medicine
Penn State Milton S. Hershey Medical Center
200 University Drive – Box 4010
Milton S. Hershey Medical Center
Hershey, PA 17033 – Physician Recruiter
mgillick@hmc.psu.edu

To advertise in The Hospitalist or The Journal of Hospitalist Medicine

Contact:
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**Hospitalist Opening in South Carolina!**

Our hospitalist team at Conway Medical Center in Conway, SC is actively seeking full-time hospitalists who strive to provide excellent care to patients. This 222-bed/25-ICU bed facility features an established hospital medicine program, and physicians see an average of 17-20 patients/day. Day-shift coverage is from 7am-7pm with APC coverage 7 days a week. The right candidate must be BC/BE in IM or FM with hospitalist experience, and have ACLS certification.

- No procedures required
- Hourly rate offered plus performance and productivity bonuses paid quarterly for full-time physicians
- Comprehensive health and wellness benefits
- Yearly CME allowance
- Paid PLI with tail coverage

IM or FP Residents with heavy inpatient rotations are encouraged to apply.

To learn more about these and other opportunities, contact Mimi Hagan at 866.768.8362 or mimi_hagan@teamhealth.com, or visit www.teamhealth.com/join.

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**Hospitalist opportunities in:**
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- Methodist Stone Oak Hospital, San Antonio, TX
- Methodist Specialty and Transplant Hospital, San Antonio, TX
- Metropolitan Methodist Hospital, San Antonio, TX
- Methodist Texan Hospital, San Antonio, TX
- Northeast Methodist Hospital, Live Oak, TX

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- Methodist Stone Oak Hospital, San Antonio, TX
- Methodist Specialty and Transplant Hospital, San Antonio, TX
- Metropolitan Methodist Hospital, San Antonio, TX
- Methodist Texan Hospital, San Antonio, TX
- Northeast Methodist Hospital, Live Oak, TX

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**Envision**

**Physician Services**

MUSTAFA SARDINI, M.D.
Sunnyvale, TX

Berkshire Health Systems is currently seeking BC/BE Internal Medicine & Med/Peds physicians to join our comprehensive Hospitalist Department

- Day, Evening and Nocturnist positions
- Team of 10 hour shift schedule
- Previous Hospitalist experience is preferred

Located in Western Massachusetts Berkshire Medical Center is the region’s leading provider of comprehensive health care services

- 320-bed community teaching hospital
- A major teaching affiliate of the University of Massachusetts Medical School
- The latest technology including a system-wide electronic health record
- A closed ICU/CCU
- A full spectrum of specialties to support the team.

We understand the importance of balancing work with a healthy personal lifestyle

- Located just 2½ hours from Boston and New York City
- Small town New England charm
- Excellent public and private schools
- A major teaching affiliate of the University of Massachusetts Medical School
- The latest technology including a system-wide electronic health record
- A closed ICU/CCU
- A full spectrum of specialties to support the team.

Berkshire Health Systems offers a competitive salary and benefits package, including relocation.

Interested candidates are invited to contact:
Liz Mahan at Emahan@bhs1.org or apply online at www.berkshirehealthsystems.org

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www.the-hospitalist.org I NOVEMBER 2017 I THE HOSPITALIST 39
St Luke’s University Health Network (SLUHN) has hospitalist and nocturnist opportunities in eastern Pennsylvania for BC/BE physicians. Nocturnist opportunities are available at our Bethlehem Campus with additional opportunities at our Anderson, Miners, Allentown and our newest hospital in Monroe County that opened in October of 2016.

We offer:
• Starting bonus and up to $100,000 in loan repayment
• 7 on/7 off schedules
• Additional stipend for nights
• Attractive base compensation with incentive
• Excellent benefits, including malpractice, moving expenses, CME

SLUHN is a non-profit network comprised of physicians and 7 hospitals, providing care in eastern Pennsylvania and western NJ. We employ more than 500 physician and 200 advanced practitioners. St. Luke’s currently has more than 180 physicians enrolled in internship, residency and fellowship programs and is a regional campus for the Temple/St. Luke’s School of Medicine. Visit www.slnm.org.

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

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

Hospitalist/Nocturnist Opportunities in PA
Starting Bonus and Loan Repayment

Division of Hospital Medicine of Cooper University Hospital
Board Certified/Eligible Internal Medicine and Family Medicine
Hospitalists and Nocturnists

The Division of Hospital Medicine of Cooper University Hospital seeks motivated physicians to join a dynamic team of 80 physicians and 20 nurse practitioners at more than ten locations in Southern New Jersey.

