



Dr. Marina Farah

In search of high-value care

Six steps that can help your team

By Marina Farah, MD, MHA

U.S. spending on health care is growing rapidly and expected to reach 19.7% of gross domestic product by 2026.¹ In response, the Centers for Medicare & Medicaid Services and national organizations such as the American Board of Internal Medicine (ABIM) and the American College of Physicians (ACP) have launched initiatives to ensure that the value being delivered to patients is on par with the escalating cost of care.

Over the past 10 years, I have led and advised hundreds of small- and large-scale projects that focused on improving patient care quality and cost. Below, I share what I, along with other leaders in high-value care, have observed that it takes to implement successful and lasting improvements – for the benefit of patients and hospitals.

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Malpractice suits are less frequent – but more costly

By Alicia Gallegos

MDedge News

Lawsuits against physicians declined across virtually all specialties by more than a quarter over a 10-year span, but the cost to manage legal challenges went up, a recent analysis finds.

From 2007 to 2016, the rate of claims fell by 27% per 100 doctors from 5.1 to 3.7, according to a review of 124,000 cases by CRICO Strategies, a division of CRICO, the medical liability insurance provider for the Harvard medical community. CRICO's database of claims contains

about 30% of legal cases filed against health providers across the United States.

For internists, the rate of lawsuits decreased by 35%, according to CRICO data

provided to MDedge News. Ob.gyns. saw a 44% drop in claims over the 10-year period, and surgeons experienced a 23% rate decrease. Claims decreased by a combined 29% for cardiologists, dermatologists, endocrinologists, family physicians, gastroenterologists, hematologists/oncologists, hospitalists, infectious disease specialists, internists, nephrologists, neurologists, pulmonologists, and rheumatologists/immunologists, according to the report published on CRICO's website.

The findings are consistent with prior research on claim trends, said Seth Seabury, PhD, a medical liability researcher and director of the Keck-Schaeffer Initiative for Population Health Policy at the University of Southern California, Los Angeles.

"Malpractice claim frequency has been falling pretty steadily for a while now, reflecting a number of factors including the widespread adoption of tort reform and other measures to shield physicians from malpractice risk," Dr. Seabury said in an interview. "Interestingly, the decline seems greatest in the claims with lower potential stakes as you see average indemnity holding flat

or rising. Some of this likely reflects the unwillingness of attorneys to take cases with lower potential payouts because of the high cost of litigating a malpractice case."

However, the price of defending a malpractice lawsuit has risen an average of 3.5% annually over the 10-year period from \$36,000 to \$46,000. For cases that ended with no payment (indemnity) to plaintiffs, the cost to manage a case rose an average of 5% annually.

These trends in such expenses are striking, particularly since the time to resolve cases has decreased, said Michelle Mello, PhD, a health research and policy professor at Stanford (Calif.) University. From 2007 to 2016, the average time to resolve a case dropped from 29 to 27 months.

"CRICO nods to disclosure and apology approaches as perhaps underlying the more encouraging trend in time to resolution, but it was surprising to me that such approaches have not translated into lower defense costs," Dr. Mello said in an interview. "In particular, a lot is still being spent to manage cases that never result in a payment to the patient. My hope was that, as hospitals got better at communicating with patients about adverse events, including the fact that about three-quarters of them are not due to substandard care, there would be fewer claims involving such events and also less money spent dealing with such claims when they do arise."

For cases that do end in payment, high payouts are on the rise. Cases that ended in payments of \$1 million or more increased 4% over the 10-year time frame, while payments of \$3 million to \$11 million increased 7% annually. Cases that ended in payment lower than \$1 million dropped over the 10-year span.

"It's hard to say exactly why high payouts are on the rise as payout levels reflect a number of factors ... that can be difficult to disentangle," Dr. Seabury said. "But it is probably concerning for doctors in the sense that, while claims are becoming less likely, when they do happen, it could be more catastrophic in the sense of having large damages that exceed the policy limit."



Dr. Mello

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scheurerd@muscc.edu

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Suzanne Bopp; Randy Dotinga;
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Greg Maynard, MD, MSc, MHM;
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cell 610-506-3474 tlapella@mdedge.com

Advertising Offices 7 Century Drive,

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973-206-3434, fax 973-206-9378

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Letters to the Editor: rpizzi@mdedge.com

The Society of Hospital Medicine's headquarters is located at 1500 Spring Garden, Suite 501, Philadelphia, PA 19130.

Editorial Offices: 2275 Research Blvd, Suite 400, Rockville, MD 20850, 240-221-2400, fax 240-221-2548

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Embracing an executive leadership role

Dr. Bryce Gartland says hospitalists thrive as leaders

By Larry Beresford

Bryce Gartland, MD, was working as a full-time hospitalist at Emory University Hospital in Atlanta when hospital administrators first started asking him to take on administrative roles, such as clinical site director or medical director of care coordination.

Today, Dr. Gartland is hospital group president and cochief of clinical operations for Emory Healthcare, with responsibility for overall performance and achievement across all 11 Emory hospitals. In that role, he keeps his eyes open for similar talent and leadership potential in younger physicians.

Following internal medicine residency at Cedars-Sinai Medical Center in Los Angeles, Dr. Gartland moved into a traditional private practice setting in Beverly Hills. “Two years later, my wife and I decided to move back to my home town of Atlanta. This was 2005 and hospital medicine was a nascent movement in health care. I was intrigued, and Emory had a strong hospitalist program based in a major academic medical setting, which has since grown from approximately 20 physicians to over 120 across seven hospitals,” he said.

Senior leaders at Emory recognized something in Dr. Gartland and more administrative offers were forthcoming.

“After a year of practicing at Emory, the system’s chief financial officer knocked on my door to ask if I would be interested in becoming medical director for care coordination. This role afforded me tremendous opportunities to get involved in clinical/administrative activities at Emory – utilization review, hospice and palliative care, transitions of care, interface with managed care organizations. The role was very rewarding. In some ways, I became a kind of chief translator at the hospital for anything clinical that also had financial implications,” he recalled.

“Then we went through a reorganization, and I was offered the opportunity to step into the chief operating officer position at Emory University Hospital. Shortly thereafter, there was leadership turnover within the division of hospital medicine, and I was asked by the CEO of Emory Healthcare and chair of the department of medicine to serve as section head for hospital medicine.” Dr. Gartland wore both of those hats for about 2 years, later becoming the CEO of Emory University Hospital and two other facilities within the system. He was appointed to his current position as hospital group president and cochief of clinical operations for Emory Healthcare in 2018.

Consumed with administrative responsibilities, he largely had to step away from patient care, although with mixed emotions.

“Over the years, I worked hard to maintain a strong clinical role, but the reality is that, if you are not delivering patient care routinely, it’s difficult to practice at the highest level of current medical practice,” he said. Nonetheless, Dr.

Gartland tries to keep a hand in patient care by routinely rounding with hospitalist teams and attending care conferences.

Fixing the larger health care system

“I am a huge supporter of more physicians becoming actively engaged in administrative positions in health care. They are key to helping us best fix the larger health care system,” Dr. Gartland said. “However, we’ve all seen clinicians drafted into administrative positions who were not great administrators. One needs to be bilingual in both medicine and business. While some skills, such as strong communication, may cross over, it’s important to recognize that clinical strength and success do not necessarily equate to administrative achievement.”



Dr. Gartland

Dr. Gartland also believes in the importance of mentorship in developing future leaders and in seeking and engaging mentors from other disciplines outside of one’s own specialty. “I’ve been fortunate to have a number of mentors who saw something in me and supported investment in my personal and professional development. I am now fortunate to be in the position to give back by mentoring a number of younger hospitalists who are interested in growing their nonclinical roles.”

“One bit of advice from a mentor that really resonated with me was: Don’t let the urgent get in the way of the important,” Dr. Gartland said. “Life is busy and full of urgent day-to-day fires. It’s important to take the time to pause and consider where you are going and what you are doing to enhance your career development. Are you getting the right kinds of feedback?” He explained that a coach or mentor who can provide constructive feedback is important and is something he has relied upon throughout his own professional development.

Learning business by different paths

Dr. Gartland did not pursue formal business training before the administrative opportunities started to multiply for him at Emory, although in college he had a strong interest in both business and medicine and at one time contemplated going into either.

“Over the years, my mentors have given me a lot of advice, one of which was that a medical degree can be a passport to a lot of different career paths, with real opportunities for merging business and medicine,” he said.

He has since intentionally pursued business training opportunities wherever they came up, such as courses offered by the American College of Physician Executives (now the American Association for Physician Leadership). “At one point, I considered going back to college in an MBA program, but that’s when John Fox – then Emory Healthcare’s CEO – called and said he wanted to send me to the Harvard Business School’s Manag-

ing Health Care Delivery executive education program, with an Emory team comprising the chief nurse executive, chief of human resources, and CEO for one of our hospitals.” Harvard’s roughly 9-month program involves 3 weeks on campus with assignments between the on-campus visits.

“In my current role as hospital group president, I have direct responsibility for our hospitals’ and system’s clinically essential services such as radiology, laboratory, pharmacy, and perioperative medicine. I also still serve as CEO for Emory University Hospital while we recruit my replacement,” Dr. Gartland said. “Overall, my work time breaks down roughly into thirds. One-third is spent on strategy and strategic initiatives – such as organizational and program design. Our system recently acquired a large community health system whose strategic and operational integration I am actively leading.”

