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Value of palliative care shines clearly in a crisis

Hospitalists have played a key role

By Larry Beresford

For some palliative care professionals, the COVID-19 pandemic, particularly in viral hot spots like New York City, represents a “moment” that could lead to greater awareness of what this service offers to seriously ill patients in a crisis.

They say it has provided an opportunity to show what palliative care teams can contribute to the difficult circumstances of patients with severe symptoms, isolated and alone in quarantined hospitals, with poor survival rates, perhaps sedated for extended stays on scarce ventilators – and for their family members, who are able to visit them only virtually via telephone or tablet.

But it has also highlighted gaps – including insufficient staffing for some palliative care teams. Hospitalists and other clinicians in the hospital need to learn the basics of primary palliative care, such as how to communicate bad news, initiate goals of care conversations, and address common symptoms of serious illness, such as pain. That way, they could shoulder more of the demand for this kind of care when palliative care specialists are in short supply.

Hospitalists, some of whom also have pursued a specialization in palliative care, have played key roles

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Dr. Rab Razzak,
hospitalist and
clinical director of
geriatrics and palliative
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Coming soon: The 2020 SoHM Report!

By Leslie Flores, MHA, SFHM

On behalf of SHM's Practice Analysis Committee, I am excited to announce the scheduled September 2020 release of the 2020 State of Hospital Medicine Report (SoHM)!

For reasons all too familiar, this year's SoHM survey process was unlike any in SHM's history. We were still collecting survey responses from a few stragglers in early March when the entire world shut down almost overnight to flatten the curve of a deadly pandemic. Hospital medicine group (HMG) leaders were



suddenly either up to their eyeballs trying to figure out how to safely care for huge influxes of COVID-19 patients that overwhelmed established systems of care or were trying to figure out how to staff in a low-volume environment with few COVID patients, a relative trickle of ED admissions, and virtually no surgical care. And everywhere, hospitals and their HMGs were quickly stressed in ways that would have been unimaginable just a couple of months earlier – financially, operationally, epidemiologically, and culturally.

SHM offices closed, with all staff working from home. And the talented people who would normally have been working diligently on the survey data were suddenly redirected to focus on COVID-related issues, including tracking government announcements that were changing daily and providing needed resources to SHM members. By the time they could raise their heads and begin thinking about survey data, we were months behind schedule.

I need to give a huge shout-out to our survey manager extraordinaire Josh Lapps, SHM's Director of Policy and Practice Management, and his survey support team including Luke Heisinger and Kim Schonberger. Once they were able to turn their focus back to the SoHM, they worked like demons to catch up. And in addition to the work of preparing the SoHM for publication,



Ms. Flores is a partner at Nelson Flores Hospital Medicine Consultants in La Quinta, Calif. She serves on SHM's Practice Analysis and Annual Conference Committees and helps to coordinate SHM's biannual State of Hospital Medicine survey.

they helped issue and analyze a follow-up survey to investigate how HMGs adjusted their staffing and operations in response to COVID! As I write this, we appear to be back on schedule for a September SoHM release date, with the COVID supplemental survey report to follow soon after. Thanks also to PAC committee members who, despite their own stresses, rose to the challenge of participating in calls and planning the supplemental survey.

Despite the pandemic, HMGs found survey participation valuable. When all was said and done, we had a respectable number of respondent groups: 502 this year vs. 569 in 2018. Although the number of respondent groups is down, the average group size has increased, so that an all-time high of 10,122 employed/contracted full-time equivalent (FTE) hospitalists (plus 484 locum tenens FTEs) are represented in the data set. The respondents continue to be very diverse, representing all practice models and every state – and even a couple of other countries. One notable change is a significant increase in pediatric HM group participation, thanks to a recruitment charge led by PAC member Sandra Gage, MD, PhD, SFHM, associate division chief of hospital medicine at Phoenix Children's Hospital, and supported

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Dear 2020, where do we go from here?

By Darlene Tad-y, MD, SFHM

The first few months of 2020 have shone a light on the challenges we face in this new decade as a health care industry and society. As the new decade dawned, we glimpsed at just the tip of the iceberg of social injustice and longstanding inequality in our society as the COVID-19 pandemic gripped our world. The evident health disparities revealed what we have always known: that our health care system is a microcosm of our society, and that this crisis laid bare the systematic bias present in our everyday lives.

The events of early 2020 have allowed hospitalists to take our rightful place among the few who can and will be the problem solvers of the most complex puzzles. Any discussion of the year 2020 would be incomplete without talking about COVID-19, the first modern pandemic. The rapid global spread, severity, and transmissibility of the novel coronavirus presented unique clinical and operational challenges.

Hospitalists in my communities stepped up to care not only for our most acutely ill, but also our critically ill COVID-19 patients. We were in lockstep with our emergency medicine and critical care medicine colleagues to ensure that patients – COVID-19 positive or negative – received the right care at the right time in the right place. We partnered with our disaster and emergency preparedness colleagues, some of us members or leaders within our hospital, system, regional, state, or national emergency operations centers.

As further evidence of health dis-

parities emerged in the outcomes of care of patients with COVID-19 and the homicide of George Floyd raised the alarm (again) that racism is alive and well in this country, hospitalists grieved, kneeled, and then stood with our colleagues, patients, and fellow humans to advocate for

“Hospitalists in my communities stepped up to care not only for our most acutely ill, but also our critically ill COVID-19 patients.”

change. At the front lines, we ensured that crisis standards of care action plans would not disadvantage any person for whom we may care during acute illness. Behind closed doors and in open forums, we spoke in defense of the most vulnerable and wrote about how each and every person can throw a wrench into the existing system of bias and discrimination to produce lasting, real change for the better.

I am proud to be a hospitalist, a member of this club, with game changers like Kimberly Manning, Samir Shah, Tracy Cardin, Jason Persoff, Charlie Wray, Chris Moriates, and Vineet Arora – to name just a few. Even more so, I am grateful to be a new member of the Society of Hospital Medicine's board of directors, where I find myself in the company of admired colleagues as we chart the course of SHM into the new decade. With such a jarring launch, we face a daunting task. In the short term, the board must guide SHM in weathering the eco-

nomie storm kicked off by COVID-19 and the new social distanced norms we all practice. In the long run, we have to stay the ambitious and steep course of excellence and accomplishment set by our founders.

If we as a community of hospitalists intend to lead our field – and health care in general – each one of us must individually commit to the following pursuits:

1. Maintain excellence in our clinical practice. First and foremost, our impact on patients happens at the bedside. Honing our clinical skills; staying up to date on the latest, breaking changes in best practices in caring for hospitalized patients; and establishing the kind of relationship with those patients that we would wish for ourselves must be a core function. With the staggering volume of knowledge and the rapidity with which new information is constantly added to that existing body, this may seem like an impossibly daunting task. Thankfully, SHM recognizes this vital need and provides resources to allow each one of us to succeed in this endeavor. The Journal of Hospital Medicine brings us the best and most relevant evidence for our practice, ensuring that studies are rigorously performed and reviewed and that the outcomes produced are the ones that we are after. We can maintain board certification with a focused practice in hospital medicine by utilizing the multimodal study tools available through Spark. And, when we are once again able to gather together as a community, the annual conference will provide the best education about hospital medicine available. In the meantime, feel free to explore HM20 Virtual, featuring select offer-



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ings from the original HM20 course schedule and the opportunity to earn CME.

2. Guide our future hospitalist colleagues to be 21st-century practitioners. Medical students and residents are entering our profession in a very dynamic time. The competencies they must have in order to succeed as hospitalists in 2020 and onward are different than they were when I went through training. COVID-19 has shown us that hospitalists must be “digital doctors” – they must be facile in utilizing virtual health tools, be capable of harnessing the power of health information technology in the electronic medical record to provide care, and also be able to incorporate and interpret the incredible amount of information in health care “big

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by the inclusion of several new pediatric HM-specific questions to better capture unique attributes of these hospital medicine practices.

We had more multisite respondents than ever, and the multisite respondents overwhelmingly used the new “retake” feature in the online version of the survey. I'm happy to report that we received consistent positive feedback about our new electronic survey platform, and thanks to its capabilities data analysis has been significantly automated, enhancing both efficiency and data reliability.

The survey content is more wide ranging than ever. In addition to the usual topics such as scope of services, staffing and scheduling, compensation models, evaluation and management code distribution, and HM group finances,

the 2020 report will include the afore-referenced information about HM groups serving children, expanded information on nurse practitioner (NP)/physician assistant (PA) roles, and data on diversity in HM physician leadership. The follow-up COVID survey will be published separately as a supplement, available only to purchasers of the SoHM report.

Multiple options are provided for SoHM report purchase. All survey participants will receive access to the online version of the survey. Others may purchase the hard copy report, online access, or both. The report has a colorful, easy-to-read layout, and many of the tables have been streamlined to make them easier to read. I encourage you to sign up to preorder your copy of the SoHM Report today at www.hospitalmedicine.org/sohm; you'll almost certainly discover a

treasure trove of worthwhile information.

Use the report to assess how your practice compares to other practices, but always keep in mind that surveys don't tell you what should be; they tell you only what currently is the case – or at least, what was during the survey period. New best practices not yet reflected in survey data are emerging all the time, and that is probably more true today in the new world affected by this pandemic than ever before. And while the ways others do things won't always be right for your group's unique situation and needs, it always helps to know how you compare with others. Whether you are partners or employees, you and your colleagues “own” the success of your hospital medicine practice and, armed with the best available data, are the best judges of what is right for you.

New SHM research on EMRs calls for 'more caring, less clicking'

White paper offers concrete recommendations

By Kayla Matthews

One of the most significant shifts in hospital practice over recent decades has been the widespread adoption of electronic medical records as a replacement for conventional paper records.

While EMRs show a lot of promise – having the potential to centralize and simplify clinician notes, make information more accessible and reduce paper waste – there is strong evidence that they are not working as well as they could.

Some research suggests that these systems may decrease the working efficiency of clinicians. Now, major health care institutions are looking to understand why these systems are not working – as well as how they may be improved.

A recent white paper from the Society of Hospital Medicine's Healthcare Information Technology Special Interest Group – titled "More Caring, Less Clicking" – reviews the current shortcomings of EMRs from a hospitalist perspective and provides recommendations for how these systems can be made more workable and efficient.

Viewing the current state of EMRs

"Numerous previous papers – including SHM's 2017 white paper 'Hospitalist Perspectives on Electronic Medical Records' – have linked EMRs to decreased provider satisfaction and increased burnout related to multiple issues, including an increase in 'screen time' as opposed to patient 'face-to-face' time, and limitations in usability and interoperability," said Rupesh Prasad, MD, SFHM, medical director of care management and a hospitalist at Advocate Aurora Health in Milwaukee. "Studies have shown that most of a provider's time spent is in areas like clinical documentation, entry of orders, and accessing patient information."

The 2017 SHM white paper referenced by Dr. Prasad reported that 74% of hospitalists surveyed were dissatisfied with their EMR. One-quarter of surveyed physicians went so far as saying they would prefer switching to paper record keeping.

Other research has also found a possible link between EMRs and physician burnout and dissatisfaction. It is also not uncommon for hospitalists

to spend up to 25% of their time at work using their EMR – time that should, ideally, be spent with patients.

The 2017 paper also showed that clinician notes in the United States are four times longer, on average, than notes in other countries. There are a few reasons for this – including technology design and billing requirements encouraging longer notes.

Whatever the cause, however, longer notes linked to physician burnout may be partially responsible for the large amounts of time physicians spend looking at EMRs.



Dr. Prasad

While EMRs may hold significant potential for hospitalists, as they are designed currently, they are simply not delivering the value many expected. The new white paper from the Healthcare Information Technology Special Interest Group outlines practical changes that could be made to EMRs to improve their use in hospitals.

The new paper breaks down current issues with EMRs into five broad categories – documentation, clinical decision support, order entry, communication, and data review – to discuss how EMRs are currently failing in these areas as well as how they might be improved.

Improving EMR documentation

One of the most significant hurdles clinicians currently face lies in how EMRs currently store and display documentation. Combined with physician note-taking habits, this makes these systems much less usable than they could be. Longer notes, when displayed in current EMR user interfaces, mostly lead to clutter, making them harder to navigate and difficult to scan quickly for important information.

The authors identify a few different ways that future EMRs may be able to help with this problem.

EMR documentation tools will likely need to be redesigned to optimize documentation entry, standardize note formatting, and improve readability. Many electronic notes contain vestigial formatting and data left over from the design of paper notes. As a result, many of these electronic

notes include information that is stored elsewhere and does not need to be explicitly included in every note. Cutting down on repetitive information storage will make important data more visible and help make notes easier to scan.

The paper also recommends a few other features that would make documentation more readable – like allowing clinicians to write documentation in SOAP format (subjective, objective, assessment, and plan), to facilitate critical thinking during the note-taking process, and having the EMR display that documentation in APSO format (assessment, plan, subjective, objective).

Doctors have long called for APSO or another note-taking format to replace SOAP in EMRs. Designing EMRs to rearrange SOAP notes to APSO could be a compromise that improves note readability while not requiring that clinicians learn new note-taking strategies.

The paper's authors also recommended more extensive clinician training on writing notes. While clinicians are often taught how to write certain notes – like progress notes, histories, and physical and discharge summaries – more specific guidance is not always provided. Better training provided by institutions could help improve the quality and readability of clinician notes.

These changes, however, may not be as beneficial as possible without better institutional support for clinicians. Implementing some of the biggest changes recommended by the SHM will require some level of standardization across platforms and institution commitment to training clinicians on best use practices for EMRs. Improved responsiveness to clinician needs will require a coordinated effort with backing from both administrative and governance groups.

Expanding EMR usability

"The SHM white paper presents evidence-based recommendations that can be implemented at the ground level in collaboration with other stakeholders, including [information technology], informatics, and administration, to help improve on the current state," Dr. Prasad said.

"We believe that hospitalists as key stakeholders

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data." It is our responsibility today to prepare and coach our trainees so that they may be successful tomorrow.

3. Change the system to ensure that each patient gets the safest, most equitable care we can provide. Each one of us can be at the top of our game, but if we practice in a health care system that has gaps, we may still fail in providing the safest, highest-quality care possible.

It is each of our responsibility to use every patient interaction to discover the systemic forces, including the social and cultural biases, that can lead to patient harm. In that, it is our duty to protect the most vulnerable, to redesign systems such that every person can be healthy. Only through this work of improvement do we have hope to eliminate the health disparities that exist.