Highlights:
• Full-time or part-time Hospitalist positions
• Day or night shifts available
• Flexible scheduling
• Teaching opportunities with residents and medical students
• Emphasis on patient experience, quality and safety
• Average encounter number of 14-18/day
• Secure employment with low physician turnover
• Potential for career advancement in administrative, quality or educational roles

Cooper University Hospital is a 635 bed teaching hospital. We are the only tertiary care center and the first Advanced Certified Comprehensive Stroke Center in Southern New Jersey. We employ more than 900 physicians and 325 trainees in all medical and surgical specialties. Cooper University Hospital has its own on-campus medical school, the Cooper Medical School of Rowan University. The Cooper Health System maintains multiple partnerships with local and national institutions, including the MD Anderson Cancer Center.

Employment Eligibility:
Must be Board Certified/Eligible in Internal or Family Medicine

Contact Information:
Lauren Simon, Administrative Supervisor, 856-342-3150
Simon-Lauren@cooperhealth.com www.cooperhealth.org

ENRICHING EVERY LIFE WE TOUCH... INCLUDING YOURS!

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

Practice highlights:
• 7 on 7 off schedule (26 weeks per year) with majority of shifts less than 12 hours in length
• Collaborative, cohesive hospitalist team established in 2002 with high retention rate and growth
• 26-member internal medicine hospitalist team comprised of 16 physicians and 10 associate staff
• Primary responsibility is adult inpatient care
• Competitive compensation and benefits package, including loan forgiveness

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

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

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Where Caring Meets Excellence

Journal of Hospital Medicine

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OR
Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

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

To learn more, visit www.the-hospitalist.org and click “Advertise”
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Sandy 928-777-5487

PITTSBURGH

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

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

Interested candidates should submit their curriculum vitae, a brief letter outlining their interests and the names of three references to:
Wishwa Kapoor, MD c/o Kathy Nosko
200 Lothrop Street, 933 West MUSW • Pittsburgh, PA 15213
Noskoka@upmc.edu • Fax 412 692-4925
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Culture of Caring:
Central Maine Medical Center has served the people of Maine for more than 125 years. We are a 250-bed tertiary care facility that attracts regional referrals and offers a comprehensive array of the highest level healthcare services to approximately 400,000 people in central and western Maine. Our experienced and collegial hospitalist group cares for over half of the inpatient population and is proud of our high retention rate and professionalism.

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

- The opportunity to expand your professional interests in areas such as our nationally recognized Palliative Care team and award-winning Quality Improvement initiatives.
- Encouragement of innovation and career growth at all stages starting with mentoring for early hospitalists, and progressing to leadership training and opportunities.
- The only Hospital Medicine Fellowship in northern New England with active roles in fellow, resident and medical student education.

What we can do for you:
Welcome you to a motivated, highly engaged, outstanding group that offers a competitive compensation package with moving expense reimbursement, student loan assistance and generous sign-on bonus.
We also value your time outside of work, to enjoy the abundance of outdoor and cultural opportunities that are found in our family-friendly state. Check out our website: www.cmmc.org. And, for more information, contact Gina Mallouzi, CMMC Medical Staff Recruitment at MallozGi@cmhc.org; 800/445-7431 or 207/344-0696 (fax).

NOCTURNIST and Staff Opportunities
Earn More, Work Less, Enjoy Work-Life Balance

Division Chief ~ Hospital Medicine Division

The Department of Medicine at the University of Rochester—Strong Memorial Hospital is currently seeking a new Division Chief for our Hospital Medicine Division. This Division comprises of 35 full and part-time faculty members who not only assist with the care of a large inpatient medical service but also play a key role in the department's educational programs. This position reports directly to the Chairman of the Department of Medicine. Ideal candidates will have leadership experience, excellent interpersonal skills, expertise in quality improvement and a strong interest in medical education. The Hospital Medicine Division is noted for providing high quality education to a broad array of learners including outstanding residents in our Internal Medicine and Medicine-Pediatrics residency programs. Several members of the division have been recognized at the national level for their academic educational contributions and scholarship. The University of Rochester Medical Center is the premier academic health center in upstate New York. Visit our web site to learn more about our innovative Department and our regional health system. Appropriate candidates must possess an MD or DO or foreign equivalent; be Board Certified in Internal Medicine; and meet NY state licensing requirements. Applicants should have achieved an academic rank of Associate Professor or higher; possess excellent communication and organizational skills and a strong work ethic.