Another third of his time is focused on operations, and the final third is focused on talent management and development. “People are truly the most valuable asset any organization has, particularly in health care,” he noted. “Being intentional about organizational design, coaching, and supporting the development and deployment

“We’ve all seen clinicians drafted into administrative positions who were not great administrators. One needs to be bilingual in both medicine and business.”

of talent at all levels of the organization helps everyone achieve their full potential. It is one of the most important roles a leader can play.”

Dr. Gartland said that Emory is committed to Lean-based management systems, using both horizontal and vertical strategies for process improvement and waste reduction, with implementation beginning in urology, transplant, and heart and vascular services. Experts say Lean success starts at the very top, and Emory and Dr. Gartland are all in.

“These types of changes are measured in 5- to 7-year increments or more, not in months. We believe this is key to creating the best workplace to support the highest quality, experience, and value in health care delivery. It creates and supports the right culture within an organization, and we have made the commitment to following that path,” he said.

Recognizing leadership potential

What does Dr. Gartland look for in physicians with leadership potential?

“Are you someone who collaborates well?” he asked. “Someone who raises your hand at meetings or gets engaged with the issues? Do you volunteer to take on assignments? Are you someone with a balanced perspective, system minded in

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Survey Insights

Nontraditional specialty physicians supplement hospitalist staffing

More HMGs cover inpatient and ED settings

By Carolyn A. Sites, DO

Our profession continues to experience steady growth, and demand for hospitalist physicians exceeds supply. In a recent article in *The Hospitalist*, Andrew White, MD, SFHM, highlighted the fact that most hospital medicine groups (HMGs) are constantly recruiting and open positions are not uncommon.

When we think about recruitment and staffing, I bet many of us think principally of physicians trained in the general medicine specialties of internal medicine, family medicine, and pediatrics. Yet, to help meet demand for hospital-based clinicians, HMGs sometimes turn to physicians certified in emergency medicine, critical care, geriatric medicine, palliative care, and other fields.

To gain a better understanding of the diversity within our profession, the Society of Hospital Medicine's State of Hospital Medicine survey asked HMGs whether they employ at least one



southern United States at 70.3% and lowest in the west at 54.7%. Small-sized groups – fewer than 10 full-time equivalents (FTEs) – were also more likely to employ FPs.

This speaks to the challenge – often faced by smaller hospitals – of covering both adult and pediatric patient populations and limited workforce availability. Pediatrics- and internal medicine/pediatrics-trained physicians help meet this need and were prevalent within small-sized groups. Another

distinction found in the report is that, while 92.1% of multistate hospitalist management companies employed family physicians, only 28.8% of academic university settings did so. Partly because of Accreditation Council for Graduate Medical Education requirements for IM-certified teaching attending for internal medicine residents, FP and other specialties are filling some non-teaching hospitalist positions within our academic programs.

What may be surprising is that emergency medicine and critical care had the largest increase in representation in hospital medicine. The two specialties showed similar growth trends, with a larger presence in the South and Midwest states and 56% of multistate hospitalist management companies employing them. Small- to medium-sized groups of up to 20 FTEs were also more likely to have physicians from these fields, with up to 44% of groups doing so. This is a significant change from 2016, when less than 3.4% of all HMGs overall had a physician certified in emergency or critical care medicine.

This finding seems to coincide with the growth in hospital medicine groups who are covering both ED and inpatient services. For small and rural hospitals, it has become necessary and beneficial to have physicians capable of covering both clinical settings.

Contrast this with geriatric medicine and palliative care. Here, we saw these two specialties to be present in our academic institutions at 26.8% and



Dr. Sites is the executive medical director of acute medicine at Providence St. Joseph Health, Portland, Ore., and a member of SHM's Practice Analysis Committee. She leads the hospital medicine programs and is involved in strategy development and alignment of acute inpatient medicine services at eight member hospitals. She has been a practicing hospitalist for 20 years and volunteers on medical mission trips to Guatemala annually.

Emergency medicine and critical care had the largest increase in representation in hospital medicine.

physician in these various specialties. Results published in the recently released 2018 State of Hospital Medicine (SoHM) Report show significant differences among groups, affected by location, group size, and type of employer.

At the core of our profession are physicians trained in internal medicine, present in 99.2% of adult medicine HMGs throughout the United States. No surprise given that our field was founded by internists and remains a popular career choice for IM residency graduates. Family physicians follow, with the highest percentage of groups employing at least one FP located in the

22.5%, respectively. Large-sized HMGs were more likely to employ them, whereas their presence in multistate management groups or private multi-specialty/primary care groups was quite low. Compared with our last survey in 2016, their overall prevalence in HMGs hasn't changed significantly. Whether this will be different in the future with our aging population will be interesting to follow.

Published biannually, the SoHM report provides insight into these and other market-based dynamics that shape hospital medicine. The demand for hospital-based clinicians and the demands of acute inpatient care are leading to the broad and inclusive nature of hospital medicine. Our staffing will continue to be met not only by internal medicine and family medicine physicians but also through these other specialties joining our ranks and adding diversity to our profession.

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thinking and inquisitive, with a positive approach to problem solving?"

A lot of physicians might come to a meeting with the hospital or their boss and complain about all the things that aren't working, he said, but "it's rarer for them to come in and say: 'I see these problems, and here's where I think we can make improvements. How can I help?'" Dr. Gartland looks for evidence of emotional intelligence and the ability to effect change management across disci-

plines. Another skill with ever-greater importance is comfort with data and data-driven decision making.

"When our national health care system is experiencing so much change and upheaval, much of which is captured in newspaper headlines, it can sound scary," he said. "I encourage people to see that complex, dynamic times like these, filled with so much change, are also a tremendous opportunity. Run towards and embrace the opportunity for change. Hospitalists, by nature,

bring with them a tremendous background and experience set that is invaluable to help lead positive change in these dynamic times."

The SHM has offerings for hospitalists wanting to advance in leadership positions, Dr. Gartland said, including its annual Leadership Academy. The next one is scheduled to be held in Nashville, Tenn., Nov. 4-7, 2019.

"The Leadership Academy is a great initial step for physicians, especially those early in their careers. Also, try to gain exposure to

a variety of perspectives outside of hospital medicine," he said. "I'd love to see further advances in leadership for our specialty – growing the number of hospitalists who serve as hospital CEOs or CMOs and in other leadership roles. We have more to learn collectively about leadership as a specialty, and I'd love to see us grow that capacity by offering further learning opportunities and bringing together hospitalists who have an interest in advancing leadership."



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High-value care

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A brief history of high-value care

When compared with other wealthy countries, the United States spends disproportionately more money on health care. In 2016, U.S. health care spending was \$3.3 trillion¹, or \$10,348 per person.² Hospital care alone was responsible for a third of health spending and amounted to \$1.1 trillion in 2016¹. By 2026, national health spending is projected to reach \$5.7 trillion¹.

In response to escalating health care costs, CMS and other payers have shifted toward value-based reimbursements that tie payments to health care facilities and clinicians to their performance on selected quality, cost, and efficiency measures. For example, under the CMS Merit-based Incentive Payment System (MIPS), 5% of clinicians' revenue in 2020 is tied to their 2018 performance in four categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. The percentage of revenue at risk will increase to 9% in 2022, based on 2020 performance.

Rising health care costs put a burden not just on the federal and state budgets, but on individual and family budgets as well. Out-of-pocket spending grew 3.9% in 2016 to \$352.5 billion¹ and is expected to increase in the future. High health care costs rightfully bring into question the value individual consumers of health care services are getting in return. If value is defined as the level of benefit achieved for a given cost, what is high-value care? The 2013 Institute of Medicine report³ defined high-value care as “the best care for the patient, with the optimal result for the circumstances, delivered at the right price.” It goes beyond a set of quality and cost measures used by payers to affect provider reimbursement and is driven by day-to-day individual providers' decisions that affect individual patients' outcomes and their cost of care.

High-value care has been embraced by national organizations. In 2012, the ABIM Foundation launched the Choosing Wisely initiative to support and promote conversations between clinicians and patients in choosing care that is truly necessary, supported by evidence, and free from harm. The result was an evidence-based list of recommendations from 540 specialty societies, including the Society of Hospital Medicine. The SHM – Adult Hospital

Medicine list⁴ features the following “Five things physicians and patients should question”:

- Don't place, or leave in place, urinary catheters for incontinence or convenience or monitoring of output for non-critically ill patients.
- Don't prescribe medications for stress ulcer prophylaxis to medical inpatients unless at high risk for GI complications.
- Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds and in the



Dr. Wray

absence of symptoms of active coronary disease, heart failure, or stroke.

- Don't order continuous telemetry monitoring outside of the ICU without using a protocol that governs continuation.
- Don't perform repetitive CBC and chemistry testing in the face of clinical and lab stability.

The ACP launched a high-value care initiative that offers learning resources for clinicians and medical educators, clinical guidelines, and best practice advice. In 2012, a work group of internists convened by ACP developed a list of 37 clinical situations in which medical tests are commonly used but do not provide high value.⁵ Seven of those situations are applicable to adult hospital medicine.

High-value care today: What the experts say

More than 5 years later, what progress have hospitalists made in adopting high-value care practices? To answer this and other questions, I reached out to three national experts in high-value care in hospital medicine: Amit Pahwa, MD, assistant professor of medicine and pediatrics at Johns Hopkins University, Baltimore, and a course director of “Topics in interdisciplinary medicine: High-value

health care”; Christopher Petrilli, MD, clinical assistant professor in the department of medicine at New York University Langone Health and clinical lead, Manhattan campus, value-based management; and Charlie Wray, DO, MS, assistant professor of medicine at the University of California, San Francisco and a coauthor of an article on high-value care in hospital medicine published recently in the *Journal of General Internal Medicine*⁶.