4. Advocate for our patients. We each have seen the incredible

impact that the Affordable Care Act has had on health care delivery in the day-to-day interactions we have with our patients. Yet it is not enough. We still have room to improve the American health care system to allow better access to care, more timely provision of care, and better outcomes for our communities. Sometimes, this takes a change in policy. For each of us, it starts with being aware of how our state policy can impact how care is deliv-

ered to our patients. In addition to your own personal advocacy work, you can join forces with SHM's Advocacy & Public Policy team to use our society to amplify your voice.

The year 2020 began with eye-opening crises that exposed the depth and breadth of the work we have before us in hospital medicine. We have an important role to play in the next decade – surely to be the most interesting time to be a hospitalist.

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in health care, have both the responsibility and are uniquely positioned to directly impact EMR functionality,” he noted. “For example, hospitalists can participate in designing appropriate, actionable alerts that would help with patient safety while also improving provider efficiency. Simple steps like limiting hard stops in order entry to would help speed up the process, and free up time for direct patient care. Availability of tools like secure text messaging would help with effective patient care team communication to improve safety and care delivery.”

EMRs often lack features like voice control and speech-to-text transcription, along with other basic accessibility features like compatibility with screen readers. Implementing these features could improve the efficiency of clinicians’ note-taking while also providing wider software usability.

EMRs are not typically designed to work with mobile devices, meaning clinicians cannot enter notes or order medications until they’ve returned to their desk or workstation.

This lack of functionality creates issues in several ways. When clinicians are unable to enter notes on the

move, they will need to either keep mental notes or quickly jot down paper notes. This can effectively double the amount of note-taking that clinicians must do or introduce greater room for error. In cases where progress notes are taken throughout the day, this also means the EMR’s documentation timeline may not be accurate or usable.

Requiring clinicians to return to workstations before entering order information can also increase the risk of medication errors, which remains high despite hopes that EMRs could reduce error rates.

Adding support for cross-device and mobile EMR use could help improve the efficiency of note-taking and cut down on error. Implementing mobile access could have a few different benefits for clinicians – like improving note-taking efficiency in hospitals, where doctors often see patients far away from their workstations. EMRs also often lack support for hardware like mobile stations and widescreen monitors.

The SHM paper also recommends a few other tweaks to usability – like reducing the amount of password entry and reentry – that could make these systems easier to use and more efficient.

New features – like the use of natural language processing technology to analyze and organize information contained in clinicians’ notes – could provide further benefits and take full advantage of the advanced technologies that EMRs can integrate.

Dr. Prasad noted, however, that some of these upgrades – especially EMR compatibility with mobile devices – will require institutional support. Bring-your-own-device policies or system-provided mobile devices will be necessary if institutions want clinicians to be able to take advantage of mobile EMR access.

These policies will also likely require some kind of mobile device management solution to manage the security of sensitive patient data as it is accessed from personal devices. This may increase the level of necessary institutional buy-in for this support to work.

Designing EMRs with clinician needs in mind

Dr. Prasad said he and his coauthors recommend that EMR developers base more of their design on the needs of clinicians.

Currently, EMR interfaces can make important data unavailable, depending on what a clinician is trying to do. As a result, clinicians often need to rely on mental recall of important information as they navigate EMR systems.

These interfaces also typically do not support any level of user customization or process-specific interfaces, meaning every clinician is working with the same interface regardless of the tasks they need to perform or the information they need access to. Allowing for customization or implementing new process- or disease-specific interfaces could help avoid some of the problems caused by one-size-fits-all interfaces, which are not necessarily compatible with every clinician work flow.

EMR interfaces should also be designed, wherever possible, with familiar or standardized formats and the use of color coding and other techniques that can make interfaces easier to navigate quickly. Right now, many EMR systems utilize inconsistent layout design that can be cluttered, slowing down interface navigation and sometimes requiring backtracking from clinicians.

The white paper also recommends that EMR designers improve alert systems so that they are more actionable and interrupt clinicians less often – and that, when they do, they ensure that clinicians can respond to them. Designers should also reduce

hard-stops or in-line alerts that halt clinicians’ work flows and require immediate responses where possible.

Increased EMR support for clinical decision support systems is one of the biggest trends expected in the coming decade. Many clinicians are disappointed with the lack of flexibility and optimization of the current alerts that clinical decision support provides. Updating and improving these knowledge-based systems will likely become essential for delivering better alerts and improving decision-making and efficiency.

Overall, EMR design should be informed by the needs of the people these products are designed to support, Dr. Prasad said. The people that work with EMRs – especially frontline staff – should be involved early on in the EMR design process. Their needs are not reflected in current EMR design. IT companies, by working with hospital staff, could help improve ease of use and, ideally, prevent the errors associated with the implementation of these systems.

“System designers should be able to avoid some common problems of EMRs – and predict potential problems – by soliciting and integrating clinician feedback during the design process and over the lifespan of a product,” Dr. Prasad said.

Improving EMRs

EMRs have been adopted widely by health care institutions. However, despite hopes that EMRs could significantly improve record keeping and note-taking, these systems continue to pose serious challenges for clinicians. Evidence from recent research suggests that EMRs are inefficient and may contribute to clinician burnout.

“The growth of health IT has led to availability of large amounts of data and opportunities for applications in AI [artificial intelligence] and machine learning,” Dr. Prasad said. “While this has opened many avenues to help positively impact patient care and outcomes, it also poses multiple challenges like validation, customization, and governance. Hospitalists can partner with other health professions and IT leaders to work toward improving the health of the population while also providing a positive experience to the end user.”

Ultimately, new technological developments may help developers improve EMRs. As technology like natural language processing becomes more advanced and commonly used, it may help make EMRs more efficient and user friendly.

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Creating a student-staffed family call line to alleviate clinical burden

By Anjali Jaiman; John Hessburg; and Aron Egelko, MD

The coronavirus pandemic has fundamentally altered American health care. At our academic medical center in Brooklyn, a large safety net institution, clinical year medical students are normally integral members of the team consistent with the model of “value-added medical education.”¹ With the suspension of clinical rotations on March 13, 2020, a key part of the workforce was suddenly withdrawn while demand skyrocketed.

In response, students self-organized into numerous remote support projects, including the project described below.

Under infection control regulations, a “no-visitor” policy was instituted. Concurrently, the dramatic increase in patient volume left clinicians unable to regularly update patients’ families. To address this gap, a family contact line was created.

A dedicated phone number was distributed to key hospital personnel to share with families seeking information. After verifying patient information and the caller’s relation, students provide updates based on chart review. Calls are prefaced with the disclaimer that students are not part of the treatment team and can give only information

that is accessible via the electronic medical record.

Students created a phone script in conjunction with faculty, as well as a referral system for those seeking specific information from other departments. This script undergoes daily revision after the student huddle to address new issues. Flow of information is bidirectional: Students relay patient updates as well as quarantine precautions and obtain past medical history. This proved essential during the surge of patients, unknown to the hospital and frequently altered, arriving by ambulance. Students document these conversations in the EMR, including family concerns and whether immediate provider follow-up is needed.

Two key limitations were quickly addressed: First, patients requiring ICU-level care have fluctuating courses, and an update based solely on chart review is insufficient. In response, students worked with intensivist teams to create a dedicated call line staffed by providers.

Second, conversations regarding goals of care and end-of-life concerns were beyond students’ scope. Together with palliative care teams, students developed criteria for flagging families for follow-up by a consulting palliative care attending.

Through working the call line, students received a crash course in empathetically communicating over the phone. Particularly during the



Ms. Jaiman



Mr. Hessburg



Dr. Egelko

Ms. Jaiman is an MD candidate at State University of New York, Brooklyn, and a PhD candidate at the National Center of Biological Sciences in Bangalore, India. Mr. Hessburg is an MD/PhD candidate at State University of New York, Brooklyn. Dr. Egelko is a recent graduate of State University of New York, Brooklyn.

worst of the surge, families were afraid and often frustrated at the lack of communication up to that point. Navigating these emotions, learning how to update family members while removed from the teams, and educating callers on quarantine precautions and other concerns was a valuable learning experience.

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PHM designation remains a hot topic

Debating the boards, fellowships, and alternatives

By Larry Beresford

A late June teleconference brought together an ad hoc panel of pediatric hospitalists, with more than 100 diverse voices discussing whether there ought to be an additional professional recognition or designation for the subspecialty, apart from the new pediatric hospital medicine (PHM) board certification that was launched in 2019.

The heterogeneity of PHM was on display during the discussion, as participants included university-based pediatric hospitalists and those from community hospitals, physicians trained in combined medicine and pediatrics or in family medicine, doctors who completed a general pediatric residency before going straight into PHM, niche practitioners such as newborn hospitalists, trainees, and a small but growing number of graduates of PHM fellowship programs. There are 61 PHM fellowships (www.phm-fellows.org/phm-programs/), and these programs graduate approximately 70 new fellows per year.

Although a route to some kind of professional designation for PHM – separate from board certification – was the centerpiece of the conference call, there is no proposal actively under consideration for developing such a designation, said Weijen W. Chang, MD, FAAP, SFHM, chief of pediatric hospital medicine at Baystate Medical Center in Springfield, Mass., and associate professor of pediatrics at the University of Massachusetts–Baystate Campus.

Who might develop such a proposal? “The hope is that the three major professional societies involved in pediatric hospital medicine – the Society of Hospital Medicine, the American Academy of Pediatrics, and the Academic Pediatric Association – would jointly develop such a designation,” Dr. Chang said. However, it is not clear whether the three societies could agree on this. An online survey of 551 pediatric hospitalists, shared during the conference call, found that the majority would like to see some kind of alternative designation.

What is the reality of the boards?

The pediatric subspecialty of PHM was recognized by the American Board of Medical Specialties in 2015 following a petition by a group of PHM leaders seeking a way to credential their unique skill set. The first PHM board certification exam was offered by the American Board of Pediatrics on

Nov. 12, 2019, with 1,491 hospitalists sitting for the exam and 84% passing. An estimated 4,000 pediatric hospitalists currently work in the field.

Certification as a subspecialty typically requires completing a fellowship, but new subspecialties often offer a “practice pathway” allowing those who already have experience working in the field to sit for the exam. A PHM practice pathway, and a combined fellowship and experience option for those whose fellowship training was less than 2 years, was offered for last year’s exam and will be offered again in 2021 and 2023. After that, board certification will be available only to graduates of recognized fellowships.

But concerns began to emerge last summer in advance of ABM’s initial PHM board exam, when some applicants were told that

they weren’t eligible to sit for it, said H. Barrett Fromme, MD, associate dean for faculty development in medical education and section chief for pediatric hospital medicine at the University of Chicago. She also chairs the section of hospital medicine for the AAP.

Concerns including unintended gender bias against women, such as those hospitalists whose training is interrupted for maternity leave, were raised in a petition to ABP. The board promptly responded that gender bias was not supported by the facts, although its response did not account for selection bias in the data. But the ABP removed its practice interruption criteria.^{1,2}

There are various reasons why a pediatric hospitalist might not be able or willing to pursue a 2-year fellowship or otherwise qualify for certification, Dr. Fromme said, including time and cost. For some, the practice pathway’s requirements, including a minimum number of hours worked in pediatrics in the previous 4 years, may be impossible to meet. Pediatric hospitalists boarded in family medicine are not eligible.

For hospitalists who can’t achieve board certification, what might that mean in terms of their future salary, employment opportunities, reimbursement, other career goals? Might they find themselves unable to qualify for PHM jobs at some university-based medical centers? The answers are not yet known.

What might self-designation look like?

PHM is distinct from adult hospital medicine by virtue of its designation as a board-certified

subspecialty. But it can look to the broader HM field for examples of designations that bestow a kind of professional recognition, Dr. Chang said. These include SHM’s merit-based Fellow in Hospital Medicine (www.hospitalmedicine.org/membership/fellows-designations/) program and the American Board of Medical Specialties’ Focused Practice in Hospital Medicine (www.abim.org/maintenance-of-certification/moc-requirements/focused-practice-hospital-medicine.aspx), a pathway for board recertification in internal medicine and family medicine, he said.

But PHM self-designation is not necessarily a pathway to hospital privileges. “If we build it, will they come? If they come, will it mean anything to them? That’s the million-dollar question?” Dr. Chang said.

Hospitalists need to appreciate that this issue is important to all three PHM professional societies, SHM, AAP, and APA, Dr. Fromme said. “We are concerned about how to support all of our members – certified, noncertified, nonphysician. Alternative designation is one idea, but we need time to understand it. We need a lot more conversations and a lot of people thinking about it.”

Dr. Fromme is part of the Council on Pediatric Hospital Medicine, a small circle of leaders of PHM interest groups within the three professional associations. It meets quarterly and will be reviewing the results of the conference call.

“I personally think we don’t understand the scope of the problem or the needs of pediatric hospitalists who are not able to sit for boards or pursue a fellowship,” she said. “We have empathy and concern for our colleagues who can’t take the boards. We don’t want them to feel excluded, and that includes advanced practice nurses and residents. But does an alternative designation actually provide what people think it provides?”

There are other ways to demonstrate that professionals are serious about developing their practice. If they are looking to better themselves at quality improvement, leadership, education, and other elements of PHM practice, the associations can endeavor to provide more educational opportunities, Dr. Fromme said. “But if it’s about how they look as a candidate for hire, relative to board-certified candidates, that’s a different beast, and we need to think about what can help them the most.”

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Continued from previous page

As students, we have been exposed to many of the realities of communicating as a physician. Relaying updates and prognosis to family while providing emotional support is not something we are taught in medical school, but we will

be expected to handle our first night on the wards as interns. This experience has illuminated missing parts of the medical school curriculum we are working on emphasizing.

Over the first 2 weeks, students put in 848 volunteer-hours, making 1,438 calls which reached 1,114 differ-

ent families. We hope our experience proves instructive for other academic medical centers facing similar concerns in coming months. This model allows medical students to be directly involved in patient care during this crisis and shifts these time-intensive conversations away from over-

whelmed primary medical teams.

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How to truly connect with your patients

Introducing the ‘6H model’

By Swati Mehta, MD

I vividly remember the conversation that changed the way I practice medicine today. During my medicine residency rounds, my attending at a VA hospital stated: “There are three simple steps to gain your patients’ trust. The three questions they have are: Who are you? Are you any good? Do you really care about me?” The first two questions are easier to address. The third requires us to bare our authentic self behind our white coat and medical degree.

Who are you?

- Introduce yourself (everyone is wearing scrubs/white coats – state your full name and title)
- Describe your role in patient’s care plan
- Hand them your card (your name, photo, and a short description of the role of a hospitalist)

Are you any good?

