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The Hospitalist

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Dr. Elizabeth Gundersen

Experts bring clarity to end-of-life difficulties

Understanding family perspective is an important factor

By Thomas R. Collins

A Vietnam veteran steered clear of the health care system for years, then showed up at the hospital with pneumonia and respiratory failure. He was whisked to the intensive care unit, and cancerous masses were found.

The situation – as described by Jeffrey Frank, MD, director of quality and performance at Vituity, a physician group in Emeryville, Calif. – then got worse.

"No one was there for him," Dr. Frank said. "He's laying in the ICU; he does not have the capacity to make decisions, let alone communicate. So the care team needs guidance."

Too often, hospitalists find themselves in confusing situations involving patients near the end of their lives, having to determine how to go about treating a patient or withholding treatment when patients are not in a position to announce their wishes. When family is present, the health care team thinks the most sensible course of treatment is at odds with what the family wants to be done.

At the Society of Hospital Medicine 2019 Annual Conference, hospitalists with palliative care training offered advice on how to go about handling these difficult situations, which can sometimes become more manageable with certain strategies.

For situations in which there is no designated representative to speak for a patient who is unresponsive – the so-called "unbefriended patient" or

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SURVEY INSIGHTS

Tresa Muir McNeal, MD, FACP, SFHM

LEADERSHIP

Leslie Flores, MHA, SFHM

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The QI pipeline supported by SHM Student Scholar Grants

By Emily Gottenborg, MD, and Ashley Duckett, MD, FHM

As fall arrives, new interns are rapidly gaining clinical confidence, and residency recruitment season is ramping up. It's also time to announce the opening of the Society of Hospital Medicine's Student Hospitalist Scholar Grant Program applications. We are now recruiting our sixth group of scholars for both the Summer and Longitudinal Programs.

Since its creation in 2015, the grant has supported 23 students in this incredible opportunity to allow trainees to engage in scholarly work with guidance from a mentor to better understand the practice of hospital medicine and to further grow our robust pipeline.

The 2018-2019 cohort of scholars, Matthew Fallon, Philip Huang, and Erin Rainosek, have just recently concluded their projects and are currently preparing their abstracts for submission for Hospital Medicine 2020, where there is a track for Early-Career Hospitalists.

The projects targeted a diverse set of domains, including improving upon the patient experience, readmission quality metrics, geographic cohorting, and clinical documentation integrity – all highly relevant topics for a practicing hospitalist.

Matthew Fallon collaborated with his mentor, Venkata Andukuri, MD, at Creighton University School of Medicine in Omaha, Neb., to reduce the rate of hospital readmission for patients with heart failure, by analyzing retrospective data in a root-cause analysis to identify factors that influence readmission rate, then targeting those directly. They also integrated the patient experience by seeking out patient input as to the challenges they face in the management of their heart failure.

Philip Huang worked with his mentor, Ethan Kuperman, MD, at the Carver College of Medicine, University of Iowa, to improve geographic localization for hospitalized patients to improve care efficiency. They worked closely with an industrial engineering team to create a workflow model integrated into the hospital EHR to designate patient location and were able to better understand the role that other professions play in improving the health care delivery.

Finally, Erin Rainosek teamed up with her mentor, Luci Leykum, MD, at the University of Texas Health Science Center at San Antonio, to apply a design thinking strategy to redesign the health care experience for hospitalized patients. She engaged in over 120 hours of patient interviews and ultimately identified key themes that impact the experience of care, which will serve as target areas moving forward.

The student scholars in this cohort gained significant insight into the patient experience and quality issues relevant to the field of hospital medicine. We are proud of their accomplishments and look forward to their future successes and careers in hospital medicine.

If you would like to learn more about the experience of our scholars this past summer, they have posted full write-ups on the Future Hospitalist RoundUp blog in HMX, SHM's online community.