Dr. Pahwa

The experts agree that awareness of high-value care among practicing physicians and medical trainees has increased in the last few years. Major professional publications have highlighted the topic, including the *Journal of Hospital Medicine's* “Things We Do For No Reason” series, JAMA's “Teachable Moments,” and the *American Journal of Medicine's* recurring column dedicated to high-value care practice. Leading teaching institutions have built high-value care curricula as a part of their medical student and resident training. However, widespread adoption has been slow and sometimes difficult.

The barriers to adoption of high-value practices among hospitalists are numerous and deep rooted in historical practices and culture. As Dr. Petrilli said, the “culture of overordering [diagnostic tests] is hard to break.” Hospitalists may not have well-developed relationships with patients, or time to explain why some tests or treatments are unnecessary. There is a lack of cost transparency, including the cost of the tests themselves and the downstream costs of additional tests and follow-ups. The best intended interventions fail to produce durable change unless they are seamlessly integrated into a hospitalist's daily work flow.

Six steps to implementing a successful high-value care initiative

What can hospitalists do to improve the value of care they provide to their patients and hospital partners?

1. Identify high-value care opportunities at your hospital.

Dr. Wray pointed out that “all high-value care is local.” Start by looking at the national guidelines and talking to your senior clinical leaders



Dr. Petrilli

and colleagues. Review your hospital data to identify opportunities and understand the root causes, including variability among providers.

If you choose to analyze and present provider-specific data, first be transparent on why you are doing that. Your goal is not to tell physicians how to practice or to score them, but instead, to promote adoption of evidence-based high-value care by identifying and discussing provider practice variations, and to generate possible solutions. Second, make sure that the data you present is credible and trustworthy by clearly outlining the data source, time frame, sample size per provider, any inclusion and exclusion criteria, attribution logic, and severity adjustment methodology. Third, expect initial pushback as transparency and change can be scary. But most doctors are inherently competitive and will want to be the best at caring for their patients.

2. Assemble the team.

Identify an executive sponsor – a senior clinical executive (for example, the chief medical officer or vice president of medical affairs) whose role is to help engage stakeholders, secure resources, and remove barriers. When assembling the rest of the

team, include a representative from each major stakeholder group, but keep the team small enough to be effective. For example, if your project focuses on improving telemetry utilization, seek representation from hospitalists, cardiologists, nurses, utilization managers, and possibly IT. Look for people with the relevant knowledge and experience who are respected by their peers and can influence opinion.

3. Design a sustainable solution.

To be sustainable, a solution must be evidence based, well integrated in provider work flow, and have acceptable impact on daily workload (for example, additional time per patient). If an estimated impact is significant, you need to discuss adding resources or negotiating trade-offs.

A great example of a sustainable solution, aimed to control overutilization of telemetry and urinary catheters, is the one implemented by Dr. Wray and his team.⁷ They designed an EHR-based “silent” indicator that clearly signaled an active telemetry or urinary catheter order for each patient. Clicking on the indicator directed a provider to a “manage order” screen where she could cancel the order, if necessary.

4. Engage providers.

You may design the best solution, but it will not succeed unless it is embraced by others. To engage providers, you must clearly communicate why the change is urgently needed for the benefit of their patients, hospital, or community, and appeal to their minds, hearts, and competitive nature.

For example, if you are focusing on urinary catheter overutilization,

“To engage providers, you must clearly communicate why the change is urgently needed for the benefit of their patients, hospital, or community.”

you may share your hospital’s urinary catheter device utilization ratio (number of indwelling catheter days/number of patient days) against national benchmarks, or the impact on hospital catheter-associated urinary tract infections (CAUTI) rates to appeal to the physicians’ minds. Often, data alone are not enough to move people to action. You must appeal to their hearts by sharing stories of real patients whose lives were affected by

preventable CAUTI. Leverage physicians’ competitive nature by using provider-specific data to compare against their peers to spark discussion.

5. Evaluate impact.

Even before you implement a solution, select metrics to measure impact and set SMART (specific, measurable, achievable, relevant, and time-bound) goals. As your implementation moves forward, do not let up or give up – continue to evaluate impact, remove barriers, refine your solution to get back on track if needed, and constantly communicate to share ongoing project results and lessons learned.

6. Sustain improvements.

Sustainable improvements require well-designed solutions integrated into provider work flow, but that is just the first step. Once you demonstrate the impact, consider including the metric (for example, telemetry or urinary catheter utilization) in your team and/or individual provider performance dashboard, regularly reviewing and discussing performance during your team meetings to maintain engagement, and if needed, making improvements to get back on track.

Successful adoption of high-value

care practices requires a disciplined approach to design and implement solutions that are patient centered, evidence based, data driven, and integrated in provider work flow.

Dr. Farah is a hospitalist, Physician Advisor, and Lean Six Sigma Black Belt. She is a performance improvement consultant based in Corvallis, Ore., and a member of The Hospitalist’s editorial advisory board.

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Top 10 things physician advisors want hospitalists to know

By Sarguni Singh, MD, FHM; Hemali Patel, MD; Deb Anoff, MD, FHM; Sarah A. Stella, MD, FHM

The practice of hospital medicine is rapidly changing. Higher-acuity patients are being admitted to hospitals already struggling with capacity, and hospitalists are being instructed to pay attention to length of stay, improve their documentation and billing, and participate in initiatives to improve hospital throughput, all while delivering high-quality patient care.

As hospitalists and SHM members who are also physician advisors, we have a unique understanding of these pressures. In this article, we answer common questions we receive from hospitalists regarding utilization management, care coordination, clinical documentation, and Centers for Medicare & Medicaid Services regulations.

Why do physician advisors exist, and what do they do?

A physician advisor is hired by the hospital to act as a liaison between the hospital administration, clinical staff, and support personnel in order to ensure regulatory compliance, advise physicians on medical necessity, and assist hospital leadership in meeting overall organizational goals related to the efficient utilization of health care services.

Given their deep knowledge of hospital systems and processes, and ability to collaborate and teach, hospitalists are well positioned to serve in this capacity. Our primary goal as physician advisors is to help physicians continue to focus on the parts of medicine they enjoy by helping to demystify complex regulatory requirements and by creating streamlined processes to make following these requirements easier.

Why does this matter?

We understand that regulatory and hospital systems issues such as patient class determination, appropriate clinical documentation, and hospital throughput and capacity management can feel tedious, and sometimes overwhelming, to busy hospitalists. While it is easy to attribute these problems solely to hospitals' desire for increased revenue, these issues directly impact the quality of care we provide to their patients.

In addition, our entire financial system is predicated on appropriate health care resource utilization, financial reimbursement, demonstration of medical acuity, and our impact on the care of a patient. Thus, our ability to advocate for our patients and for ourselves is directly connected with this endeavor. Developing a working knowledge of regulatory and systems issues allows hospitalists to be more engaged in leadership and negotiations and allows us to advocate for resources we deem most important.

Why are clinical documentation integrity teams so important?

Accurately and specifically describing how sick

your patients are helps ensure that hospitals are reimbursed appropriately, coded data are accurate for research purposes, quality metrics are attributed correctly, and patients receive the correct diagnoses.

Clarification of documentation and/or addressing "clinical validity" of a given diagnosis (e.g., acute hypoxic respiratory failure requires both hypoxia and respiratory distress) may support an increase or result in a decrease in hospital reimbursement. For example, if the reason for a patient's admission is renal failure, renal failure with true acute hypoxic respiratory failure will be reimbursed at a rate 40% higher than renal failure without the documentation of other conditions that reflect how ill the patient really is. The patient with acute hypoxic respiratory failure (or other major comorbid condition) is genuinely sicker, thus requiring more time (length of stay) and resources (deserved higher reimbursement).

What is the two-midnight rule, and why does it matter?

In October of 2013, the CMS initiated the two-midnight rule, which states a Medicare patient can be an "inpatient" class if the admitting provider determines that 1) the patient requires medically necessary care which cannot be provided outside the hospital and 2) the patient is expected to stay at least 2 midnights in the hospital.

If, at the time of admission, an admitting provider thinks it is likely that the patient may be discharged prior to 2 midnights, then outpatient care with "observation" designation is appropriate. Incorrect patient class assignment may result in significant adverse consequences for hospitals, including improper patient billing, decreased hospital reimbursement, substantial risk for external auditing, violation of Medicare conditions of participation, and even loss of accreditation.

Who can I talk to if I have a question about a patient's class? What should I do if I disagree with the class assigned to my patient?

The Utilization Management team typically consists of nurses and physician advisors specifically trained in UM. This team functions as a liaison between providers and payers (particularly Medicare and Medicaid) regarding medical necessity, appropriateness of care received, and efficiency of health care services.

When it comes to discussions about patient class, start by learning more about why the determination was made. The most common reason for patient class disagreements is simply that the documentation does not reflect the severity of illness or accurately reflect the care the patient is receiving. Your documentation should communicate that your patient needs services that only the hospital can provide, and/or they need monitoring that must be done in the hospital to meet



Dr. Singh is physician advisor for Utilization & CM in the division of hospital medicine at the University of Colorado at Denver, Aurora. Dr. Patel is a hospitalist and assistant professor of medicine at the university. Dr. Anoff is director of clinical operations and director of nights for the Hospital Medicine Group at the University of Colorado at Denver. Dr. Stella is a hospitalist at Denver Health and Hospital Authority and an associate professor of medicine at the university.

the medical necessity criteria that CMS requires for a patient to be "inpatient" class.