- Briefly address your professional experience
- Explicitly state all the hard work you have done prior to entering the patient’s room (reviewing past medical records, hand off from ED provider or prior hospitalist)
- State your aim to collaborate with all people involved – their primary care provider, nurse, consultant

“Hello Mrs. Jones, my name is Dr. Swati Mehta. I will be your physician today. As a hospitalist, my role is to take care of your medical needs and worries. I will coordinate with your consultants, primary care physician, and other care teams to get you the answers you need. I have been working at XYZ Hospital for 6 years and have over 12 years of experience in medicine taking care of patients. I have reviewed your medical records, blood work, and x-rays before coming in. How are you feeling today? Do you mind if I ask you a few questions?” Addressing the third question is the foundation of every human interaction. Answering it involves addressing our patients’ fears: Do you care about what I think is going on with my disease? Will you judge me by my socioeconomic status, gender, color of my skin, or addictions? Am I safe to open up and trust you? Are we equal partners in my health care journey? Do you really care? A successful connection is achieved when we create a space of psychological safety and mutual respect. Once that happens, our patients open up to let us in their world and become more amenable to our opinion and recommendations.

The 6H model: Human connection with patients

Looking back at each patient interaction, good or bad, I have had in my

almost 2 decades of practicing clinical medicine, the 6H model has brought me closer to my patients. We have formed a bond which has helped them navigate their arduous hospital journey. Utilizing this model, we were fortunate to receive the highest Hospital Consumer Assessment of Healthcare Providers and Systems Survey scores for 3 consecutive years while I served as the medical director of a 40-provider hospitalist program in Oregon. In 2020, we are in the process of embedding the 6H model in several hospitalist programs across California. We are optimistic this intuitive approach will strengthen patient-provider relationships and ultimately improve HCAHPS scores. To form an authentic connection with our patients doesn’t necessary require a lot of our time. Hardwiring the 6H approach when addressing our patients’ three questions is the key. The answers can change slightly, but the core message remains the same. While we might not have much influence on all the factors that



Dr. Mehta is director of quality & performance and patient experience at Vituity in Emeryville, Calif., and vice chair of the SHM patient experience special interest group.

make or break our patients’ experience, the patient is where we can truly make a difference. Consider using this 6H model in your next clinical shift. Human connection in health care is the need of the hour. Let’s bring “care” back to health care.

The 6H model: Human connection with patients

Our patients want	Helpful phrases
HEAR my full story	<ul style="list-style-type: none">• What have I missed?• Anything else? Tell me more.• Is there anything weighing on your mind today?
HEED my worries	<ul style="list-style-type: none">• What worries you the most today?• What matters most to you in your visit today?
HELP me navigate	<ul style="list-style-type: none">• Here are the three things we will do today.• Is it okay if I share your plan of care with your (caregiver)?• Here is the number to call for questions about medications/appointments.
Be HONEST with me	<ul style="list-style-type: none">• I don’t know the answer to your question, but I will find the person who can best help you with that.• I can’t promise the pain will go away completely. I do want you to be comfortable. Here is what we can do now.
HEAL my misunderstanding	<ul style="list-style-type: none">• I am truly sorry you had to wait so long. You have my undivided attention.• I am sorry you had a poor experience. That was not our intention. Here is what I’ll do....
Leave me with HOPE	<ul style="list-style-type: none">• Together we will get through this.• You have one of our best (nurses/surgeons/docs) today. You are in great hands!• You’re doing so much better! Soon you’ll be able to go home.• We are going to take excellent care of you.

Source: Dr. Mehta



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Hospitalists confront administrative, financial challenges of COVID-19 crisis

By Larry Beresford

Hospitalists nationwide have put in longer hours, played new clinical roles, and stretched beyond their medical specialty and comfort level to meet their hospital's COVID-19 care demands. Can they expect some kind of financial recognition – perhaps in the form of “hazard pay” for going above and beyond – even though their institutions are experiencing negative financial fallout from the crisis?

Hospitals in regions experiencing a COVID-19 surge have limited elective procedures, discouraged non-COVID-19 admissions, and essentially entered crisis management mode. Other facilities in less hard-hit communities are also standing by, with reduced hospital census, smaller caseloads, and less work to do, while trying to prepare their bottom lines for lower demand.

“This crisis has put most hospitals in financial jeopardy and that is likely to trickle down to all employees – including hospitalists,” said Ron Greeno, MD, FCCP, MHM, a past president of SHM and the society's current senior adviser for government affairs. “But it's not like hospitals could or would forgo an effective hospitalist program today. Hospitalists will be important players in defining the hospital's future direction post crisis.”

That doesn't mean tighter financials, caps on annual salary increases, or higher productivity expectations won't be part of future conversations between hospital administrators and their hospitalists, Dr. Greeno said. Administrators are starting to look ahead to the post-COVID-19 era even as numbers of cases and rates of growth continue to rise in various regions, and Dr. Greeno sees a lot of uncertainty ahead.

Even prior to the crisis, he noted, hospital margins had been falling, while the cost of labor, including hospitalist labor, was going up. That was pointing toward an inevitable collision, which has only intensified with the new financial crisis facing hospitals – created by SARS-CoV-2 and by policies such as shutting down elective surgeries in anticipation of a COVID-19 patient surge that, for some institutions, may never come.

Brian Harte, MD, MHM, president of Cleveland Clinic Akron General and a past president of SHM, said that the Cleveland Clinic system has been planning since January its response to the coming crisis. “Governor Mike DeWine and the state Department of Health led the way in flattening the curve in Ohio. We engaged our hospitalists in brainstorming solutions. They have been excellent partners,” he said.

Approaching the crisis with a sense of urgency from the outset, the Cleveland Clinic built a COVID-19 surge team and incident command structure, with nursing, infectious diseases, critical care and hospital medicine represented. “We used that time to get ready for what was coming. We worked on streamlining consultant work flows.”

But utilization numbers are off in almost every service line, Dr. Harte said. “It has forced us to look at things we've always talked about, including greater use of telemedicine and exploring other ways of caring for patients, such as increased use of evening hours.”

Cleveland Clinic contracts with Sound Physicians of Tacoma, Wash., for its hospitalist coverage. “We have an excellent working relationship with Sound at the local, regional, and national levels, with common goals for quality and utiliza-

tion. We tried to involve our hospitalists as early as possible in planning. We needed them to step in and role model and lead the way,” Dr. Harte said, for everybody's anxiety levels.

“We're still in the process of understanding the long-term financial impact of the epidemic,” Dr. Harte added. “But at this point I see no reason to think our relationship with our hospitalists needs to change. We're the stewards of long-term finances. We'll need to keep a close eye on this. But we're committed to working through this together.”

Hazard pay for frontline health care workers was included in the COVID-19 relief package assembled in mid-May by Democrats in the House of Representatives. The \$3 trillion HEROES Act includes \$200 billion to award hazard pay to essential workers, including those in the health field, but Senate Majority Leader Mitch McConnell (R-Ky.) declared the legislation “dead on arrival” in the Senate.

Supplementary hazard payments made by hospitals to their hospitalists as a reward for sacrifices they made in the crisis is an interesting question, Dr. Greeno noted, and it's definitely on the table at some hospitals. “But I think it is going to be a tough ask in these times.”

Dr. Harte said he has not offered nor been asked about hazard pay for hospitalists. Cleveland Clinic Akron General made a strategic decision that hazard pay was not going to be part of its response to the pandemic. Other hospital administrators interviewed for this article concur.



Dr. Greeno



Dr. Harte

Hospitals respond to the fiscal crisis

Hospitals in other parts of the country also report significant fiscal fallout from the COVID-19 crisis, with predictions that 100 or more hospitals may be forced to close. Jeff Dye, president of the New Mexico Hospital Association, told the Albuquerque Journal on May 1 that hospitals in his state have been squeezed on all sides by increased costs, patients delaying routine care, and public health orders restricting elective surgeries. New Mexico hospitals, especially in rural areas, face incredible financial strain.

The University of Virginia Medical Center, Charlottesville, recently announced 20% reductions in total compensation for its providers through July 31, along with suspension of retirement contributions. Those changes won't affect team members caring for COVID-19 patients. And the Spectrum Health Medical Group of 15 hospitals in western Michigan, according to Michigan Public Radio, told its doctors they either needed to sign “contract addendums” giving the system more control over their hours – or face a 25% pay cut, or worse.

Cheyenne (Wyo.) Regional Medical Center issued a statement April 24 that it expected losses of \$10 million for the month of April. “CRMC, like every other hospital in Wyoming, is certainly feeling the financial impact that COVID-19 is having,” CEO Tim Thornell told the Cowboy State Daily on April 24. That includes a 30% reduction in inpatient care and 50% reduction in outpatient care, while the hospital has only had a handful of COVID-19 patients at any time. Capital projects are now on hold, overtime is limited, and a hiring freeze is in effect.

“We're certainly prepared for a larger surge, which hasn't come yet,” Mr. Thornell said in an interview. CRMC's ICU was split to create a nine-bed dedicated COVID-19 unit. Intensivists see most of the critical care patients, while the hospital's 15 directly employed hospitalists are treating all of the non-ICU COVID-19 patients. “Among themselves, the

hospitalists volunteered who would work on the unit. We've been fortunate enough to have enough volunteers and enough PPE [personal protective equipment]," he said.

Preparing for the COVID-19 pandemic has strengthened the medical center's relationship with its hospitalists, Mr. Thornell explained. "Hospitalists are key to our operations, involved in so much that happens here. We're trying to staff to volume with decreased utilization. We've scaled back, which only makes fiscal sense. Now, how do we reinfuse patients back into the mix? Our hospitalists are paid by the number of shifts, and as you distribute shift reductions over 15 providers, it shouldn't be an intolerable burden." But two open hospitalist positions have not been filled, he noted.

CRMC is trying to approach these changes with a Lean perspective, Mr. Thornell said. "We had already adopted a Lean program, but this has been a chance to go through a life-altering circumstance using the tools of Lean planning and applying them instantaneously."

Providers step up

At Emory Healthcare in Atlanta, a major center for COVID-19 cases, communication has been essential in the crisis, said Bryce Gartland, MD, SFHM, Emory's hospital group president and cochief of clinical operations. "Our group was prepared for a significant influx of patients. Like every other institution, we made the decision to postpone elective care, with a resulting plummet in volume," he said.

As COVID-19 patients entered the Emory system, frontline hospitalists stepped up to care for those patients. "We've had ample providers in terms of clinical care. We guaranteed our physicians' base compensation. They have flexed teams up and down as needed." Advanced practice professionals also stepped up to bridge gaps.

With regard to the return of volumes of non-COVID-19 patients, the jury's still out, Dr. Gartland said. "None of us has a crystal ball, and there are tremendous variables and decision points that will have significant impact. We have started to see numbers of time-sensitive and essential cases increase as of the first week of May."

What lies ahead will likely include some rightsizing to future volumes. On top of that, the broader economic pressures on hospitals from high rates of unemployment, uninsured patients, bad debt, and charity care will push health care systems to significantly address costs and infrastructure, he said. "We're still early in planning, and striving to maintain flexibility and nimbleness, given the uncertainties to this early understanding of our new normal. No hospital is immune from the financial impact. We'll see and hear about more of these conversations in the months ahead."

But the experience has also generated some positives, Dr. Gartland noted. "Things like telehealth, which we've been talking about for years but previously faced barriers to widespread adoption." Now with COVID-19, the federal government issued waivers, and barriers – both internal and external – came down. "With telehealth, what will the role and deployment of hospitalists look like in this new model? How will traditional productivity expectations change, or the numbers and types of providers? This will make the relationship and partnership between hospitalist groups and hospital administrators ever more important as we consider the evolution toward new care models."

Dr. Gartland said that "one of the great things about hospital medicine as a field is its flexibility and adaptability. Where there have been gaps, hospitalists were quick to step in. As long as hospital medicine continues to embrace those kinds of behaviors, it will be successful." But if the conver-

sation with hospitals is just about money, it will be harder, he acknowledged. "Where there is this kind of disruption in our usual way of doing things, there are also tremendous opportunities for care model innovation. I would encourage hospitalist groups to try to be true value partners."

Command center mode initiated

Like other physicians in hospital C-suites, Chad Whelan MD, FACP, SFHM, chief executive officer of Banner–University Medicine in Tucson, Ariz., led his two hospitals into command center mode when the crisis hit, planning for a surge of COVID-19 cases that could overwhelm hospital capacity.

"In terms of our hospitalists, we leaned in to them hard in the beginning, preparing them to supervise other physicians who came in to help if needed," he said. "Our [non-COVID-19] census is down, revenues are down, and the implications are enormous – like nothing we've ever seen before."

"We're fortunate that we're part of the Banner health system. We made a decision that we would essentially keep our physicians financially protected through this crisis," Dr. Whelan said. "In return, we called on them to step up and be on the front lines and to put in enormous hours for planning. We asked them to consider: How could you contribute if the surge comes?"

He affirmed that hospital medicine has been a major part of his medical center's planning and implementation. "I've been overwhelmed by the degree to which the entire delivery team has rallied around the pandemic, with everybody saying they want to keep people safe and be part of the solution. We have always had hospitalist leaders at the table as we've planned our response

and as decisions were made," said Dr. Whelan, a practicing hospitalist and teaching service attending since 2000 until he assumed his current executive position in Arizona 18 months ago.

"While we have kept people whole during the immediate crisis, we have acknowledged that we don't know what our recovery will look like. What if [non-COVID-19] volume doesn't return? That keeps me awake at night," he said. "I have talked to our physician leadership in hospital medicine and more broadly. We need to ask ourselves many questions, including: Do we have the right levels of staffing? Is this the time to consider alternative models of staffing, for example, advanced practice providers? And does the compensation plan need adjustments?"

Dr. Whelan thinks that the COVID-19 crisis is an opportunity for hospital medicine to more rapidly explore different models and to ask what additional value hospitalists can bring to the care model. "For example, what would it mean to redefine the hospitalist's scope of practice as an acute medicine specialist, not defined by the hospital's four walls?" he noted.

"One of the reasons our smaller hospital reached capacity with COVID-19 patients was the skilled nursing facility located a few hundred feet away that turned into a hot spot. If we had imported the hospital medicine model virtually into that SNF early on, could there have been a different scenario? Have we thought through what that would have even looked like?" Dr. Whelan asked.

He challenges the hospital medicine field, once it gets to the other side of this crisis, to not fall back on old way of doing things. "Instead, let's use this time to create a better model today," he said. "That's what we're trying to do at a system level at Banner, with our hospital medicine groups partnering with the hospital. I want to see our hospitalists create and thrive in that new model."



Dr. Gartland



Dr. Whelan



How to get a position as a physician leader

The best ways to start

It's been said that physicians tend to fall into leadership roles. Few physicians set out to become leaders, and then one day they realize that they desire to be a leader and an agent for change.