Send CV and Cover letter to:
Linda_Marchionda@URMC.Rochester.edu

EOE Minorities/Females/Protected Veterans/Disabled

To advertise in The Hospitalist or The Journal of Hospitalist Medicine
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HOSPITALISTS & NOCTURNISTS

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

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

Please view our online job tour: www.mshajobtour.com/jmh
Please Contact:
Tina McLaughlin, CMSR, Johnston Memorial Hospital Office (276) 258-4580, tina.mclaughlin@msha.com

Alberta Physician Group (APG) is the largest physician-owned multi-specialty group in Alberta, Canada. We are seeking BE/BC/CEP Internal Medicine Physicians and Hospitalists to join our dynamic group of 200 physicians. We are a leading provider of advanced medical services to a diverse population of approximately 1.4 million.

• Competitive salary
• Generous compensation package
• Comprehensive benefits
• Relocation assistance
• Sign-on bonus
• Traditional or seven on/seven off scheduling

To learn more, contact Heather Gonroski • 973-290-8259 • hgonroski@frontlinemedcom.com or Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

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President Trump recently announced his intention to officially end the Deferred Action for Childhood Arrivals program, also known as DACA. The program has been controversial since its inception, almost as controversial as the decision to end it. What impact has DACA had on the medical community, including hospitalists, and what are the implications of ending it?

DACA is a program started in 2012 by an executive action under the Obama administration. The program currently protects approximately 800,000 undocumented immigrants in the United States from being deported. All DACA recipients were brought to this country illegally as children. When the DACA program began, in order to enroll, recipients had to prove that they had arrived here before age 16, and that they had been living in the United States continuously since 2007. Once enrolled, the protections they receive from the program include the ability to legally work and to go to school, as well as obtain a social security number and driver’s license. These protections are then afforded for renewable 2-year periods of time.1

DACA recipients are also known as “Dreamers,” as DACA was created by the Obama administration after Congress did not pass the Development, Relief, and Education for Alien Minors (DREAM) act. If the DREAM act had passed, it would have offered these same DACA recipients the opportunity to potentially gain permanent legal residency. Although attempted many times, neither the DREAM Act nor any other legislation like it has garnered any support for at least one of the proposed policies (although that is certainly not guaranteed sufficient votes to pass). There also is support from many Americans, given that most DACA recipients have been productive members of society, and most Americans believe that DACA is constitutional, as it was established purely by executive order. In the meantime, Mr. Trump is urging Congress to replace DACA with a type of equivalent legislation. According to his staff, the dismantling of DACA means:
• No new applications will be accepted.
• All existing permits will be honored until they expire.
• All applications in process will continue to be processed.
They contend that no current DACA recipients will be affected before March 2018. Unfortunately for the Trump administration, this has been a very unpopular move, as two-thirds of Americans support allowing the Dreamers to stay in the United States.2

Impact on health care
The concern for the medical industry is that a “dismantling” of DACA could exacerbate an already existing physician shortage in the United States. For example, the Association of American Medical Colleges estimates the physician shortage will rise as the population ages and medical access increases; they currently estimate a physician shortage of approximately 40,000-104,000 by 2030.3 Along similar lines, the American Medical Association wrote in a letter to congressional leaders: “We particularly are concerned that this reversal in policy could have severe consequences for many in the health care workforce, impacting patients and our nation’s health care system. . . . Our nation’s health care workforce depends on the care provided by international medical graduates— one out of every four physicians practicing in the United States is an IMG. These individuals include many with DACA status who are filling gaps in care.”4

But objectively evaluating the impact of the DACA program on the medical industry is difficult. We do know that most of the DACA recipients arrived from Mexico, El Salvador, Guatemala, and Honduras, as well as from Asia (primarily South Korea and the Philippines). We also know they reside in every state, with the largest numbers in California (222,795), Texas (124,300), New York (41,970), Illinois (42,376), and Florida (32,795). Most appear to be using DACA to work and to go to school; in a recent survey, 91% were employed, and 45% were enrolled in school.5

Pertaining specifically to medical school, during the 2016-2017 school year, there were 113 DACA applicants to U.S. medical schools, 65 of which were accepted and enrolled. The AAMC expects the 2017-2018 enrollment to be even higher. Almost half of medical school enrollees attend Loyola University Chicago, Maywood, Ill; this year alone, Loyola Stritch Medical School enrolled 32 DACA medical students. This is because, in 2013, Loyola was the first medical school nationwide to openly accept DACA students who have severe medical issues.6

Students were welcomed by most Americans. Having Dreamers in limbo is bad for everyone; the time to act is now.7

References