If you disagree with a determination provided by the UM nurse and/or physician advisor, then the case will be presented to the hospital UM committee for further review. Two physicians from the UM committee must review the case and provide their own determinations of patient status, and whichever admission determination has two votes is the one that is appropriate.

How do I talk to patients about class determinations?

An AARP Bulletin article from 2012 advised patients to "ask [their] own doctor whether observation status is justified." Patients should be informed that providers understand the implications of patient class determinations and are making these decisions as outlined by CMS.

We recommend informing patients that the decision about whether a patient is "inpatient" or "outpatient with observation" class is complex and involves taking into consideration a patient's medical history, the severity of their current medical condition, need for diagnostic testing, and degree of health resource utilization, as well as a provider's medical opinion of the risk of an adverse event occurring.

Continued on following page

Treating patients during disasters raises liability

AAP guidance useful for pediatric hospitalists

By Alicia Gallegos

MDedge News

The American Academy of Pediatrics has released new guidance about how pediatric hospitalists can protect themselves from liability risks when caring for children during disasters.

In a 2019 technical report, the AAP outlines common claims that can arise when treating children during disasters and how certain circumstances can force you to deviate from routine medical practices. In an accompanying policy statement by the AAP committee on medical liability and risk management, recommendations are offered for how to prepare for and prevent such legal risks.

During disasters, liability dangers can increase when circumstances “devolve into an environment of limited choices for both patients and providers,” and you have fewer treatment options available, according to the guidance authored by a team led by Robin L. Altman, MD, FAAP, chief of general pediatrics and hospital medicine at Boston Children’s Hospital.

Common claims that stem from treating patients during disasters are negligence, abandonment, and lack of informed consent. The AAP technical report offers examples of how these accusations can occur, including:

- When during a disaster, you are forced to alter treatment because of scarce medical supplies or equipment, you may later be accused of negligence if the patient’s outcome

is negatively affected by the modified treatment.

- When a disaster progresses to overwhelming conditions, and you must practice in an altered health care environment that demands atypical actions, such actions may later be questioned and be accused of providing suboptimal care. Documentation of medical decision making for instance, a primary defense for one’s actions, may be compromised because of an inoperable electronic medical record. Similarly, past medical history may be unavailable, which may impact the appropriateness of care provision.
 - In chaotic conditions, you may have to stop treating some patients to focus your time and resources elsewhere, which may lead to an abandonment claim, defined as unilateral termination of a physician-patient relationship – without proper patient notice – when treatment is still required. An abandonment claim also may arise when you have to make decisions in extreme conditions about which patients to transfer or evacuate first and whom to leave behind.
 - With medical care for children during disasters, a lack of informed consent claim can arise if adequate parental permission is unattainable. This may result from families that are separated or displaced children in need of medical care.
- Other claims that can arise from providing care during disasters include HIPAA breaches, licensing

violations, discrimination claims, and Emergency Medical Treatment and Labor Act (EMTALA) violations.

To reduce liability risks, you should strive to understand liability risks and limitations during disasters and take steps to mitigate them by crafting a disaster-readiness plan.



Dr. Altman

The plan should include provider and staff education on improving medical care during disasters and how best to document medical decisions made in disaster-affected health care environments.

Proactively identifying obstacles to care during disasters also is key. You can use the AAP division of state government affairs as a resource; it can provide current information on disaster liability in the different states.

You also should understand potential limits to your medical malpractice insurance coverage during disasters and take steps to add coverage for identified gaps.

AAP recommends that you advocate for your health center to have active disaster plans that cover children’s needs and for your hospital to conduct regular drills that test pediatric capabilities. Throughout the guidelines, the AAP calls on the U.S. Department of Health & Human Services to review current state and federal liability laws, and for the agency

to recommend new laws that address disaster-response liability protections for doctors. HHS also should assess the liability coverage needs of physicians during crisis times and take action to reduce inconsistencies in state malpractice protections for volunteer physicians and nonvolunteer physicians, according to AAP.

The AAP policy statement is timely because of the number of recent disasters in the United States.

Citing the Federal Emergency Management Agency, Dr. Altman said there were 59 major disaster declarations and 16 emergency declarations in 2017, along with more than 300 mass-shooting incidents and more than 110 other man-made disasters such as fires and industrial accidents.

“Disaster conditions can result in pediatric health care providers being faced with the need to address medical conditions outside of their scope of training and experience, without access to the usual fund of patient history and background information, without the usual input or consent from parents or guardians, without the usual assistance of data such as laboratory values or physiologic monitoring, and without knowledge of how long dire conditions will last,” Dr. Altman said. “In addition, this can occur within the backdrop of one’s own physical exhaustion, concerns for the safety of one’s own family members, and the risk of loss of valuable and expensive professional property and supplies.”

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Is it true that observation patients receive higher hospital bills?

It is a common misperception that a designation of “observation” class means that a patient’s medical bill will be higher than “inpatient” class. In 2016, CMS changed the way observation class patients are billed so that, in most scenarios, patients do not receive a higher hospital bill when placed in “observation” class.

How do I approach a denial from a payer?

Commercial payers review all hospitalizations for medical necessity and appropriateness of care received during a patient’s hospitalization. If you receive notice that all or part of your patient’s hospital stay was denied coverage, you have the option of discussing the case with the medical director of the insurance company – this is called a peer-to-peer discussion.

We recommend reviewing the patient’s case and your documentation of the care you provided

prior to the peer to peer, especially since these denials may come weeks to months after you have cared for the patient. Begin your conversation by learning why the insurance company denied coverage of the stay and then provide an accurate portrayal of the acuity of illness of the patient, and the resources your hospital used in caring for them.

How can care management help with “nonmedical” hospitalizations?

Care managers are your allies for all patients, especially those with complex discharge needs. Often patients admitted for “nonmedical” reasons do not have the ability to discharge to a skilled nursing facility, long-term care facility, or home due to lack of insurance coverage or resources and/or assistance. Care managers can help you creatively problem solve and coordinate care. Physician advisors are your allies in helping create system-level interventions that might avert some of these “nonmedical” admissions. Consider

involving both care managers and physician advisors early in the admission.

How can hospitalists get involved?

According to CMS, the decision on “whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital ... can typically be made in less than 48 hours, usually in less than 24 hours.” In reality, this is not black and white. The “2 midnights” has brought a host of new challenges for hospitals, hospitalists, and patients to navigate. SHM released an Observation White Paper in 2017 challenging the status quo and proposing comprehensive observation reform.

We encourage hospital medicine providers to more routinely engage with their institutional physician advisors and consider joining the SHM Public Policy Committee to become more involved in advocacy, and/or consider becoming a physician advisor.

Reducing sepsis

Joint Commission develops targeted tool

The CDC estimates that 1.7 million people in the United States acquire sepsis annually; sepsis accounts for nearly 270,000 patient deaths per year.

Decreasing mortality and improving patient outcomes requires early detection and appropriate timely treatment. The Joint Commission Center for Transforming Healthcare's recent sepsis project demonstrated this by analyzing root causes and reducing sepsis mortality with five leading hospitals by an aggregate of nearly 25%.

"Most organizations can tell you how they are doing with regard to whether or not they are ordering lactates or fluids, but many can't tell you where in the process these elements are failing," said Kelly Barnes, Black Belt III, Joint Commission Center for Transforming Healthcare. "For instance, is the issue in ordering lactates, drawing lactates, or getting the results of lactates in a timely manner? The key is to understand where in the

process things are breaking down to identify what solutions an organization needs to put in place."

During the Joint Commission project, one organization found that patients had inadequate fluid resuscitation due to staff fear of fluid overload, while another organization found they had issues with fluids being disconnected when patients were taken for tests and then not reconnected – different problems that needed different solutions.

The Joint Commission Center for Transforming Healthcare is currently developing a Targeted Solutions Tool® (TST®), scheduled for release in 2019, to help organizations determine their issues with sepsis recognition and barriers to meeting sepsis bundle element requirements and implement targeted solutions to address their specific issues.

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Bringing hospitalist coverage to critical access hospitals

Telemedicine may expand capabilities

"As a hospitalist, I believe that my specialty improves care for inpatients," said Ethan Kuperman, MD, MS, FHM, clinical associate professor of medicine at University of Iowa Health Care in Iowa City. "I want hospitalists involved with as many hospitals as possible because I believe we will lead to better patient outcomes."

But, he adds, it's not feasible to place dedicated hospitalists in every rural hospital in the United States – especially those running far below the average hospitalist census. "As a university, academic hospitalist, I wanted to make sure that the innovations and knowledge of the University of Iowa could penetrate into the greater community, and I wanted to strengthen the continuity of care between our partners in rural Iowa and our physical location in Iowa City," he said.

Enter the virtual hospitalist: A telemedicine "virtual hospitalist" may expand capabilities at a fractional cost of an on-site provider.

Dr. Kuperman's 6-month pilot program provided "virtual hospitalist" coverage to patients at a critical access hospital in rural Iowa.

"Our rural partners want to ensure that they are providing high-quality care within their communities and aren't transferring

patients without a good indication to larger centers," he said. "For patients, this program means more of them can remain in their communities, surrounded by their families. I don't think the virtual hospitalist program delivers equivalent care to the university hospital – I think we deliver better care because of that continuity with local providers and the ability of patients to remain in contact with their support structures."



Dr. Kuperman

The study concludes that the virtual hospitalist model increased the percentage of ED patients who could safely receive their care locally, and a single virtual hospitalist may be able to cover multiple critical access hospitals simultaneously.

"We have the technology to deliver hospitalist expertise to rural hospitals through telehealth in a way that benefits patients, rural hospitals, and academic hospitals," he said.