They may be rotating through the chairmanship of a clinical department or the management of a small practice and decide they like the work. In a large organization, doctors get assigned to committees, or specialists agree to run a new service line for a while, and it changes their lives.

Some physicians have a natural aptitude for managerial work. Often, colleagues tell them they are a good fit, but they may still have some reservations. In any case, it's good to do a bit of soul-searching before taking the leap.

1. Weigh the pluses and minuses of a leadership role

When you stand at the precipice of a totally new career in physician leadership, it's worthwhile to step back and consider the pluses and minuses of the work.

One plus is that there may be fewer work hours than on the clinical side, but being a physician leader is by no means a 9-to-5 job. In a large organization, a physician on the executive team can be on administrative call – dealing with institutional crises on off-hours – for a length of time. Board and strategic planning retreats tend to occur on weekends, and you may need to attend frequent dinner meetings.

Another plus is that the pay is pretty good. In 2016, physician leaders in large organizations earned an average of \$350,000 a year, according to a survey by Cejka Executive Search and the American Association for Physician Leadership (AAPL).¹

On the minus side, an executive probably won't be as beloved as a clinician serving a host of grateful patients. And you will not have the kind of job security that most clinicians have. There may be frequent turnover among health care executives because of change of top leadership, pressure for more profitability, or a host of other reasons.

2. Try on different roles

To decide whether you want to make a career of being a physician leader, it's useful to try out several different jobs. Volunteer for committees or take on a special project if it's possible to do so in your organization.

You can also volunteer for posts outside the organization, such as joining the board of your local cancer or heart association or helping them out on a committee. You might volunteer for Little League or a school or civic organization. Your choices are wide open. The goal is to get a feel for directing an organization and whether that fits your lifestyle.

Also, talk to current physician leaders. Contact a cross-section of people, including those who are unhappy with their jobs and those who had to struggle with their new roles. This will give you some good perspective into whether the work is right for you, as well as tips on how to cope.

3. Find a mentor

This is also a good time to find a mentor for your new calling. Choose a seasoned physician leader who can help you over the long haul – someone who can get you up to speed and then advise you during crucial junctures in your career.

Good mentors should be willing to spend the time with you, have your best interests in mind, and be willing to provide honest assessments. They can also help you find opportunities for further learning and professional growth.

Some organizations assign mentors to physicians they

want to develop for leadership roles. You can also choose specific mentors to help you in areas where you think you need more work, such as finance, quality improvement, or information systems.

Choose a path

There are many different paths you can take as a physician leader. In large organizations in particular, there are more leadership jobs open to physicians than ever before.

Jobs open to physicians can be found in the areas of clinical quality and safety, population health, managed care, and information technology. You can even look beyond these traditional roles to jobs that don't usually attract physicians, such as in strategy, innovation, patient experience, and fundraising. In these roles, you are often expected to continue doing some clinical work.

Physician leaders now tend to have more influence than in the past. According to the Cejka-AAPL survey, 61% of physician executives said they had more strategic input currently than in the previous year.

A roster of potential physician leader jobs

1. Executive-level roles

Vice president for medical affairs. This is the traditional role for the physician executive, which involves acting as a liaison with the organization's physicians. These officers oversee quality of care as well as hiring, training, and performance evaluation of physicians on staff.

Chief medical officer (CMO). This is now the typical term for the highest medical role in the organization. The CMO is part of the C-suite team and participates in governance, strategic planning, and business operation decisions. CMOs may be responsible for supporting value-based strategies and making sure that those strategies are efficient and medically necessary.

Physician-in-chief. This is a new term for the hospital's top physician, who works with the senior leadership team to maintain standards of care and customer service. The physician-in-chief may also oversee operational efficiency and support organizational transformation.

Chief clinical officer (CCO). CCOs oversee patient engagement and clinical quality outcomes. They may lead initiatives to reduce waste and improve care quality, and they can be involved in implementation of electronic health records (EHRs) and data integration. They may also assist in medical staff development, clinical integration, and physician partnerships.

2. Quality, safety, and research roles

Chief patient safety officer (CPSO). CPSOs oversee the hospital or health system's patient safety initiatives. Their goal is to reduce medical errors and near-misses.

Chief quality officer (CQO). CQOs are responsible for collecting quality data and supporting patient safety efforts. They advise on quality initiatives and hold clinicians accountable for meeting specific quality indicators. They may also be involved in developing a culture of continuous improvement in the organization.

Chief research officer (CRO). CROs oversee the organization's research activities, including clinical trials, internal investigator-initiated research programs, and sponsored studies.

3. Technology

Chief medical information officer (CMIO). The CMIO is the information technology (IT) department's liaison with

the clinical staff, working on selection and improvement of EHR systems. The CMIO finds new ways for EHRs to improve healthcare delivery in the organization.

Chief health information officer (CHIO). CHIOs deal with EHR implementation and health informatics. They may report to the chief information officer, the chief operations officer, or another C-suite executive, and they manage health informatics, telehealth, business and clinical intelligence, and predictive analytics initiatives.

Chief technology officer (CTO). CTOs oversee the organization's technology capabilities. They are responsible for leading the IT team and contributing to the organization's strategic plan.

4. Jobs not usually for physicians

There are other leadership positions that may not traditionally appeal to physicians but could be worth considering:

Chief experience officer (CXO). This involves evaluating and improving the inpatient experience. CXOs work with physicians and staff on their performance in this area.

Chief innovation officer (CIO). CIOs keep up with industry trends, market disruptions, and new opportunities, and support policy innovations and training initiatives.

Chief transformation officer (CTO). CTOs are responsible for carrying out major changes in the organization. They are supposed to act as role models for change.

5. Salaries for selected physician executives

In addition to placing the average salary for a physician leader at \$350,000, the 2016 Cejka-AAPL survey pinpointed average salaries for specific types of physician leaders. Chief medical officers earned \$388,000, chief patient safety officers and chief quality officers \$375,000, and chief medical information officers \$372,500, the survey found.

Several emerging physician leader roles – physician-in-chief, chief strategy officer, chief transformation officer, chief innovation officer, and chief integration officer – earned on average \$499,000 a year, according to the survey.

Those jobs provided even higher salaries than the \$437,500 reported by Cejka-AAPL for physician CEOs. In comparison, a CEO at a medical group with fewer than 200 physicians had an average salary of \$438,500 in 2018, according to SullivanCotter, a health care workforce strategy company.²

Some types of physician leaders have seen unusually high pay raises recently. From 2013 to 2016, the average salary for CMIOs rose 18%, and physician leaders working at the corporate level in a health system saw median compensation rise 67%, the Cejka-AAPL survey found.

Moving ahead

For physician leaders, moving up the ladder often means reinventing yourself. If you're leaving clinical practice, be sure to develop a solid CV for your new role so that if your leadership position doesn't work out, you are able to find an appropriate new position.

According to a 2003 assessment, CMOs typically lasted 18-24 months on the job.³

Expect to make mistakes and try to learn from them. If necessary, move on to the next job. There is always a market for seasoned physician executives who took a few punches, learned something from the experience, and found something new.

Start to network

One way to navigate the challenges of a new role is to have a strong network, a group of colleagues and mentors who can help you figure out your path forward. They can serve as sounding boards and contacts for new jobs in an industry that is constantly changing.

A well-functioning network takes constant maintenance.

You can find people for your network by attending a variety of different meetings that physician leaders and other healthcare executives attend. Make a point of keeping their contact information on file and periodically reaching out to them.

Learn in a dyad

Some healthcare organizations assign physician leaders to dyads, where they are matched with nonphysicians who have skills that the physician lacks, such as finance, data management, or organizational politics.

Dyads are less effective when the nonphysician has all the authority and the physician is basically a figurehead. But in an effective dyad, both partners share authority and they can teach skills to each other. While the physician in the dyad brings clinical insight, the nonphysician can provide managerial know-how.

Seek out coaching

There may be points in your leadership career when you become aware of areas where you need improvement. You may have gotten negative feedback on communication skills or political sensitivity. Consider hiring an executive coach; coaches provide concentrated sessions over limited periods of time.

Coaches can also help you prepare for the future. They can help you find ways to promote yourself for new projects or create a network of allies. They also can help you establish yourself as a thought leader in a particular field through writing and speaking engagements.

Some organizations provide in-house coaches. It is worthwhile to take advantage of this benefit. If you need to find a coach on your own, ask mentors or people in your network for recommendations.

Getting to the top

It can take years to rise to the level of the corporate C-suite or even to CEO of a large organization. At the top levels of management, you often have to cut back substantially on clinical work or even give it up entirely.

Becoming CEO of a hospital can be a logical fit for physicians. A physician CEO can relate to doctors on staff, who are a key constituency, and understands what clinical care is all about. However, physician CEOs also need to have a large degree of knowledge about finance, strategy, crisis management, quality improvement, and other nonclinical considerations, not to mention good people skills.

Physicians on boards

Some physicians would rather sit on the board of trustees than take the reins of CEO. Board membership allows you to continue practicing while still having a great deal of influence over the organization. Some physicians hold board seats for many years and enjoy a great deal of respect as the go-to person on clinical care.

Physicians are increasingly serving on the boards of hospitals and health systems. Trustees welcome physicians because they want more input from clinicians in decision-making. They tend to choose physicians who already have executive duties, such as having been a department head.

Which new skills should you learn?

Physician executives often put off learning business and management skills until after being appointed to a leadership position. Even then, they may prefer to take courses focused on a particular topic rather than earn a degree such as master of business administration (MBA).

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Is your job performance being evaluated for the wrong factors?

By Leigh Page

Most physicians get an annual performance review, and may be either elated, disappointed, or confused with their rating.

But some physicians say the right factors aren't being evaluated or, in many cases, the performance measures promote efforts that are counterproductive.

"Bonuses are a behaviorist approach," said Richard Gunderman, MD, professor in the schools of medicine, liberal arts, and philanthropy at Indiana University, Indianapolis. "The presumption is that people will change if they get some money – that they will do what the incentive wants them to do and refrain from what it doesn't want them to do."

Dr. Gunderman said this often means just going through the motions to get the bonus, and not sharing goals that only the administration cares about. "The goals might be to lower costs, ensure compliance with regulations or billing requirements, or make patterns of care more uniform. These are not changes that are well tailored to what patients want or how doctors think."

The bonus is a central feature of the annual review. Merritt Hawkins, the physician search firm, reported that 75% of the physician jobs that it searches for involve some kind of production bonus (2019 Review of Physician and Advanced Practitioner Recruiting Incentives, 2019 Jul 8. <https://www.merrithawkins.com/trends-and-insights/article/reports/2019-review-of-physician-and-advanced-practitioner-recruiting-incentives/>). Bonuses often make up at least 5% of total compensation, but they can be quite hefty in some specialties.

Having to fulfill measures that they're not excited about can lead physicians to feel disengaged from their work, Dr. Gunderman said. And this disengagement can contribute to physician burnout, which has climbed to very high rates in recent years.

A 2018 paper by two physician leadership experts explored this problem with bonuses. "A growing consensus [of ex-

perts] suggests that quality-incentive pay isn't paying the dividends first envisioned," they wrote.

The problem is that the measurements tied to a bonus represent an extrinsic motivation – involving goals that doctors don't really believe in. Instead, physicians need to be intrinsically motivated. They need to be inspired "to manage their own lives," "to get better at something," and "to be a part of a larger cause," they wrote (American Association for Physician Leadership, Bringing Value: What to Consider in a Physician Incentive Plan, 2018 May 17.

<https://www.physicianleaders.org/news/what-consider-physician-incentive-plan>).

A better review process can be developed

"The best way to motivate improved performance is through purpose and mission," said Robert Pearl, MD, former CEO of the Permanente Medical Group in California and now a lecturer on strategy at Stanford (Calif.) University.

The review process, Dr. Pearl said, should inspire physicians to do better. The doctors should be asking themselves: "How well did we do in helping maximize the health of all of our patients? And how well did we do in avoiding medical errors, preventing complications, meeting the needs of our patients, and achieving superior quality outcomes?"

When he was CEO of Permanente, the huge physician group that works exclusively for health maintenance organization Kaiser, Dr. Pearl and fellow leaders revamped the review system that all Permanente physicians undergo.

First, the Permanente executives provided all physicians with everyone's patient-satisfaction data, including their own. That way, each physician could compare performance with others and assess strengths and weaknesses. Then Per-

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Learning on the job

A number of executive skills can be learned on the job, such as dealing with quality measures, utilization, billing and coding, disease management, committees, and interpreting data. If you are not in a dyad model, you can ask someone knowledgeable in one of these skills to take you through the steps.

Many physicians could benefit from finance and business courses in order to learn some of the budgetary, accounting, and operational skills required to perform the job optimally.

In a survey of healthcare CEOs, only 30% said their most senior physician leader had a business or medical management degree, and only 21% required a degree.⁴

Taking classes

Physician executives who want to brush up on a particular topic can "mix and match," taking short, focused classes on the particular topic whenever they feel the need. In addition to resources offered by SHM, courses are available from organizations such as the AAPL, American Hospital Association, the Medical Group Management Association, or the Healthcare Information and Management Systems Society, to name a few examples.

Pursuing degree programs

Degree programs like MBA, master of public health (MPH), and master of health care administration (MHA) are popular with many physician executives because they get a full overview of needed skills and the potential to earn more money with their new credentials. Physician leaders with an MBA earned 13% more in 2016 than did those with no MBA, according to the Cejka-AAPL survey.

Getting a master's degree, however, takes time and money. For example, an MBA can cost \$20,000 to as much as \$100,000.⁵ MBA, MHA, and MPH degrees take 2 years to complete, while a master of medical management (MMM) and a physician-executive MBA – focusing specifically on what physician leaders need to learn – take 1 year.

Many part-time degree programs are available for those with full-time jobs. You can find them at nearby universities as well as far-off institutions. Much of the coursework is done online, but some on-site work is usually required. You'll find that working directly with others enriches the learning experience and helps you build your network of colleagues.

Straight MBA or other degree?

In general, degree programs cover finance, communication, strategy, information systems, marketing, organizational be-

manente offered educational programs so that physicians could get help in meeting their goals.

"This approach helped improve quality of care, patient satisfaction, and fulfillment of physicians," Dr. Pearl said. Kaiser Permanente earned the highest health plan member satisfaction rating by J.D. Power and higher rankings by the National Committee for Quality Assurance.

Permanente does not base the bonus on relative value units but on performance measures that are carefully balanced to avoid too much focus on certain measures. "There needs to be an array of quality measures because doctors deal with a complex set of problems," Dr. Pearl said. For example, a primary care physician at Permanente is assessed on about 30 different measures.