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Quick Byte: Hope for heart failure patients

Repairing the mitral valve

A new device shows promise for heart failure patients, according to a recent study.

In a trial, 614 patients with severe heart failure were randomly assigned to receive standard medical treatment and a MitraClip, which helps repair the damaged mitral valve, or to receive medical treatment alone.

Among those who received only medical treatment, 151 were

hospitalized for heart failure in the ensuing 2 years and 61 died. Among those who got the device, 92 were hospitalized for heart failure during the same period and 28 died.

Reference

Kolata G. Tiny device is a 'huge advance' for treatment of severe heart failure. *New York Times*. Sep 23, 2018. <https://www.nytimes.com/2018/09/23/health/heart-failure-valve-repair-microclip.html>. Accessed Oct 10, 2018.



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Breaking the high-utilization cycle

Multidisciplinary interventions cut readmissions, show cost reductions

Hospitalists know that a small percentage of patients account for a disproportionately large percentage of overall health care spending, much of which comes from inpatient admissions. Many programs have been developed around the country to work with this population, and most of these programs are – appropriately – outpatient based.

“However, a subset of frequently admitted patients either don’t make it to outpatient care or are unengaged with outpatient care and programs, for whom hospital stays can give us a unique opportunity to coordinate and streamline care, and to build trust that can then lead to increased patient engagement,” said Kirstin Knox, MD, PhD, of the Hospital of the University of Pennsylvania in Philadelphia, and lead author of an abstract describing a method to address this challenge. “Our program works with these patients, the ‘outliers among the outliers’ to re-engage them in care, streamline admissions, coordinate inpatient and outpatient care, and address the underlying barriers/drivers that lead to frequent hospitalization.”

Their program designed and implemented a multidisciplinary intervention targeting the



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highest utilizers on their inpatient general medicine service. Each was assigned an inpatient continuity team, and the patient case was then presented to a multidisciplinary high-utilizer care committee that included physicians, nurses, and social workers, as well as representatives from a community health worker program, home care, and risk management to develop a care plan.

Analysis comparing the 6 months before and

after intervention showed admissions and total hospital days were reduced by 55% and 47%, respectively, and 30-day readmissions were reduced by 65%. Total direct costs were reduced from \$2,923,000 to \$1,284,000.

The top takeaway, Dr. Knox said, is that, through efforts to coordinate care and address underlying drivers of high utilization, hospital-based programs for the most frequently admitted patients can streamline inpatient care and decrease utilization for many high-risk, high-cost patients.

“I hope that hospitalists will consider starting inpatient-based high-utilizer programs at their own institutions, if they haven’t already,” she said. “Even starting with one or two of your most frequently admitted patients can be incredibly eye

opening, and streamlining/coordinating care (as well as working overtime to address the underlying drivers/barriers that lead to high utilization) for these patients is incredibly rewarding.”

Reference

Knox K et al. Breaking the cycle: a successful inpatient based intervention for hospital high utilizers. Abstract published at Hospital Medicine 2018; Apr 8-11; Orlando, Abstract 319. Accessed 2018 Oct 2.

Searching for a life-changing innovation

Book celebrates artificial heart and LVAD

It might be the ultimate medical innovation – an artificial heart – and generations of physicians have pursued it, a story told in “Ticker: The Quest to Create an Artificial Heart.”

Author Mimi Swartz feared this history was being forgotten. “The larger-than-life personalities – Dr. Michael DeBakey and Dr. Denton Cooley – were such dominant figures for more than 50 years; I couldn’t stand for that history to be lost,” she said. “Also, so many innovations happened in Houston, including the implantation of the first artificial heart and the development of the Left Ventricular Assist Device – I couldn’t stand for that information to be lost too.”

Writing this book taught her a lot about innovation in medicine, the trade-offs involved in medical progress, even who benefits most.

“One of the most important things

to think about is how many of these high-tech devices we need, and who will get them – who will be able to afford them,” she said.

“Medical innovation over the last 50 years is a global, billion dollar business, fraught with pitfalls: legal, governmental, ethical, financial, and, finally, personal,” Ms. Swartz said. “A great invention that could save millions of lives can end up on the junk heap because a hedge fund lost interest, while another great invention moves forward, but was stolen from the lab of another researcher. The persistence required to bring a medical device to market is daunting. One inventor told me, ‘If I’d known what was going to happen, I never would have even started.’”

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Clinician reviews of HM-centric research

By David Schmit, MD; Emily Wang, MD; Sadie Trammell Velasquez, MD; and Tony Ho, MD

Division of General and Hospital Medicine, University of Texas Health San Antonio

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By David Schmit, MD

1 Is it safe to discharge patients with anemia?

CLINICAL QUESTION: What is the prevalence of anemia at the time of and after discharge from the hospital, and what is the associated morbidity and mortality at 6 months?

BACKGROUND: Anemia is common in hospitalized patients and is associated with short- and long-term morbidity and mortality. Current evidence shows that reduced red blood cell (RBC) use and more restrictive transfusion practices do not increase short-term mortality; however,



Dr. Schmit

few data exist on the long-term outcomes of anemia.

STUDY DESIGN: Retrospective cohort study.

SETTING: Integrated health care system (Kaiser Permanente) with 21 hospitals located in Northern California.

SYNOPSIS: From 2010 to 2014, there were 801,261 hospitalizations among 445,371 patients who survived to discharge. The prevalence of moderate anemia (hemoglobin between 7 and 10 g/dL) at hospital discharge increased from 20% to 25% (P less than .001) while RBC transfusions decreased by 28% (P less than .001). Resolution of moderate anemia within 6 months of hospital discharge decreased from 42% to 34% (P less than .001). RBC transfusion and rehospitalization rates at 6 months decreased as well. During the study period, adjusted 6-month mortality decreased from 16.1% to 15.6% ($P = .04$) in patients with moderate anemia.

Given the retrospective design of this study, data must be interpreted with caution in determining a causal relationship. The authors also acknowledge that there may be unmeasured confounding variables not accounted for in the study results.

BOTTOM LINE: Despite higher rates of moderate anemia at discharge, there was not an associated rise in subsequent RBC transfusions, readmissions, or mortality in the 6 months after hospital discharge.

CITATION: Roubinian NH et al. Long-term outcomes among patients discharged from the hospital with moderate anemia: A retrospective cohort study. *Ann Intern Med*. 2019 Jan 14. doi: 10.7326/M17-3253.

2 Using ultrasound guidance for adult abdominal paracentesis

CLINICAL QUESTION: What are the best practices for ultrasound use while performing abdominal paracentesis in adults?

BACKGROUND: Abdominal paracentesis is a commonly performed procedure, and with appropriate training, hospitalists can deliver similar outcomes when compared to interventional radiologists.

STUDY DESIGN: Position statement.

SETTING: The Society of Hospital Medicine Point-of-Care Ultrasound (POCUS) Task Force developed these guidelines after reviewing available literature and voted on the appropriateness and consensus of a recommendation.

SYNOPSIS: A total of 794 articles were screened, and 91 articles were included and incorporated into the recommendations. The 12 recommendations fall into three categories (clinical outcomes, technique, and training), and all 12 recommenda-

tions achieved consensus as strong recommendations.

To improve clinical outcomes, the authors recommended ultrasound guidance in performing paracentesis to reduce the risk of serious complications, to avoid attempting paracentesis with insufficient fluid, and to improve overall procedure success.

The authors advocated for several technique recommendations, including using the ultrasound to assess volume and location of intraperitoneal fluid, to identify the needle insertion site and confirm in multiple planes, to use color flow Doppler to identify abdominal wall vessels, to mark the insertion site immediately prior to the procedure, and to consider real-time ultrasound guidance.

When health care professionals are learning ultrasound-guided paracentesis, the authors recommended use of dedicated training sessions with simulation if available and that competency should be demonstrated before independently attempting the procedure.

BOTTOM LINE: These recommendations from SHM POCUS Task Force provides consensus guidelines on the use of ultrasound guidance when performing or learning abdominal paracentesis.

CITATION: Cho J et al. Recommendations on the use of ultrasound guidance for adult abdominal paracentesis: A position statement of the Society of Hospital Medicine. 2019 Jan 2. doi: 10.12788/jhm.3095.

Dr. Schmit is an associate professor of medicine in the division of general and hospital medicine at UT Health San Antonio and a hospitalist at South Texas Veterans Health Care System, also in San Antonio.

By Emily Wang, MD

3 Effects of hospitalization on readmission rate

CLINICAL QUESTION: Does the trauma of hospitalization increase the risk of 30-day readmission or ED visit rate?

BACKGROUND: There is increasing concern that the patient experience in the hospital may be associated with post-hospital adverse outcomes, including new or recurrent

illnesses after discharge or unplanned return to the hospital or readmission.

STUDY DESIGN: Prospective cohort that included 207 patients.

SETTING: Two academic hospitals in Toronto.

SYNOPSIS: These patients had been admitted to the internal medicine ward for more than 48 hours and were interviewed at discharge using a standardized questionnaire to assess four domains of the trauma of hospitalization defined as the cumulative effects of



Dr. Wang

patient-reported sleep disturbance, mobility, nutrition, and mood. Among these patients, 64.3% experienced disturbance in more than one domain, and patients who

experienced disturbance in three to four domains had a 15.8% greater absolute risk of 30-day readmission or ED visit.

Because this is an observational study, causal inferences were not possible; however, hospitalists should keep in mind the possible association of the patient experience and the link to clinical outcomes.

BOTTOM LINE: Trauma of hospitalization is common and may be associated with an increased 30-day risk of readmission or ED visit.

CITATION: Rawal J et al. Association of the trauma of hospitalization with 30-day readmission or emergency department visit. *JAMA Intern Med*. 2019;179(1):38-45.

4 POCUS for hospitalists: The SHM position statement

CLINICAL QUESTION: What is point-of-care ultrasound, and how are hospitalists using POCUS?

BACKGROUND: POCUS is becoming more prevalent in the daily practice of hospitalists; however, there are currently no established standards or guidelines for the use of POCUS for hospitalists.

STUDY DESIGN: Position statement.

SETTING: SHM Executive Commit-

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Continued from page 16

tee and Multi-Institutional POCUS faculty meeting through the Society of Hospital Medicine 2018 Annual Conference reviewed and approved this statement.

SYNOPSIS: In contrast to the comprehensive ultrasound exam, POCUS is used by hospitalists to answer focused questions, by the same clinician who is generating the clinical question, to evaluate multiple body systems, or to serially investigate changes clinical status or evaluate responses to therapy.

This position statement provides guidance on the use of POCUS by hospitalists and the administrators who oversee it by outlining POCUS in terms of common diagnostic and procedural applications; training; assessments by the categories of basic knowledge, image acquisition, interpretation, clinical integration, and certification and maintenance of skills; and program management.

BOTTOM LINE: This position statement by the SHM provides guidance for hospitalists and administrators on the use and oversight of POCUS.

CITATION: Soni NJ et al. Point-of-care ultrasound for hospitalists: A position statement of the Society of

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Dr. Wang is an associate professor of medicine in the division of general and hospital medicine at UT Health San Antonio and a hospitalist at South Texas Veterans Health Care System.

By Sadie Trammell Velasquez, MD

5 Apixaban prevents clots with cancer

CLINICAL QUESTION: Does apixaban therapy decrease venous thromboembolism (VTE) in ambulatory patients with cancer at intermediate to high risk who are starting chemotherapy?

BACKGROUND: Active cancer places patients at increased risk for VTE. Ambulatory patients can be risk stratified using the validated Khorana score to assess risk for VTE, a complication resulting in significant morbidity, mortality, and health care costs.

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

SETTING: Ambulatory; Canada.

SYNOPSIS: A total of 1,809 patients were assessed for eligibility, 1,235 were excluded, and 574 with a Khorana score of 2 or higher were

randomized to apixaban 2.5 mg twice daily or placebo. Treatment or placebo was given within 24 hours after the initiation of chemotherapy and continued for 180 days. The primary efficacy outcome – first episode of major VTE within 180 days of randomization – occurred in 4.2% of the apixaban group and in 10.2% of the placebo group (hazard ratio, 0.41; 95% confidence interval, 0.26-0.65; P less than .001). Major bleeding in the modified intention-to-treat analysis



Dr. Trammell Velasquez

occurred in 3.5% in the apixaban group and 1.8% in the placebo group (HR, 2.00; 95% CI, 1.01-3.95; P = .046).

There was no significant difference in overall survival, with 87% of deaths were related to

cancer or cancer progression.

BOTTOM LINE: VTE is significantly lower with the use of apixaban, compared with placebo, in intermediate- to high-risk ambulatory patients with active cancer who are initiating chemotherapy.

CITATION: Carrier M et al. Apixaban to prevent venous thromboembolism in patients with cancer. *N Engl J Med.* 2018 Dec 4. doi: 10.1056/NEJMoa1814468.

6 Caution with IVC filters in elderly

CLINICAL QUESTION: Are inferior vena cava (IVC) filters in older adults safe for prevention of subsequent pulmonary embolism (PE)?

BACKGROUND: Acute pulmonary embolism is a common cause of morbidity and mortality in older adults, and IVC filters have historically and frequently been used to prevent subsequent PE. Almost one in six elderly Medicare fee-for-service (FFS) beneficiaries with PE currently receives an IVC filter.

STUDY DESIGN: Retrospective, matched cohort study.

SETTING: United States inpatients during 2011-2014.

SYNOPSIS: Of 214,579 Medicare FFS patients aged 65 years or older who were hospitalized for acute PE, 13.4% received an IVC filter. Mortality was higher in those receiving an IVC filter (11.6%), compared with those who did not receive an IVC filter (9.3%), with an adjusted odds ratio of 30-day mortality of 1.02 (95% CI, 0.98-1.06). One-year mortality rates were 20.5% in the IVC filter group and 13.4% in the group with no IVC filter, with an

Short Takes

AFM cases continue to rise

Cases of Acute Flaccid Myelitis (AFM) are on the rise, with 210 confirmed cases of AFM in 40 states in 2018, up from 35 confirmed cases in 2017. AFM is a rare but serious condition that usually affects children, causing polio-like symptoms – focal extremity weakness, hyporeflexia, and sometimes cranial nerve dysfunction. The Centers for Disease Control and Prevention encourage all health care providers to contact their local health departments with any suspected cases of AFM.

CITATION: Centers for Disease Control and Prevention. AFM Investigation. 2019 Jan. <https://www.cdc.gov/acute-flaccid-myelitis/afm-surveillance.html>.

adjusted OR of 1.35 (95% CI, 1.31-1.40).

In the 76,198 Medicare FFS patients hospitalized with acute PE in the matched cohort group, 18.2% received an IVC filter. The IVC-filter group had higher odds for 30-day mortality, compared with the no-IVC filter group (OR, 2.19; 95% CI, 2.06-2.33).

BOTTOM LINE: In patients aged 65 years or older, use caution when considering IVC filter placement for prevention of subsequent PE. Future studies across patient subgroups are needed to analyze the safety and value of IVC filters.

CITATION: Bickdeli B et al. Association of inferior vena cava filter use with mortality rates in older adults with acute pulmonary embolism. *JAMA Intern Med.* 2019;179(2):263-5.

Dr. Trammell Velasquez is an associate professor of medicine in the division of general and hospital medicine at UT Health San Antonio and a hospitalist at South Texas Veterans Health Care System.

By Tony Ho, MD

7 Oral anticoagulant and PPI cotherapy cuts upper GI bleed risk

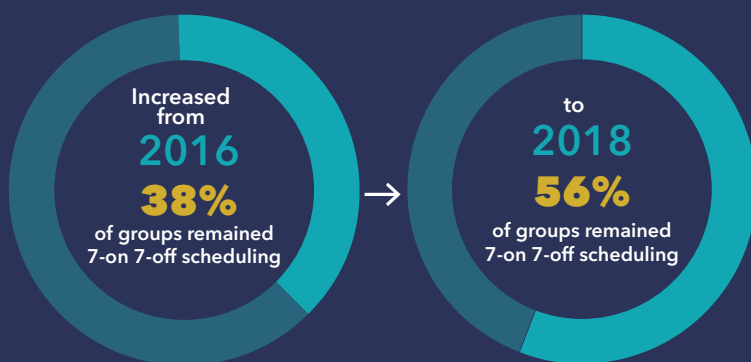
CLINICAL QUESTION: Does proton pump inhibitor (PPI) cotherapy affect the risk of upper GI bleed in patients on oral anticoagulation?

BACKGROUND: PPIs reduce gastric acid production, promote ulcer healing, and prevent ulcer recurrence; however, limited evidence is available describing the incidence of anticoagulant-related serious upper GI tract bleeding from the newer

Findings from the 2018 State of Hospital Medicine Report

Hospitalist scheduling is a key focus area of the 2018 State of Hospital Medicine Report.

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non-vitamin K anticoagulants and PPI cotherapy.

STUDY DESIGN: Retrospective cohort.

SETTING: Medicare enrollees.

SYNOPSIS: With use of computerized Medicare beneficiaries files, researchers identified 1,643,123 patients with 1,713,183 new episodes of oral anticoagulant treatment between Jan. 1, 2011, and Sept. 30, 2015. This analysis showed that cotherapy with PPIs was associated with a lower incidence of upper GI bleed, with the largest difference associated with dabigatran with an incidence rate ratio of 0.49 (95% CI, 0.52-0.85), followed by warfarin (IRR, 0.65; 95% CI, 0.62-0.69), apixaban (IRR, 0.66; 95% CI, 0.52-0.85), and rivaroxaban (IRR, 0.75; 95% CI, 0.68-0.84).

Generalizability was limited by population (Medicare enrollees) and the study excluded prior hospitalizations for GI bleed, as well as switches in anticoagulant therapy during the study period.

BOTTOM LINE: PPI cotherapy with oral anticoagulation reduces risk of hospitalization for upper GI bleed.

CITATION: Ray WA et al. Association of oral anticoagulants and proton pump inhibitor cotherapy with hospitalization for upper gastrointestinal tract bleeding. JAMA. 2018 Dec 4;320(21):2221-30.

8 Epidemiology and costs of sepsis in the United States

CLINICAL QUESTION: What is the economic burden of sepsis in the U.S. health care system?

BACKGROUND: Sepsis is responsible for an increasingly disproportionate fraction of health care burden. Delays in diagnosis of sepsis are associated with worse outcomes.

STUDY DESIGN: Retrospective observational study.

SETTING: Premier Healthcare database, including 20% of U.S. private/academic hospitals.

SYNOPSIS: With use of the Premier Healthcare database, researchers identified 2,566,689 cases of sepsis using ICD-9 and MS-DRG codes between Jan. 1, 2010, and Sept. 30, 2016. Increasing severity of sepsis was associated with increasing mortality and cost, but there was a large discrepancy in cost in patients with sepsis present at admission versus those without it at admission (\$18,023 vs. \$51,022) and was associated with increases in both mean hospital length of stay and mortality rate across all levels of sepsis severity.