Physicians are more likely to be successful when you emphasize collaboration. Dr. Pearl said.

Although Permanente physicians are compared with each other, they are not pitted against each other but rather are asked to collaborate. "Physicians are more likely to be successful when you emphasize collaboration," he said. "They can teach each other. You can be good at some things, and your colleague can be good at others."

Permanente still has one-on-one yearly evaluations, but much of the assessment work is done in monthly meetings within each department. "There, small groups of doctors look at their data and discuss how each of them can improve," Dr. Pearl noted.

The 360-degree review is valuable but has some problems

Physicians should be getting a lot more feedback about their behavior than they are actually getting, according to Milton Hammerly, MD, chief medical officer at QualChoice Health Insurance in Little Rock, Ark.

"After residency, you get very little feedback on your work," said Dr. Hammerly, who used to work for a hospital system. "Annual reviews for physicians focus almost exclu-

"Annual reviews for physicians focus almost exclusively on outcomes, productivity, and quality metrics."

sively on outcomes, productivity, and quality metrics, but not on people skills, what is called 'emotional intelligence.'"

Dr. Hammerly said he saw the consequence of this lack of education when he was vice president for medical affairs at the hospital system. He was constantly dealing with physicians who exhibited serious disruptive behavior and had to be disciplined. "If only they had gotten a little help earlier on," he noted.

Dr. Hammerly said that 360-degree evaluations, which are common in corporations but rarely used for physicians, could benefit the profession. He discovered the 360-degree evaluation when it was used for him at QualChoice, and he has been a fan ever since.

The approach involves collecting evaluations of you from your boss, from your peers, and from people who work for you. That is, from 360 degrees around you. These people are asked to rate your strengths and weaknesses in a variety of competencies. In this way, you get feedback from all of your work relationships, not just from your boss.

Ideally, the evaluators are anonymous, and the subject works with a facilitator to process the information. But 360-degree evaluations can be done in all kinds of ways.

Critics of the 360-degree evaluations say the usual anonymity of evaluators allows them to be too harsh. Also, evaluators may be too subjective: What they say about you says more about their own perspective than anything about you.

But many people think 360-degree evaluations are at least going in the right direction, because they focus on people skills rather than just meeting metrics.

Robert Centor, MD, an internist in Birmingham, Ala., and a member of the performance measures committee of the American College of Physicians, said the best way to improve performance is to have conversations about your work with colleagues on the department level. "For example, 20 doctors could meet to discuss a certain issue, such as the need for more vaccinations. That doesn't have to get rewarded with a bonus payment."

Dr. Pearl said that "doctors need feedback from their colleagues. Without feedback, how else do you get better? You can only improve if you can know how you're performing, compared to others."

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havior, operational management, and quality improvement. Straight MBA programs don't focus on healthcare, but some physician executives still prefer this route, especially if it involves degrees from prestigious business schools.

MHA, MMM, physician-executive MBA, and other degree programs focused on healthcare are popular with many physicians on the executive track. The MPH is less business-oriented but may be preferable to some because of its focus on population-based health, which fits well with decision-making on health insurance and value-based care.

Conclusion

Physicians need to prepare for leadership because these roles are very different from clinical work. It's easy to stumble and lose direction without mentors, a network of helpful colleagues, and at least some education in business principles.

Finding a mentor should start early in your new career. A seasoned physician executive can help you understand your options and point out your strengths and shortcomings. Beyond that, concentrated work with an executive coach can help you improve your skills and choose from among the many executive roles that are now available.

You can learn many skills on the job through dyads and other relationships with more seasoned colleagues, or take short classes on particular skills that need to be learned or sharpened. Many physician executives go a step further and get a master's degree, such as an MBA, MHA, or MMM. This involves a year or two of study, but much of it can be done online.

This article is excerpted from the Medscape Physician Business Academy course "How to become an effective leader." You can find more information on the course at www.medscape.com/courses/business/100018.

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Would you be happier in a leadership position? This hospitalist wasn't

By Alicia Gallegos

After practicing clinical care for 4 years, hospitalist Suneel Dhand, MD, was ready for a change and eager for the chance to help improve the broader health care system.

So when the opportunity arose to direct an internal medicine program at a large hospital, Dr. Dhand gladly accepted the role. He aimed to enhance frontline staffing, expand his hospital medicine team's influence, and raise the standard of care for patients.

Almost immediately, however, Dr. Dhand knew the administrative route was the wrong path for him.

"I realized very quickly that initiating change and being a positive force, while working with multiple competing interests, is far from easy," said Dr. Dhand. "I didn't particularly feel well supported by the high-level administrators. Without resources, it's extra difficult to make things happen."

A year and half into the role, Dr. Dhand left the position and returned to purely clinical work. He now practices as a Boston-area hospitalist while writing, filming, and podcasting about medicine on the side.

"I have no intention of leaving clinical medicine," he said. "If somebody gave me a very highly compensated offer right now to come and be a hospital leader, I wouldn't do it. It's not me, and I wouldn't enjoy it."

Taking on an administrative or executive role can sound appealing to many clinicians. The Medscape Physician Compensation Report 2018 found that 42% of employed physicians were aiming for a promotion. Another physician survey by The Physicians Foundation found that 46% planned to change career paths in 2018 and that more than 12% planned to seek a nonclinical job in the next 1-3 years.

Interest in executive and leadership roles has also increased because of the COVID-19 pandemic, particularly as more physicians struggle financially and search for alternative compensation, said Peter B. Angood, MD, CEO and president for the American Association for Physician Leadership.

"Because of the COVID-19 impacts on health care and our country as a whole, the strengths of physician leadership have been better recognized at multiple levels," Dr. Angood said. "As a result, there is definitely early interest as the ongoing impacts of COVID-19 are appreciated in how to further integrate physicians as leaders within the health care industry as a whole."

Is administration the way to go?

But as Dr. Dhand's experience highlights, administration is not the right direction for every physician. Are physicians prepared for executive positions before making the move, and who makes the best fit for an administrative job?

"It's certainly something most folks should not just jump into," said Dr. Angood. "In the same way that physicians spend an awful lot of time developing their expertise to become an expert clinician, the same philosophy for becoming an expert administrative leader should be applied."

The motivations behind moving to an administrative role vary among physicians, said Carson F. Dye, fellow and faculty member at the American College of Healthcare Executives and a leadership consultant. Some doctors make the shift because they have a natural proclivity for leading,

whereas others want to make a greater impact on patient care and quality, Mr. Dye said. Still other physicians simply want a greater say in the everyday areas that affect them.

At the same time, there are more physician leadership opportunities than before. Positions such as chief quality officer, chief medical information officer, president of the employed medical group, and chief population health officer rarely existed 20 or 30 years ago, Mr. Dye noted.

"Moreover, nonclinical executives have begun to see the great value in having more physician leaders involved because it enhances physician engagement and provides valuable input for strategic change," Mr. Dye said.

North Carolina internist Michael Lalor, MD, says leadership responsibilities landed in his lap early in his career

"If somebody gave me a very highly compensated offer right now to come and be a hospital leader, I wouldn't do it."



Dr. Dhand

and led to his ultimate post as a full-time administrator. Dr. Lalor was a couple years out of residency and working for a small private practice when the owner decided to retire early and asked him to take over the group, he explained.

After accepting, Dr. Lalor hired another physician, expanded the group, and later merged with a larger network.

"I loved it from the perspective of the intersection of business and medicine," he said. "It really gave me experience you don't get in training, such as the actual operations of running a medical group, contract negotiations, expansion plans, payroll, accounting."

Dr. Lalor also served as a medical director for a small, nonprofit hospice in the area, which spurred him to become board certified in hospice and palliative medicine. He now acts as chief medical officer for a large hospice and palliative care organization based in North Carolina.

Chicago-area family physician John Jurica, MD, made his way up the executive ladder through a series of steps. Dr. Jurica said he felt drawn to committees and projects that addressed population health and quality issues. Tapping into this interest, he became medical director for Riverside Medical Center in Kankakee, Ill., followed by vice president of medical affairs and then chief medical officer for the hospital. Today, Dr. Jurica is medical director and part owner of two urgent care centers.

Dr. Jurica said he hears a range of reasons for seeking a change from clinical care, including disillusionment with medicine; high debt; outside interests; and burnout. Although burnout prompts some physicians to pursue administrative roles, Dr. Angood cautions that this is like entering a rebound relationship after leaving a bad relationship. Making the move merely because of dissatisfaction with your current position can set you up for disappointment.

"Too often, physicians who are frustrated with the complexities of clinical care will view administrative roles as a parachute for themselves out of that situation," he said. "If they don't understand the nuances of administrative work, they run the risk of moving into a role that will ultimately provide them a different level of dissatisfaction, rather than the higher level of satisfaction they were seeking."

Who's right for an administrative job?

Nearly any type of personality can make a good fit for an administrative post, said Dr. Jurica.



"If you look at most leadership teams, they usually have a team of people that have different personality types that complement one another," he said.

Certain attributes, however, are more helpful for executive positions, according to Mr. Dye, including comfort in dealing with ambiguity, a willingness to make difficult decisions, an aptitude for interpreting nonverbal cues, and the ability to demonstrate confidence, but not arrogance.

"Someone who is collaborative and cooperative, a good listener, and has a compelling vision for change in health care also makes a great leader," he said.

The ability to balance and manage the needs of different groups is also key, said Heidi Moawad, MD, a neurologist, career consultant, and author of "Careers Beyond Clinical Medicine" (New York: Oxford University Press, 2013).

"Sometimes the needs of one group step on the toes of the needs of another group," said Dr. Moawad. "You have to be someone who isn't so overwhelmed by pleasing everyone."

Dr. Jurica stressed that strong leaders can come from any specialty and that many medical backgrounds can fit an administrative or executive position. "It's more related to interests, desires, personality, and experiences over time as to whether they fit that role or mature into that role," he said.

Just because you're a great clinician doesn't mean you'll make a good administrative leader, Dr. Lalor said. Physicians can often fall into leadership positions because they're considered the best or most productive clinician in a group.

"The skill set is not 100% the same," he said. "Not everybody is necessarily suited for it. They kind of fall into it and then have great missteps in their earliest experiences."

Will you miss your former responsibilities?

Some physicians who enter the administrative realm really miss the clinical world and the satisfaction of helping patients directly, added Mr. Dye. He hears from many physicians who miss the "short-term nature" of clinical practice, meaning encountering a patient, determining an intervention, and moving on to another patient.

"Decisions are made, and the physician gets to see the result of those decisions," he said. "One physician remarked to me that she lived her clinical life in '15-minute segments' and that her executive world had many issues that went on for years, making it frustrating."

For physicians such as family physician Krista Skorupa, MD, who straddle both the clinical and administrative spheres, obstacles can arise in the form of time and balance. Dr. Skorupa splits her time between practicing medicine and acting as vice president of medical practice for the M Health Fairview Primary Care Service Line in St. Paul, Minn.

"Most people will tell you it's the balance that's one of the hardest things," she said. "You always feel like you're doing one job not as well as you could because you're trying to do two jobs at 100%."

Dr. Skorupa said she has been fortunate to work for organizations that have provided the time and compensation for both jobs. But she warns that some institutions expect physicians to excel at dual clinical and administrative roles, yet fail to allot enough time or compensation for both.

Doctors going the executive route should also prepare for their work relationships to change – some for the worse.

Some peers may perceive a physician's trek into administration as going to "the dark side," Dr. Angood said. Not everyone may be accepting of your new role, he advised.

And as Dr. Dhand experienced, conflict can stem from having to act as an intermediary between staff physicians and administrators. In his director position, Dr. Dhand had to relay administrative policies to his physician colleagues. The task was challenging because Dr. Dhand did not necessarily agree with the policies and felt they burdened already overworked physicians.

"I believe almost all physician leaders feel this way," he said. "They walk in the same shoes as clinicians and know what a tough job it is. Yet, we are part of the system and have to follow rules and protocols. When you are the one giving bad news, you frequently become the fall guy."

Is administration right for me?

To decide whether administration is right for you, start by talking to other physicians in the industry and asking questions, said Dr. Skorupa.

"I strongly encourage mentorship and network," she said. "I learned a lot by just asking physicians who were in different leadership roles, to 'Tell me your story. How did you get to where you're at?' It's been hearing those stories that helped me craft my own."

Consider joining committees within your local hospital or among your national specialty organization to evaluate whether the work interests you, Dr. Moawad advises.

Another way to measure your interest is by taking on a part-time job in physician leadership, Mr. Dye said. This allows physicians to try out leadership without leaving clinical practice behind.

"Dyad roles where physicians are paired with a nonphysician partner can be helpful to physicians who are wanting to move slowly into leadership," he said. "Typically, the physician in a dyad model also continues to practice clinically part time and does not lose that connection with medicine."

In addition to getting some leadership experience, you may want to consider formal training in executive leadership. Many specialty societies offer formal coursework related to leadership, as do some hospital organizations.

The Society of Hospital Medicine offers a 3-course Leadership Academy that prepares clinical and academic leaders with skills traditionally not taught in medical school or residency programs. SHM also offers a Leadership Capstone program for hospitalists with 3 or more years of experience, who are already leading or preparing to lead an academic, business, or clinical change initiative at their institution.

Some physicians heading down the administrative road pursue more formal degrees, such as an MBA, MHA, or MMM, added Dr. Jurica. A business degree is not required, but degrees do have advantages, he said.

"The most important factor in preparing a physician for this career shift is taking on progressively more challenging duties managing people, running important projects, working with budgets, and honing your leadership skills," he said. "There are benefits to having a degree. It provides formal education in these areas. Pursuing such a degree demonstrates a commitment to your leadership career and can be helpful when competing with other physician leaders."

The reality is that more hospitals and health systems are recognizing the value of having physicians in leadership and executive functions, Dr. Angood said. Data show that health systems and hospitals with physician leaders perform better.

"This is because physicians not only have strong leadership and administrative capabilities, but they already have a strong sense of the clinical environment and how best to deliver good clinical care. It's a double benefit nonclinical administrators are unable to match."

As for Dr. Dhand, he doesn't regret his stint in administration, despite finding out the path was not his calling.

"My experience was an eye-opener; I'm glad I did it," he said. "I would change certain things looking back, like having lower expectations and understanding that change takes time. It's also okay to be unpopular. I'm much happier now, though, only doing clinical medicine, and have found fulfillment through other nonclinical ventures."