BOTTOM LINE: Early identification

Short Takes

HHS recommends prescribing naloxone to patients at high risk for opioid overdose

The U.S. Department of Health & Human Services recommends clinicians strongly consider prescribing or coprescribing naloxone to patients at high risk of opioid overdose. This includes patients who are on relatively high doses of opioids, take other medications which enhance opioid complications, or have underlying health conditions. Clinicians are also advised to educate patients and those likely to respond to an overdose on when and how to use naloxone in its variety of forms.

CITATION: U.S. Department of Health & Human Services. HHS recommends prescribing or co-prescribing naloxone to patients at high risk for an opioid overdose. 2018 Dec 18. <https://www.hhs.gov/about/news/2018/12/19/hhs-recommends-prescribing-or-co-prescribing-naloxone-to-patients-at-high-risk-for-an-opioid-overdose.html>.

Fentanyl tops the list of opioid overdose drugs

The total number of drug overdose deaths per year in the United States increased 54%, from 41,340 deaths in 2011 to 63,632 deaths in 2016. Among opioids, mention of fentanyl increased during 2011-2016; that drug took the lead in 2016 with 29% of all drug overdose deaths. Among the drug overdose deaths involving fentanyl, 69% also involved one or more other drugs.

CITATION: Hedegaard H et al. Drugs most frequently involved in drug overdose deaths: United States, 2011-2016. Natl Vital Stat Rep. 2018 Dec;67(9):1-14.

of sepsis (at admission vs. later in the stay) may be important as a factor to reduce its overall burden on the health care system.

CITATION: Paoli CJ et al. Epidemiology and costs of sepsis in the United States – An analysis based on timing of diagnosis and severity level. Crit Care Med. 2018 Dec;46(12):1889-97.

Dr. Ho is an assistant professor of medicine in the division of general and hospital medicine at UT Health San Antonio and a hospitalist at South Texas Veterans Health Care System.



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Mentorship can boost equity in leadership

Academic medicine and the health care industry

By Nancy D. Spector, MD

Achieving equity in leadership in academic medicine and the health care industry doesn't have to be a pipe dream. There are clear, actionable steps that will lead us there.

The benefits of diversity are numerous and well documented. Diversity brings competitive advantage to organizations and strength to teams. With academic health centers (AHCs) facing continual stressors while at the same time being significant financial contributors to – and anchors in – their communities, ensuring their high performance is critical to society as a whole. To grow, thrive, and be ethical examples to their communities, health centers need the strongest and most innovative leaders who are reflective of the communities that they serve. This means more diversity in leadership positions.

When we look at the facts of the gender makeup of academic med-

icine and the health care industry, we can clearly see inequity – only 22% of medical school full professors, 18% of medical school department chairs, and 17% of medical school deans are women. Note that it has taken 50 years to get from 0 women deans to the 25 women deans who are now in this role. Only 28% of full and associate professors and 21% of department chairs are nonwhite. In the health care industry, only 13% of CEOs are women. The pace toward equity has been excruciatingly slow, and it's not only women and underrepresented minorities who lose, but also the AHCs and their communities.

So how do we reach equity? Mentorship is a key pathway to this goal. In a session at Hospital Medicine 2019 (HM19), "What Mentorship Has Meant To Me (And What It Can Do For You): High Impact Stories from Leaders in Hospital Medicine," fellow panelists and I outlined how mentorship can positively affect your career, defined the qualities of effective mentors and mentees,

described the difference between mentorship and sponsorship, and explained how to navigate common pitfalls in mentor-mentee relationships.

We spoke about the responsibility the mentee has in the relationship

To grow, thrive, and be ethical examples to their communities, health centers need the strongest and most innovative leaders who are reflective of the communities that they serve.

and the need to "manage up," a term borrowed from the corporate world, where the mentee takes responsibility for his or her part in the relationship and takes a leadership role in the relationship. The mentee must be an "active participant" in the relationship for the relationship to be successful. We hope that attendees at the session took some key points back to their institutions to open dialogue on strategies to

achieve equity through building mentoring relationships.

When I look back on my time in residency and fellowship, I recognize that I was surrounded by people who offered guidance and advice. But once I became a faculty member, that guidance was less apparent, and I struggled in the first few years. It wasn't until I attended a conference on peer mentoring that I recognized that I didn't just need a didactic mentor, but that I needed a portfolio of mentors and that I had to take the initiative to actively engage mentorship. So I did, and its effects on my career have been powerful and numerous.

The evidence is there that mentorship can play a major role in advancing careers. Now it is up to the leadership of academic and non-academic health centers to take the initiative and establish formalized programs in their institutions. We all benefit when we have diversity in leadership – so let's get there together.

Dr. Spector is executive director, Executive Leadership in Academic Medicine, associate dean of faculty development, Drexel University, Philadelphia.

In defense of hospital administrators

Improving relationships between leaders and clinicians

By Leslie Flores, MHA, SFHM

In the March 2019 issue of *The Hospitalist*, I wrote about some key findings from a 2018 survey of U.S. physicians by The Physicians Foundation. It's no surprise to anyone working in health care today that the survey found alarming levels of professional dissatisfaction, burnout, and pessimism about the future of medicine among respondent physicians. Sadly, it appears that much of that pessimism is directed toward hospitals and their leaders: 46% of survey respondents viewed the relationships between physicians and hospitals as somewhat or mostly negative and adversarial.

Several physicians posted comments online, and they deeply sad-

dened me. My heart hurt for those doctors who wrote, "I loved medicine. It was good for my soul, but medicine left me. Doctors gave up most of their power and large corporations without an ethical foundation and no god, but money took over." Or "They are waiting so all the senior physicians will retire. Nurses will become leaders who will follow administration's lead and control physicians. Money and cost cutting is the major driver. Physicians are not valuable anymore because they have different opinions which cost a lot. There is a lot of window dressing, but they actually don't care. They just want to run a business." I also read "I was tossed out like dirty laundry water at age 59." And "On a personal basis, I will try to reason

Continued on following page

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Speaking at a conference? Read these tips first

A powerful messenger is just as important as the power of the message

By Vineet Arora, MD, MAPP, MHM

Recently, I was asked to present my top public speaking tips for a group of women leaders. This is a topic near and dear to my heart, and one that I teach a number of groups, from medical students to faculty.

I also benefited from just returning from the Harvard Macy Educators Course, where Victoria Brazil, MD, an experienced emergency medicine physician from Australia, provided her top tips. Here is a mash-up of the top tips to think about for any of the speakers out there among us – with a few shout-outs for the ladies out there. Please add your own!



Dr. Arora

- **Do pause strategically:** The human brain needs rest to process what you are about to say. You can ask people to “think of a time” and take a pause. Or “I want you to all think about what I just said for one moment.” And TAKE a moment. But think about Emma’s pause during the March For Your Lives. Pauses are powerful and serve as a way to cement what you are saying for even the most critical crowd. Think about when anyone on their phone pauses, even if you’re on a boring conference call others will wake up and wonder what is going on and are now engaged in the talk.

- **Do strategically summarize:** Before you end, or in between important sections, say the following: “There are three main things you can do.” Even if someone fell asleep, they will wake up to take note. It’s a way to get folks’ attention back. There is nothing like challenging others to do something.

The Don’ts

- **Don’t start with an apology for “not being an expert”:** Or whatever you are thinking about apologizing for. The voice in your head does not need to be broadcast to others. Just say thank you after you are introduced, and launch in. Someone has asked you to talk, so bring your own unique expertise and don’t start with undermining yourself!
- **Don’t use your slides as a crutch:** Make your audience look at you and not your slides. That means at times, you may be talking and your slides will not be moving. Other times, if you

are starting with a story, maybe there is no slide behind you and the screen is blacked out. Some of the most powerful moments in a talk are when slides are not being used.

- **Don’t stand behind the lectern** if you can help it. This means ask for a wireless microphone. Most lecterns will overwhelm you. If you have to use a lectern, go back to the posture in the “dos.” One year, I had a leg injury and definitely used the lectern, so obviously

Don’t use your slides as a crutch. Some of the most powerful moments in a talk are when slides are not being used.

there may be times you need to use a lectern; even then, try as hard as possible to make sure you are seen.

- **Don’t engage grandstanders during Q&A:** Invariably, you will get someone who stands up and goes into a long comment that is not a question to hear themselves speak. Insert yourself, say “thank you” and take the next question. If there is not a next question, you can add, “Before I forget, I want to share another question I am often asked which may be of help to you.” Then, *answer your own question*. You get the final word this way!

Happy speaking! I look forward to seeing you in warmer weather during the spring conference season.

For more posts from the Hospital Leader blog, visit hospitalleader.org.

Continued from previous page

with management exactly once before I bail.” Sigh.

These commenters are well-meaning physicians who had bad experiences with hospital leaders they

Is it possible that hospital leaders and doctors are making assumptions about each other’s intentions that get in the way of having constructive dialogue?

saw as uncaring and unresponsive to their concerns as clinicians. Their experiences left them demoralized and embittered. I’m truly sorry for that.

I’m a recovering hospital administrator myself. My business partner John Nelson, MD, MHM, likes to

tell people that he has successfully deprogrammed me from the way most administrators think about doctors, but he’s mostly joking (at least I think he is). I can tell you that most of the hospital leaders I have met – both when I was still an administrator and now in my consulting work – are well-intentioned people who care deeply about patients and their fellow health care professionals and are trying hard to do the right thing. Many of them could have earned more and had better career opportunities doing similar work in a field other than health care, but they chose health care out of a sincere desire to do good and help people.