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Manage the pandemic with a multidisciplinary coalition

Implement a 6-P framework

By Chandra Lingisetty, MD, MBA, MHCM; Monica L. Wang, ScD, MS; Venkataraman Palabindala, MD, MBA, SFHM

The ongoing COVID-19 pandemic, arguably the biggest public health and economic catastrophe of modern times, elevated multiple deficiencies in public health infrastructures across the world, such as a slow or delayed response to suppress and mitigate the virus, an inadequately prepared and protected health care and public health workforce, and decentralized, siloed efforts.¹ COVID-19 further highlighted the vulnerabilities of the health care, public health, and economic sectors.^{2,3} Irrespective of how robust health care systems may have been initially, rapidly spreading and deadly infectious diseases like COVID-19 can quickly derail the system, bringing the work force and the patients they serve to a breaking point.

Hospital systems in the United States are not only at the crux of the current pandemic but are also well positioned to lead the response to the pandemic. Hospital administrators oversee nearly 33% of national health expenditure that amounts to the hospital-based care in the United States. Additionally, they may have an impact on nearly 30% of the expenditure that is related to physicians, prescriptions, and other facilities.⁴

The two primary goals underlying our proposed framework to target COVID-19 are based on the World Health Organization recommendations and lessons learned from countries such as South Korea that have successfully implemented these recommendations.⁵

1. Flatten the curve. According to the WHO and the Centers for Disease Control and Prevention, flattening the curve means that we must do everything that will help us to slow down the rate of infection, so the number of cases do not exceed the capacity of health systems.

2. Establish a standardized, interdisciplinary approach to flattening the curve. Pandemics can have major adverse consequences beyond health outcomes (e.g., economy) that can impact adherence to advisories and introduce multiple unintended consequences (e.g., deferred chronic care, unemployment). Managing the current pandemic and thoughtful consideration of and action regarding its ripple effects is heavily dependent on a standardized, interdisciplinary approach that is monitored, implemented, and evaluated well.

To achieve these two goals, we recommend establishing an interdisciplinary coalition representing multiple sectors. Our 6-P framework described below is intended to guide hospital administrators, to build the coalition, and to achieve these goals.

Structure of the pandemic coalition

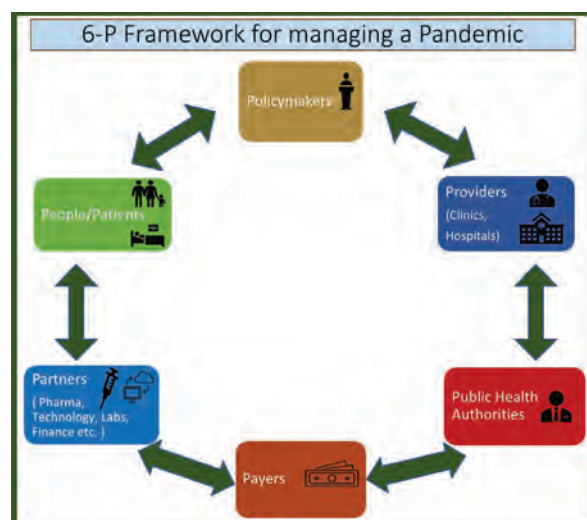
A successful coalition invites a collaborative partnership involving senior members of respective disciplines, who would provide valuable,

complementary perspectives in the coalition. We recommend hospital administrators take a lead in the formation of such a coalition. While we present the stakeholders and their roles below based on their intended influence and impact on the overall outcome of COVID-19, the basic guiding principles behind our 6-P framework remain true for any large-scale population health intervention.

Although several models for staging the transmission of COVID-19 are available, we adopted a four-stage model followed by the Indian Council for Medical Research.⁶ Irrespective of the origin of the infection, we believe that the four-stage model can cultivate situational awareness that can help guide the strategic design and systematic implementation of interventions.

Our 6-P framework integrates the four-stage model of COVID-19 transmission to identify action items for each stakeholder group and appropriate strategies selected based on the stages targeted.

1. Policy makers: Policy makers at all levels are critical in establishing policies, orders, and advisories, as well as dedicating resources and infrastructure, to enhance adherence to recommendations and guidelines at the community and population levels.⁷ They can assist hospitals in work-force expansion across county/state/discipline lines (e.g., accelerate the licensing and credentialing process; authorize graduate medical trainees, nurse practitioners, and other allied health professionals), as well as policy revisions for data sharing, privacy, communication, liability, and telehealth expansion.⁸



2. Providers: The health of the health care work force itself is at risk because of their frontline services. Their buy-in will be crucial in both the formulation and implementation of evidence- and practice-based guidelines.⁹ Rapid adoption of telehealth for care continuum, policy revisions for elective procedures, visitor restriction, surge/resurge planning, capacity expansion, effective population health management, and work with employee unions and



Dr. Lingisetty



Dr. Wang



Dr. Palabindala

Dr. Lingisetty is a hospitalist and physician executive at Baptist Health System, Little Rock, Ark. He is cofounder/president of SHM's Arkansas chapter. Dr. Wang is assistant professor in the department of community health sciences at Boston University and adjunct assistant professor of health policy and management at the Harvard School of Public Health. Dr. Palabindala is the medical director, utilization management and physician advisory services, at the University of Mississippi Medical Center, Jackson. He is an associate professor of medicine and academic hospitalist at the University of Mississippi.

professional staff organizations are a few, but very important, action items that need to be implemented.

3. Public health authorities: Representation of public health authorities will be crucial in standardizing data collection, management, and reporting; providing up-to-date guidelines and advisories; developing, implementing, and evaluating short- and long-term public health interventions; and preparing and helping communities throughout the course of the pandemic. They also play a key role in identifying and reducing barriers related to the expansion of testing and contact tracing efforts.

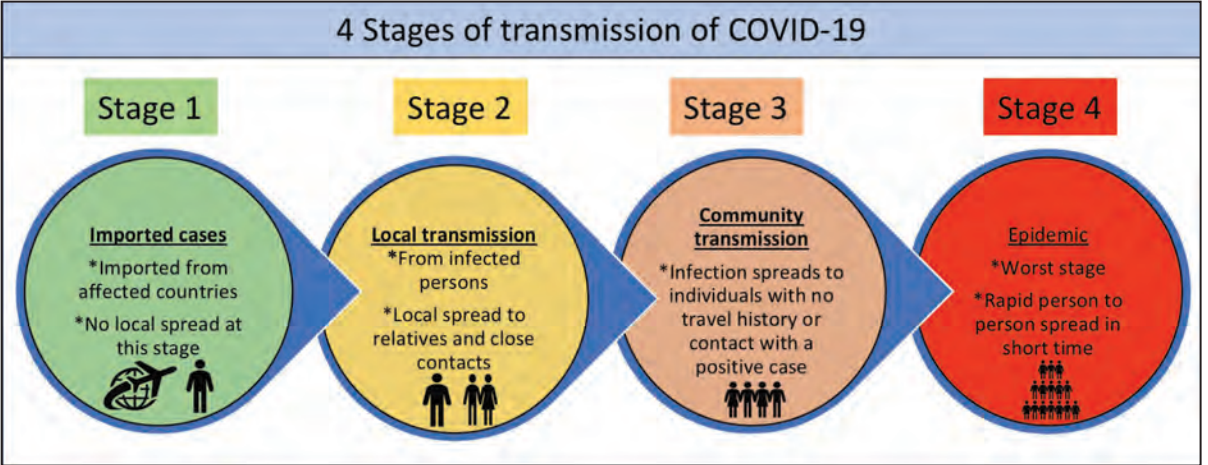
4. Payers: In the U. S., the Centers for Medicare & Medicaid Services oversees primary federally funded programs and serves as a point of reference for the American health care system. Having representation from all payer sources is crucial for achieving uniformity and standardization of the care process during the pandemic, with priority given to individuals and families who have recently lost their health insurance because of job loss from COVID-19-related furloughs, layoffs, and closures. Customer outreach initiatives, revision of patients' out-of-pocket responsibilities, rapid claim settlement and denial management services, expansion of telehealth, elimination of prior authorization barriers, rapid credentialing of providers, data sharing, and assistance for hospital systems in chronic disease management are examples of time-sensitive initiatives that are vital for population health management.

5. Partners: Establishing partnerships with pharma, health IT, labs, device industries, and other ancillary services is important to facili-

tate rapid innovation, production, and supply of essential medical devices and resources. These partners directly influence the outcomes of the pandemic and long-term health of the society through expanding testing capability, contact tracing, leveraging technology for expanding access to care, home monitoring of cases, innovating treatment and prevention, and data sharing. Partners should consider options such as flexible medication delivery, electronic prescription services, and use of drones in supply chain to deliver test kits, test samples, medication, and blood products.

6. People/patients: Lastly and perhaps most critically, the trust, buy-in, and needs of the overall population are vital to enhance adherence to guidelines and recommendations. Many millions more than those who test positive for COVID-19 have and will continue to experience the crippling adverse economic, social, physical, and mental health effects of stay-at-home advisories, business and school closures, and physical distancing orders. Members of each community need to be heard and provide input on public health interventions to enhance acceptance and adherence (e.g., face coverings in public, engage in physical distancing, etc.). Special attention should be given to managing chronic or existing medical problems and seek care when needed.

An interdisciplinary and multipronged approach is necessary to address a complex, widespread, disruptive, and deadly pandemic. Our suggestions are by no means exhaustive, nor do



we expect all coalitions to be able to carry them all out. Our intention is that the 6-P framework encourages cross-sector collaboration to facilitate the design, implementation, evaluation, and scalability of preventive and intervention efforts based on the menu of items we have provided. Each coalition may determine which strategies they are able to prioritize and when within the context of specific national, regional, and local advisories, resulting in a tailored approach for each community or region.

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Palliative care

Continued from page 1

in clarifying and redefining the new role for palliative care, whom it is meant for, and who should provide it. Central to this new role is the greater use of telemedicine – for talking to hospitalized patients without increasing viral exposure, for linking up with family members who can't visit their loved ones in the hospital, and for helping frontline hospital staff who need a palliative care consultation – or just a chance to debrief on what they are seeing.

A pandemic wake-up call

Elizabeth Gundersen, MD, FHM, FAAHPM, director of the hospice and palliative medicine fellowship program at the Charles E. Schmidt College of Medicine at Florida Atlantic University (FAU) in Boca Raton, practiced hospital medicine for 10 years before pursuing a fellowship in hospice and palliative medicine and working as an academic palliative medicine physician. She calls the pandemic a wake-up call for gaps in care and all the things that weren't working well in the health care system.

"Now we are seeing more clearly what's lacking – or broken – and what we will carry forward from this experience into the post-COVID world," she said. Some hospitalists do palliative care very well, and others don't feel as comfortable in having these difficult conversations with patients. But in the uncertain course of the virus they get thrust into it.



Dr. Gundersen

Although FAU's associated hospitals were not as inundated with COVID-19 patients in the early weeks of the pandemic as were other regions, the volume of other patients plummeted, Dr. Gundersen said, adding that "there's still been incredible intensity and worry about the virus. For me, the basic role of palliative care hasn't changed, and the phrase I have always used when introducing myself – 'we're an extra layer of support for the patient and family' – still holds true," she said.

"I try to make it clear to people that palliative care is not synonymous with end-of-life care. We don't want people to think that a palliative care referral implies imminent

"The phrase I have always used when introducing myself – 'we're an extra layer of support for the patient and family' – still holds true."

death. The goal is not to get more people to have a do not attempt resuscitation (DNAR) order, but to determine the patient and family's treatment goals and whether a DNAR order fits those goals."

The tough conversations

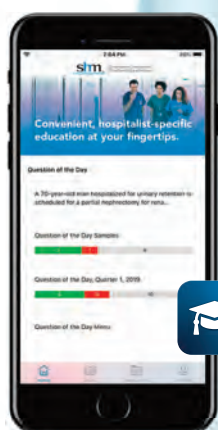
Dr. Gundersen is cochair of SHM's Palliative Care Special Interest Group, along with Rab Razzak, MD, clinical director of geriatrics and palliative medicine at University Hospitals Cleveland Medical Center, one

of the hospitals affiliated with Case Western University in Cleveland. (Connect with them on Twitter: @Top_Gundersen and @rabrazzak.)

Dr. Razzak also transitioned from hospital medicine to palliative medicine 10 years ago. "As a hospitalist, I enjoyed the tough conversations and bringing the human element into my health care interactions," he explained. "To me, palliative care is a philosophy of care that puts the person we call the patient at the center of the interaction, while we try to figure out how to best care for them as a person."

When the pandemic hit, University Hospitals made 20 ICU beds available for COVID-19 patients, Dr. Razzak said. This unit has since been full but not overflowing, while overall hospital census went down. The palliative care team at the hospital includes four inpatient doctors, nurse practitioners, and a chaplain, as well as an outpatient team primarily focused on oncology.

"In some settings, palliative care has been at the forefront of difficult conversations, when things aren't



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going well for the patient and there's much uncertainty," Dr. Razzak said. The interface between hospital medicine and palliative care can be complementary, he added. "We talk about primary palliative care, which we want every discipline to be able to do – lead meaningful conversations, help manage symptoms."

The take-home message for hospitalists, he said, is to get training in how to have these discussions, using such resources as VitalTalk (<https://www.vitaltalk.org/>), a nonprofit organization that disseminates education in communication skills for difficult conversations, and the Center to Advance Palliative Care (www.capc.org) at Icahn School of Medicine at Mount Sinai in New York City. "Once you've mastered the conversation, it will get easier. But ask for help when you need it, and learn how to know when you need it."

Dr. Gundersen added that hospital medicine groups and palliative care teams could reach out to each other and talk about what they did in the crisis and how they can work together in the future. She recommends frequent ongoing support and collaboration that could range from formal conferences or training sessions to informal team interactions, perhaps with sandwiches in the doctor's lounge – provided that there's room for social distancing. She has recently started giving talks in the community and grand rounds presentations in hospitals about palliative care.

Other approaches and applications

In New York City, the initial epicenter for the pandemic in the United States, the adult palliative care service of Columbia University Medical Center (CUMC) experienced a sevenfold increase in consultation requests at the apex of the crisis, said its director, Craig Blinderman, MD. That demand was impossible to meet with existing staff. So Dr. Blinderman and colleagues established a virtual consultation model, recruiting and deploying volunteer out-of-state palliative care specialists to staff it.

An eight-bed palliative care unit was opened at CUMC for COVID-19 patients whose surrogates had opted not to initiate or continue intubation or life-sustaining treatments. This helped to relieve some of the pressures on the ICUs while making it possible for in-person visits to the hospice unit by families – in full personal protective equipment. Palliative care staff were embedded in

“People had to take action right away to develop work flows and the technology to allow us to see as many patients as possible.”

various units in the hospital.

A palliative care response team composed of a hospice and palliative medicine fellow and four psychiatry residents or fellows, based in the emergency department and with supervision from the palliative care team, provided time-critical goals of care conversations with families using telemedicine – and a forum for listening to their suffering. Dr. Blinderman and colleagues also have found time to write up their experience for medical journals.^{1,2}

There's no reason to think that hospitalists, with a little basic training, couldn't be having these same goals of care conversations, Dr. Blinderman said. "But the fact that hospitalists, at the pandemic's peak, along with ICU doctors, were seeing an unprecedented magnitude of dying on a daily basis generated a lot of moral distress for them."

Palliative care professionals, because they engage with these issues in a different way, may be somewhat better equipped to deal with the sheer emotional demands when so many are dying, as at the peak of the surge in New York. "We don't see dying as a failure on our part but an opportunity to relieve suffering," Dr. Blinderman said. And the palliative care field also emphasizes the importance of self-care for its practitioners.

"How do we meet the incredible palliative care needs in the epicenter of a pandemic? That question also applies to other kinds of crises we could imagine, for example, climate-related disasters," Dr. Blinderman said. "What lessons have we learned about the value of palliative care and how to start incorporating it more integrally into the delivery of hospital care? Here we showed that we could work collaboratively with our colleagues at other major medical centers, bringing together their expertise to help us when we didn't have the bandwidth to meet the demand," he said.

Helpful scripts

"Also, it won't make sense to just go back to normal (after the crisis fades)," Dr. Blinderman said. "We need to take a close look at how



Dr. Youngwerth

our society is functioning in the wake of the pandemic and the ways the health care system has failed us. We have learned that we're all interconnected and we need to work together to

serve our communities – locally and nationally – applying basic distributive justice."

Could there be, for example, a national infrastructure for mobilizing and deploying palliative care resources to areas of greatest need, similar to what was done in New York?

At Northwestern Medicine in Chicago, a number of palliative care clinicians at the system's hospitals worked together to develop scripts designed to help other clinicians start goals of care conversations with patients and families, for use in the hospital as well as in outpatient primary care and other settings, with results integrated into the system's electronic health record.

Front-line clinicians may not have the time to ask for formal consults from palliative care because of high volume and rapidly changing patient status, explained Eytan Szmuiłowicz, MD, director of the section of palliative medicine at Northwestern Memorial Hospital. Or they may not have access to specialty-level palliative care in their settings.

The scripts are aimed at primary care, emergency physicians, and hospitalists needing to consider critical care placement or attempted resuscitation and to ICU clinicians helping families make decisions about life-sustaining treatments. They

also can help facilitate advance care planning discussions. An example is "CALMER," a six-step mnemonic guide to promote goals of care discussions with hospitalized patients. For more information on these scripts, contact Dr. Szmuiłowicz: Eytan.Szmuiłowicz@nm.org.

Eerily quiet

The COVID-19 crisis has been quite a whirlwind for hospital medicine, said Jeanie Youngwerth, MD, a hospitalist and program director of the palliative care service at the University of Colorado in Denver, which was a significant viral hotspot early on.

"When it first started, things seemed to change almost overnight – starting on Friday, March 13. People had to take action right away to develop work flows and the technology to allow us to see as many patients as possible," she said. By the time Monday came, it was a whole new ballgame.

Dr. Youngwerth and two colleagues worked quickly to develop inpatient telemedicine capacity where none existed. "We knew we would not be going into patients' rooms, but most of our team showed up in the hospital to work with the primary care teams. Our job was to see what we could do that actually made a difference," she said.

"The hospital became a very strange place. You'd walk down the hallway and it was eerily quiet. Everybody you came across was being so nice to each other." Televisits became a powerful way to bring the human connection back to medical care.

"What we learned from families was that they were thirsting to have some kind of connection with their loved one, and to be able to talk about their loved one and who they were as a person," she said. "We'd contact the family through video visits and then, when the family meeting ended, the nurse would bring an iPad into the patient's room so the family could see their loved one on a ventilator. They would immediately start communicating with their loved one, praying aloud, singing, playing music. It would make a huge difference for the family – and for the staff."

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Pride profile: Keshav Khanijow, MD

Balancing personal identities with professional aspirations

By Thomas R. Collins

Pride Month is observed in June each year to celebrate people who identify as lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+) and to honor those that were involved in the Stonewall Riots, which took place in New York City on June 28, 1969. Police raided the Stonewall Inn, a center of the LGBTQ+ community, on that date, leading to violence when patrons at the club and bystanders defended themselves. The uprising sparked the modern gay rights movement. The Hospitalist published online profiles of LGBTQ+ hospitalists, including the one below, in honor of Pride Month.

Keshav Khanijow, MD, is a hospitalist at Northwestern Memorial Hospital and assistant professor at Northwestern University, Chicago. Originally from the San Francisco Bay area, he studied anthropology as an undergrad at Johns Hopkins University, Baltimore, then went to medical school at the University of California, San Francisco, followed by internal medicine residency and a hospital medicine fellowship at Johns Hopkins Bayview Medical Center. He came out as gay in 2006 as an undergrad. He is a founding member of the Society of Hospital Medicine's LGBTQ+ Task Force and is involved with SHM's Diversity and Inclusion Special Interest Group.

What challenges have you faced because of your sexual orientation in the different stages of your career, from training to now as a practicing physician?

In my early training, there weren't a lot of accessible LGBTQ role models to talk about balancing my personal identities with my professional aspirations. Being a double minority as both South Asian and a gay male, made it that much more difficult. "What is it like to work in health care as a gay cismale? Will being out on my personal statement affect my entry into medical school? Should I list my LGBTQ activism activities or not?" Those were important to me.

And did you make your activism known?

Thankfully, I did. I joke that my application might as well have been printed on rainbow paper, if you

will. I decided to be out because I wanted to be part of an environment that would accept me for who I was. But it was a difficult decision.

In medical school at UCSF, it's San Francisco, so they were a little ahead of the game. They had a lot of social networking opportunities with LGBTQ and ally faculty. Those connections were important in helping me explore different fields, and I even got to write my first publication. That said, networking could sometimes be challenging, especially when it came to residency interviews. While many people would talk about family activities and engagements, I'd only been out to my family for a few years. As such, there would be somewhat of a disconnect. On the flip side, there were LGBTQ celebrations and cultural concepts important to me, but I couldn't always connect on those fronts either.

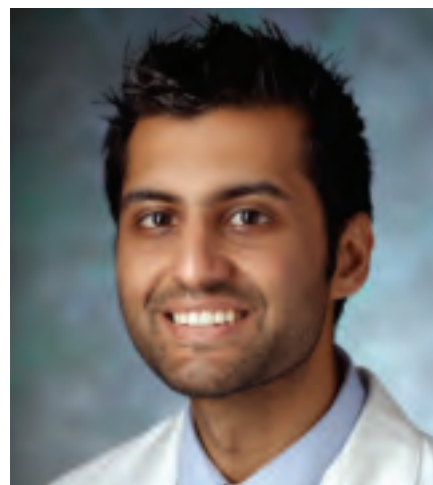
When it comes to patients, I do have a bit of a higher-pitched voice, and my mannerisms can be gender nonconforming. While it did make me the target of some cruel middle school humor, I've come to be proud of myself, mannerisms and all. That said, I have had patients make remarks to me about being gay, whether it be positive or negative. For LGBTQ patients, they're like, "this is great, I have a gay doctor. They'll know a bit more about what I'm talking about or be able to relate to the community pressures I face."

But sometimes homophobic patients can be a bit more cold. I've never had anyone say that they don't want to have me as their physician, but I definitely have patients who disagree with me and say, essentially, "oh well, you don't know what you're talking about because you're gay." Of course, there have also been comments based on my ethnicity as well.

What specific progress could you point to that you've seen over the

course of your training and your career so far with regard to LGBTQ health care workers' experience and LGBTQ patients?

When I was in college, there was a case in 2007 where a woman wasn't able to see her partner or children before dying in a Florida hospital.



Dr. Keshav Khanijow

Since then, there's been great strides with a 2011 executive order extending hospital visitation rights to LGBTQ families. In 2013, there was the legalization of same-sex marriage. More recently, in June 2020, the Supreme Court extended protections against workplace discrimination to LGBTQ employees.

But there are certain things that continue to be problems, such as the recent Final Rule from the Department of Health & Human Services that fails to protect our LGBTQ patients and friends against discrimination in health care.

Can you remember a specific episode with a patient who was in the LGBTQ community that was particularly satisfying or moving?

There are two that I think about. In medical school, I was working in a more conservative area of California, and there was a patient who identified as lesbian. She felt more able to talk about her fears of raising a family in a conservative area. She even said, "I feel you can understand the stuff, I can talk to you a bit more about it freely, which is really nice." Later on, I was able to see them on another rotation I was on, after she'd had a baby with her partner. I was honored that they considered me a part of their family's journey.

A couple years ago as an attending hospitalist, I had a gay male patient

that came in for hepatitis A treatment. Although we typically think of hepatitis A as a foodborne illness, oral-anal sex (rimming) is also a risk factor. After having an open discussion with him about his sexual practices, I said, "it was probably an STI in your case," and was able to give him guidelines on how to prevent giving it to anyone else during the recovery period. He was very appreciative, and I was glad to have been there for that patient.

What is SHM's role in regard to improving the care of LGBTQ patients, improving inclusiveness for LGBTQ health professionals?

Continuing to have educational activities, whether it be lectures at the annual conference or online learning modules, will be critical to care for our LGBTQ patients. With regard to membership, we need to make sure that hospitalists feel included and protected. To this end, our Diversity and Inclusion Special Interest Group was working toward having gender-neutral bathrooms and personal pronoun tags for the in-person 2020 annual conference before it was converted to an online format.

Does it ever get tiring for you to work on "social issues" in addition to strictly medical issues?

I will say I definitely experienced a moment in time during residency where I had to take a step back and recenter myself. Sometimes, realizing how much work needs to get done, coupled with the challenges of one's personal life, can be daunting. That said, I can only stare at a problem so long before needing to work on creating a solution. At the end of the day I didn't want to run away from these newfound problems of exclusion – I wanted to be a part of the solution.

In my hospital medicine fellowship, I was lucky to have Flora Kisuule, MD, SFHM, as a mentor who encouraged me to take my prior work with LGBTQ health and leverage it into hospital medicine projects. As such, I was able to combine a topic I was passionate about with my interests in research and teaching so that they work synergistically. After all, the social issues affect our medical histories, just as our medical issues affect our social being. They go hand in hand.



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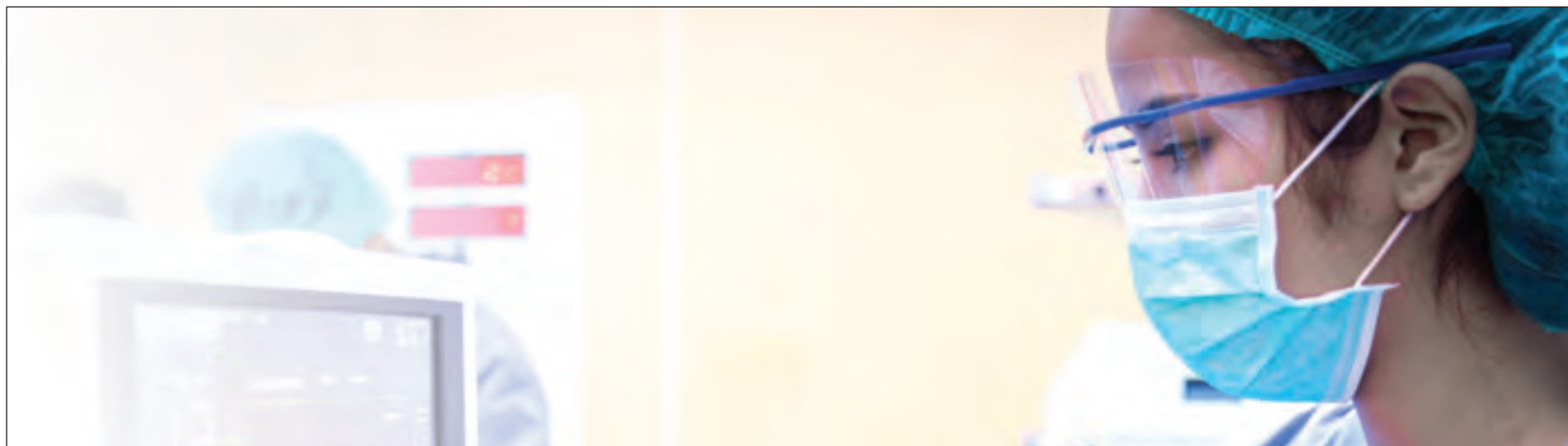
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Key Clinical Question

Serum cortisol testing for suspected adrenal insufficiency

Evaluating the hospitalized adult patient

By Lesley B. Gordon, MD, MS, and Elizabeth L. Herrle, MD

Case
A 45-year-old female with moderate persistent asthma is admitted for right lower-extremity cellulitis. She has hyponatremia with a sodium of 129 mEq/L and reports a history of longstanding fatigue and lightheadedness on standing. An early-morning serum cortisol was 10 mcg/dL, normal per the reference range for the laboratory. Has adrenal insufficiency been excluded in this patient?

Overview
Adrenal insufficiency (AI) is a clinical syndrome characterized by a deficiency of cortisol. Presentation may range from nonspecific symptoms such as fatigue, weight loss, and gastrointestinal concerns to a fulminant adrenal crisis with severe weakness and hypotension (Table 1). The diagnosis of AI is commonly delayed, negatively impacting patients' quality of life and risking dangerous complications. AI can occur because of diseases

of the adrenal glands themselves (primary) or impairment of adrenocorticotropin (ACTH) secretion from the pituitary (secondary) or corticotropin-releasing hormone (CRH) secretion from the hypothalamus (tertiary). In the hospital setting, causes of primary AI may include autoimmune disease, infection, metastatic disease, hemorrhage, and adverse medication effects. Secondary and tertiary AI would be of particular concern for patients with traumatic brain injuries or pituitary surgery, but also are seen commonly as a result of adverse medication effects in the hospitalized patient, notably opioids and corticosteroids through suppression the hypothalamic-pituitary-adrenal (HPA) axis and immune checkpoint inhibitors via autoimmune hypophysitis. Testing for AI in the hospitalized patient presents a host of challenges. Among these are the variability in presentation of different types of AI, high rates of exogenous corticoste-

roid use, the impact of critical illness on the HPA axis, medical illness altering protein binding of serum cortisol, interfering medications, the variation in assays used by laboratories, and the logistical challenges of obtaining appropriately timed phlebotomy.