A big part of the problem is that doctors and administrators come to health care from very different starting points, and so have very different perspectives. They generally function in separate silos, each paying attention to their own comfortable little part of that mon-

ster we call a health care delivery system. Often, neither administrators nor doctors have made enough effort to cross over and understand the issues and perspectives of people in other silos. As a result, it’s easy for assumptions and biases to creep in and poison our interactions.

When we interpret the behavior of others, we humans tend to overemphasize dispositional factors, such as personality or motives, and to discount situational factors, such as external stressors. Psychologists call this the fundamental attribution error or correspondence bias, and the result is usually heightened conflict as a result of presumed negative intentions on the part of others (“All she cares about is making a profit”) and discounting circumstantial factors that might be influencing others’ behavior (“She is

facing reduced market share and a funding shortfall, and she’s fearful for the future of the institution”).

Add in another phenomenon known as the actor-observer bias, in which we tend to attribute others’ behavior to their dispositions but attribute our own behavior to the circumstances (“That administrator

lost his temper because he’s a demanding jerk, but I only lost my temper because he pushed me over the edge”).

Is it possible that hospital leaders and doctors are reading each other inaccurately and that they’re making assumptions about each other’s intentions that

get in the way of having constructive dialogue? How can we get to a place of greater trust? I don’t know the whole answer, of course, but I have a few ideas to offer.

Read the full post at hospitalleader.org.



Ms. Flores

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NYU Winthrop Hospital

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Attn: Vice Chairman, Dept of Medicine-Hospital Operations

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For more information please contact: Heather J. Peffley, PHR FASPR, Penn State Health Physician Recruiter
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Job description:

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- Serves as mentor, guide and support for Hospitalists system wide.
- Leads recruitment/retention of physicians and APPs to actively grow the Section.
- Position is 50% Administrative and 50% clinical.

Clinical

- Participates in quality and system improvement within group and across hospital.
- Participates in all group clinical decisions with the goal of high quality care.
- Participates in group performance reviews with regard to quality of care, satisfaction, and efficiency metrics.
- Coordinates schedule with group to maintain 24/7 coverage at all hospitals within the integrated health system.
- Ensures coverage of shifts.

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- Participates in strategic plan for hospital medicine group, including marketing, growth/recruiting, service, and quality.
- Establish annual goals for quality, efficiency growth and satisfaction.
- Responsible for developing, updating and maintaining clinical standards and care paths.
- Participates in utilization review and peer review activities as they relate to the Hospitalist program.

- Oversees the development of the annual budget and key operating indicators for the Department and monitors the Department's performance in relation to these annual targets.

- Works collaboratively with the Program Director for the Internal Medicine Residency Program, the Fellowship Directors and the Director of Medical Education to ensure that the quality of the residency and fellowship(s).

- M.D. or D.O.; BC in Internal Medicine. Advanced degree (MBA, MHA, MMM) desirable.

- Five or more years of successfully leading a Hospitalist program.

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Guthrie, founded in 1910, provides comprehensive team-based care to patients from an 11-county service area. Guthrie Clinic is comprised of four hospitals, 500 physicians and advanced practice providers in a regional office network made up of 45 sub-specialty and primary care sites in 21 communities. In addition, we offer a wide range of services and programs including home health and home care services, GME and a research institute. Guthrie was the first system to implement EPIC EMR, in 2002, with the go-live of Epic CPOE (Certified Physician Order Entry).

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For more information about this leadership opportunity, please contact **Krisi VanTassel** at krisi.vantassel@guthrie.org or (570) 887-5203, www.ichoseguthrie.org.



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Reference # SHM2017.



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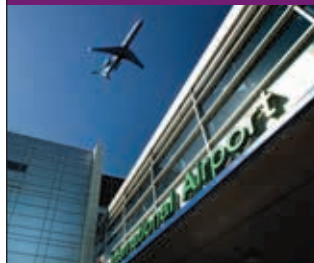
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Just a series of fortunate events?

Building a career in hospital medicine

By Greg Maynard, MD, MSc, MHM

Residents and junior faculty have frequently asked me how they can attain a position similar to mine, focused on quality and leadership in a health care system. When I was first asked to offer advice on this topic, my response was generally something like, “Heck if I know! I just had a series of lucky accidents to get here!”

Back then, I would recount my career history. I established myself as a clinician educator and associate program director soon after Chief Residency. After that, I would explain, a series of fortunate events and health care trends shaped my career. Evidence-based medicine (EBM), the patient safety movement, a shift to incorporate value (as well as volume) into reimbursement models, and the hospital medicine movement all emerged in interesting and often synergistic ways.

A young SHM organization (then known as NAIP) grew rapidly even while the hospitalist programs I led in Phoenix, then at University of California, San Diego, grew in size and influence. Inevitably, it seemed, I was increasingly involved in quality improvement (QI) efforts, and began to publish and speak about them. Collaborative work with SHM and a number of hospital systems broadened my visibility regionally and nationally. Finally, in 2015, I was recruited away from UC San Diego into a new position, as chief quality officer at UC Davis.

On hearing this history, those seeking my sage advice would look a little confused, and then say something like, “So your advice is that I should get lucky??? Gee, thanks a lot! Really helpful!” (Insert sarcasm here.)

The honor of being asked to contribute to the “Legacies” series in *The Hospitalist* gave me an opportunity to think about this a little differently. No one really wanted to know about how past changes in the health care environment led to my career success. They wanted advice on tools and strategies that will allow them to thrive in an environment of ongoing, disruptive change that is likely only going to accelerate. I now present my upgraded points of advice, intertwined with examples of how SHM positively influenced my career (and could assist yours):

Learn how your hospital works. Hospitalists obviously have an inside track on many aspects of hospital operations, but sometimes remain oblivious to the organizational and committee structure, priorities of hospital leadership, and the mechanism for implementing standardized care. Knowing where to go with new ideas, and the process of implementing protocols, will keep you from hitting political land mines and unintentionally encroaching on someone else’s turf, while aligning your efforts with institutional priorities improves the buy-in and resources available to do the work.

Start small, but think big. Don’t bite off more than you can chew, and make sure your ideas for change work on a small scale before trying to

sell the world on them. On the other hand, think big! The care you and others provide is dependent on systems that go far beyond your immediate control. Policies, protocols, standardized order sets, checklists, and an array of other tools can be leveraged to influence care across an entire health system, and in the SHM Mentored Implementation programs, can impact hundreds of hospitals.

Broaden your skills. Commit to learning new skills that can increase your impact and career diversity. Procedural skills; information technology; and EMR, EBM, research, public health, QI, business, leadership, public speaking, advocacy, and telehealth can all open up a whole world of possibilities when combined with a medical degree. These skills can move you into areas that keep you engaged and excited to go to work.

Engage in mentor/mentee relationships. As an associate program director and clinician-educator, I had a lot of opportunity to mentor residents and fellows. It is so rewarding to watch the mentee grow in experience and skills, and to eventually see many of them assume leadership and mentoring roles themselves. You don’t have to be in a teaching position to act as a mentor (my experience mentoring hospitalists and others in leadership and quality improvement now far surpasses my experience with house staff).

The mentor often benefits as much as the mentee from this relationship. I have been inspired by their passion and dedication, educated by their ideas and innovation, and frequently find I am learning more from them than they are from me. I have had great experiences in the SHM Mentored Implementation program in the role of mentee and mentor.

Participate in a community. When I first joined NAIP, I was amazed that the giants (Wachter, Nelson, Whitcomb, Holman, Williams, Greeno, Howell, Huddleston, Wellikson, and on and on) were not only approachable, they were warm, friendly, interesting, and extraordinarily welcoming. The ever-expanding and evolving community at SHM continues that tradition and offers a forum to share innovative work, discuss common problems and solutions, contact world experts, or just find an empathetic ear. Working on toolkits and collaborative efforts with this community remains a real highlight of my career, and the source of several lasting friendships. So don’t be shy; step right up; and introduce yourself!

Avoid my past mistakes (this might be a long list). Random things you should try to avoid.

- Embracing tribalism – It is natural to be protective of your hospitalist group, and to focus on the injustices heaped upon you from (insert favorite punching bag here, such as the ED, orthopedists, cardiologists, nursing staff, evil administration penny pinchers). While some



Dr. Maynard is chief quality officer, University of California Davis Medical Center, Sacramento.

of those injustices might be real, tribalism, defensiveness, and circling the wagons generally makes things only worse. Sit down face to face, learn a little bit about the opposing tribe (both about their work, and about them as people), and see how much more fun and productive work can be.

- Storming out of a meeting with the CMO and CEO, slamming the door, etc. – not productive. Administrative leaders are doing their own juggling act and are generally well intentioned and doing the best they can. Respect that, argue your case, but if things don’t pan out, shake their hand, and live to fight another day.
- Using e-mail (evil-mail) to resolve conflict – And if you’re a young whippersnapper, don’t use Twitter, Facebook, Snapchat, or other social media to address conflict either!
- Forgetting to put patients first – Frame decisions for your group around what best serves your patients, not your doctors. Long term, this gives your group credibility and will serve the hospitalists better as well. SHM does this on a large scale with their advocacy efforts, resulting in more credibility and influence on Capitol Hill.

Make time for friends, family, fitness, fun, and reflection.

A sense of humor and an occasional laugh when dealing with ill patients, hospital medicine politics, and the EMR all day provides resilience, as does taking the time to foster self-awareness and insight into your own weaknesses, strengths, and how you react to different stressors. A little bit of exercise and time with family and friends can go a long way toward improving your outlook, work, and life in general, while reducing burnout. Oh yeah, it’s also a good idea to choose a great life partner as well. Thanks, Michelle!



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