Cortisol testing
An intact HPA axis results in ACTH-dependent cortisol release from the adrenal glands. Cortisol secretion exhibits circadian rhythm, with the highest levels in the early morning (6 a.m. to 8 a.m.) and the lowest at night (12 a.m.). It also is pulsatile, which may explain the range of "normal" morning serum cortisol observed in a study of healthy volunteers. Note that serum cortisol is equivalent to plasma cortisol in current immunoassays, and will henceforth be called "cortisol" in this paper. There are instances when morning cortisol may strongly suggest a diagnosis of AI on its own. A meta-analysis found that morning cortisol of <5 mcg/dL predicts AI and morning cortisol of >13 mcg/dL ruled out AI. The Endocrine Society of America favors dynamic assessment of adrenal function for most patients. Historically, the gold standard for assessing dynamic adrenal function has been the insulin tolerance test (ITT), whereby cortisol is measured after inducing hypoglycemia to a blood glucose <35 mg/dL. ITT is logistically difficult and poses some risk to the patient. The corticotropin (or cosyntropin) stim-

ulation test (CST), in which a supra-physiologic dose of a synthetic ACTH analog is administered parenterally to a patient and resultant cortisol levels are measured, has been validated against the ITT and is generally preferred. CST is used to diagnose primary AI as well as chronic secondary and tertiary AI, given that longstanding lack of ACTH stimulation causes atrophy of the adrenal glands. The sensitivity for secondary and tertiary AI is likely lower than primary AI especially in acute onset of disease. In performance of the CST a baseline cortisol and ACTH are obtained, with subsequent cortisol testing at 30 and/or 60 minutes after administration of the ACTH analog (Figure 1). Currently, there is no consensus for which time point is preferred, but the 30-minute test is more sensitive for AI and the 60-minute test is more specific.

CST is typically performed using a "standard high dose" of 250 mcg of the ACTH analog. There has been interest in the use of a "low-dose" 1-mcg test, which is closer to normal physiologic stimulation of the adrenal glands and may have better sensitivity for early secondary or partial AI. However, the 250-mcg dose is easier to prepare and has fewer technical pitfalls in administration as well as a lower risk for false-positive testing. At this point the data do not compellingly favor the use of low-dose CST testing in general practice.

Clinical decision-making
Diagnostic evaluation should be guided by the likelihood of the disease (i.e., the pretest probability) (Figure 1). Begin with a review of the patient's signs and symptoms, medical and family history, and medications with special consideration for opioids, exogenous steroids, and immune checkpoint inhibitors (Table 1). For patients with low pretest probability for AI, morning cortisol and ACTH is a reasonable first test (Figure 1). A cortisol value of 18 mcg/dL or greater does not support AI and no further testing is needed. Patients with morning cortisol of 13-18

Table 1. Key features that increase pretest probability of adrenal insufficiency

	Primary adrenal insufficiency	Secondary/tertiary adrenal insufficiency	Corticosteroid-induced adrenal insufficiency
Adrenal crisis (e.g., profound weakness, altered mental status, hypoglycemia, hypotension/shock)	↑	↑	↑
Symptoms			
Weakness, lethargy, easy fatigability, anorexia, nausea	↑	↑	↑
Salt craving	↑	-	-
Signs			
Hyperpigmentation	↑	-	-
Cushingoid features	-	-	↑
Hyponatremia	↑	↑	↑
Hyperkalemia	↑	-	-
Eosinophilia	↑	↑	-
Hypoglycemia	↑ (less common outside of crisis)	↑	↑
History			
Personal/family history of autoimmune disease	↑	-	-
Recent head trauma or intracranial surgery	-	↑	-
Medications			
Azole antifungals, metyrapone, mitotane, etomidate (impair cortisol synthesis)	↑	-	-
Mitotane, phenytoin, carbamazepine, St. John's wort (increase cortisol metabolism)	↑	↑	↑
Opioids	-	↑	-
Immune checkpoint inhibitor therapy	↑	↑	-
Any recent corticosteroid use	-	-	↑

Source: Dr. Gordon, Dr. Herrle

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mcg/dL could be followed clinically or could undergo further testing in the inpatient environment with CST, depending upon the clinical scenario. Patients with serum cortisol of <13 mcg/dL warrant CST.

For patients with moderate to high pretest probability for AI, we recommend initial testing with CST. While the results of high-dose CST are not necessarily impacted by time of day, if an a.m. cortisol has not yet been obtained and it is logistically feasible to do so, performing CST in the morning will provide the most useful data for clinical interpretation.

For patients presenting with possible adrenal crisis, it is essential not to delay treatment. In these patients, obtain a cortisol paired with ACTH and initiate treatment immediately. Further testing can be deferred until the time the patient is stable.

Potential pitfalls
Interpreting cortisol requires awareness of multiple conditions that could impact the results. (Table 2).

Currently available assays measure “total cortisol,” most of which is protein bound (cortisol-binding globulin as well as albumin). Therefore, conditions that lower serum protein (e.g., nephrotic syndrome, liver disease, inflammation) will lower the measured cortisol. Conversely, conditions that increase serum protein (e.g., estrogen excess in pregnancy and oral contraceptive use) will increase the measured cortisol.

It is important to recognize that existing immunoassay testing techniques informed the established cut-off for exclusion of AI at 18 mcg/dL. With newer immunoassays and emerging liquid chromatography/tandem mass spectrometry, this cut-

off may be lowered; thus the assay should be confirmed with the performing laboratory. There is emerging evidence that serum or plasma free cortisol and salivary cortisol testing for AI may be useful in some cases, but these techniques are not yet widespread or included in clinical practice guidelines.

Patients on exogenous steroids
Exogenous corticosteroids suppress the HPA axis via negative inhibition of CRH and ACTH release, often resulting in low endogenous cortisol levels which may or may not reflect true loss of adrenal function. Many corticosteroids will be detected by standard serum cortisol tests that rely on immunoassays. Cortisol measurement and CST should be done at least 18-24 hours after the last dose of exogenous steroids.

Although the focus has been on higher doses and longer courses of steroids (e.g., chronic use of ≥5 mg prednisone daily, or ≥20 mg prednisone daily for >3 weeks), there is increasing evidence that lower doses, shorter courses, and alternative routes (e.g., inhaled, intra-articular) can result in biochemical and clinical evidence of AI. Thus, a thorough history and exam should be obtained to determine all recent corticosteroid exposure and cushingoid features.

The data from the case
To effectively assess the patient for adrenal insufficiency, we need additional information, starting with a description of the patient’s current clinical status. If she is demon-



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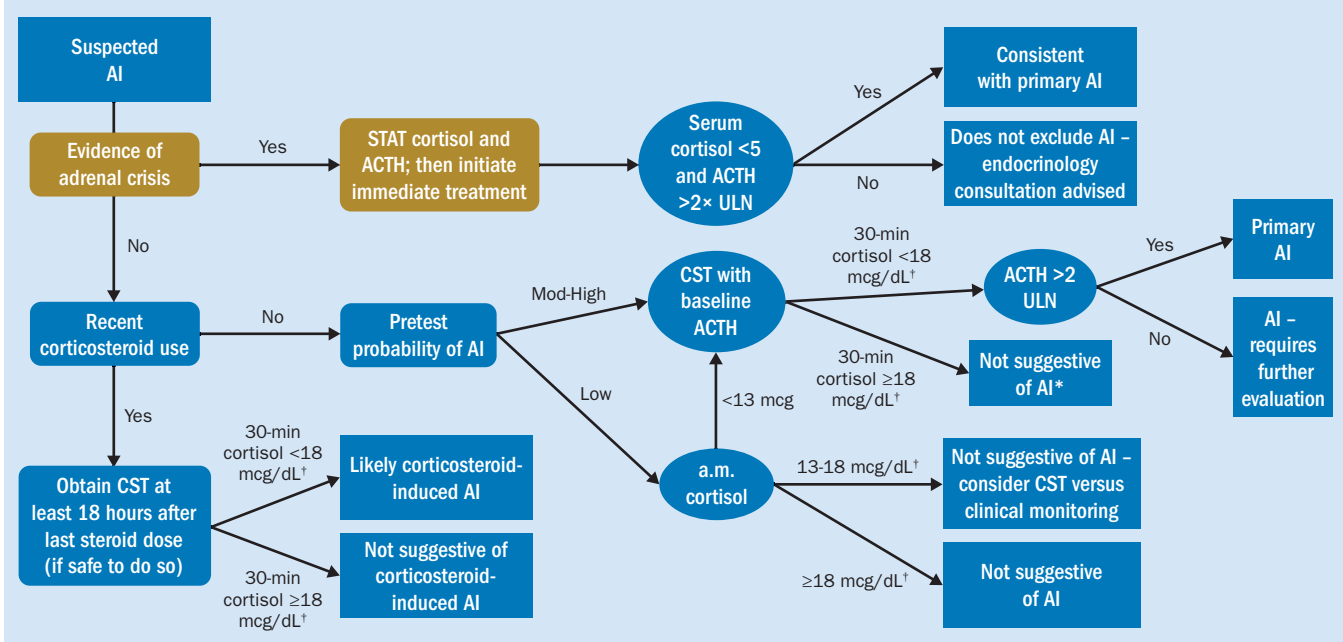
Table 2. Factors impacting reliability of total serum cortisol testing

Factor	Mechanism	Impact on cortisol level
Pregnancy and estrogen-containing oral contraceptives	Increased CBG levels	↑
Cirrhosis, nephrotic syndrome, inflammation, postop state	Decreased CBG and albumin levels	↓
Corticosteroid dose in last 24 hours (not dexamethasone)	Cross-reactivity with cortisol, thus detected by assay	↑
High-dose biotin	Interferes with some assays	↓
Time of day	Physiological diurnal variation of ACTH and cortisol release	Variable; recommend testing at 8 a.m.
Type of test	Variability between assay techniques (e.g., immunoassay, mass spectrometry)	May alter threshold for diagnosing AI

Note: CBG = cortisol-binding globulin; ACTH = adrenocorticotropic hormone; AI = adrenal insufficiency.

Source: Dr. Gordon, Dr. Herrle

Figure 1. Testing for adrenal insufficiency in the adult hospitalized patient



*Be aware that CST is more sensitive for primary adrenal insufficiency and may miss cases of secondary adrenal insufficiency (especially acute).

†Although ≥18 mcg/dL is the traditional cut-off to establish adrenal responsiveness, be aware that newer techniques (next-generation immunoassays and mass spectrometry) may lower this threshold (Bornstein et al 2016, El-Farhan et al 2017).

Note: CST = corticotropin stimulation test; ACTH = adrenocorticotropic hormone; ULN = upper limit of normal.

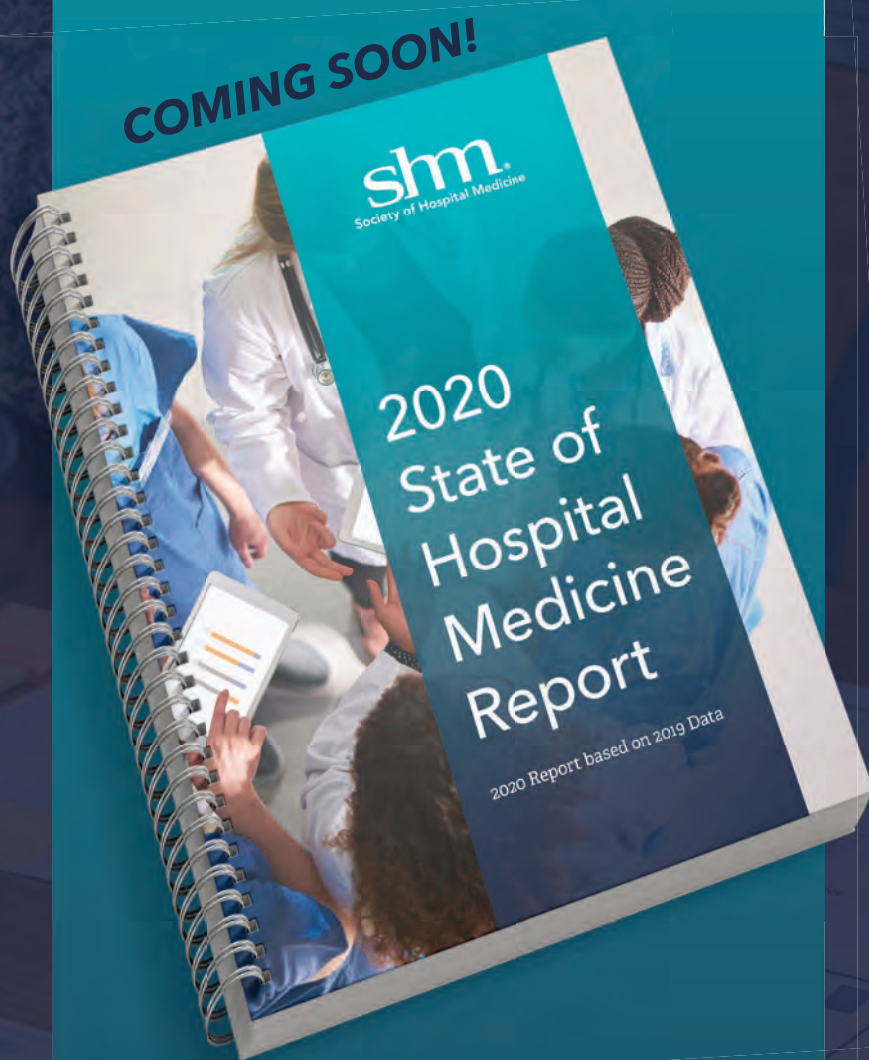
Source: Dr. Gordon, Dr. Herrle

strating evidence of adrenal crisis, treatment should not be delayed for additional testing. If she is stable, a history including use of corticosteroids by any route, pregnancy, oral contraceptives, recent surgery, and liver and kidney disease is essential.

Additional evaluation reveals the patient has been using her fluticasone inhaler daily. No other source of hyponatremia or lightheadedness is found. The patient’s risk factors of corticosteroid use and unexplained hyponatremia with associated lightheadedness increase her pretest probability of AI and a single morning cortisol of 10 mcg/dL is insufficient to exclude adrenal insufficiency. The appropriate follow-up test is a standard high-dose cosyntropin stimulation test at least 18 hours after her last fluticasone dose. A cortisol level > 18 mcg/dL at 30 minutes in the absence of other conditions that impact cortisol testing would not be suggestive of AI. A serum cortisol level of < 18 mcg/dL at 30 minutes would raise concern for abnormal adrenal reserve due to chronic corticosteroid therapy and warrants referral to an endocrinologist.

Bottom line
An isolated serum cortisol is often insufficient to exclude adrenal insufficiency. Hospitalists should be aware of the many factors that impact the interpretation of this test.

For a complete list of references, see the online version of this article at www.the-hospitalist.org.



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