For students interested in becoming scholars, SHM offers two options to eligible medical students – the Summer Program and the Longitudinal Program. Both programs allow students to participate in projects related to quality improvement, patient safety, clinical research, or hospital operations, in order to learn more about career paths in hospital medicine. Students will have the opportunity to conduct scholarly work with a mentor in these domains, with the option of participating over the summer during a 6- to 10-week period or longitudinally throughout the course of a year.

Discover additional benefits and how to apply on the SHM website. Applications will close in late January 2020.

Dr. Gottenborg is director of the Hospitalist Training Program within the Internal Medicine Residency Program at the University of Colorado. Dr. Duckett is assistant professor of medicine at the Medical University of South Carolina.

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Unit-based rounding in the real world

Balance and flexibility are essential

By Tresa Muir McNeal, MD, FACP, SFHM

Many hospitalists agree that their most productive and also sometimes least productive work can happen in the setting of interdisciplinary rounds. How can this paradox be true?

Most hospitals strive to assemble the health care team every day for a brief discussion of each patient's needs as well as barriers to a safe/successful discharge. On most floors this requires a well-choreographed "dance" of nurses, case managers, social workers, physicians, and advanced practice providers coming together at agreed-upon times. All team members commit to efficient synchronized swimming through the most high-yield details for each patient in order to benefit the patients and families being served.

Of course, there are always challenges to this process in the unpredictable world of patients with acute needs. One variable that is at least partially controllable and tends to promote a more cohesive interdisciplinary experience is that of hospitalist unit-based rounding.

The 2018 *State of Hospital Medicine* (*SoHM*) survey reveals that 68% of hospital medicine groups serving adults with greater than 30 physicians employ some degree of unit-based rounding; this trend decreases with smaller group size. About 54% of academic hospital medicine groups use some amount of unit-based rounding. Not surprisingly, smaller hospital medicine groups are less likely to have this routine, likely because they cover fewer total nursing units.

One of the most obvious benefits to unit-based rounding is that the physician or advanced practice

provider is more reliably able to participate in the interdisciplinary discussions that day. When more of the team members are at the table each day, patients and families have the best chance of hearing a consistent message around the treatment and discharge plans.

There are challenges to unit-based rounding as well. If patients transfer to different floors for any variety of reasons, strict unit-based rounding may increase handoffs in care. If a hospital has times when it isn't completely full and nursing units have a varying percentage of being occupied, strict unit-based rounding can cause significant workload inequities among physicians on different units, depending on numbers of patients on each unit.

If there is no attempt at unit-based rounding in larger hospitals, some physicians may be running among five or more units. They work to find different care managers, nurses, and pharmacists – not to mention the challenges of catching patients in their rooms between their departures for diagnostic studies and procedures.

It is often good to balance the benefit of promoting unit-based rounds with the reality of everyday patient care. Some groups maintain that the physician/patient relationship trumps the idea of perfect unit-based rounding. In other words, if a physician establishes a relationship with a patient while they are in the ED being admitted or boarding from overnight, that physician will continue seeing the patient regardless of the patient being assigned to a different unit. It can help for groups to agree that the pursuit of unit-based rounding may create some inequity in the numbers of patients seen each day because of these issues.

In a larger hospital, certain units are often dedicated to specialty care. While most hospitalists want to maintain general medical knowledge, there are some who may enjoy having portions of their practice devoted to perioperative medicine or cardiac care, for instance. This promotes familiarity among hospitalists and groups of consultant physicians and nurse practitioners/physician assistants. Over time this allows for enhanced teamwork among those physicians, the nursing team, and the specialty physicians.

Depending on the group's schedule, patients can be reassigned coinciding with the primary change of service day. This resets the physicians' patients in the most ideal unit-based way on the evening prior to the first day of rounding for that week or group of shifts.

No matter how you do it, the goal of unit-based rounding is time efficiency for the care team and care coordination benefits for patients and families. If you have other suggestions or questions, go online to SHM HMX to join the discussion.

Take-home message: Unit-based rounding likely has its benefits. Don't let the inability to achieve perfection in patient distribution to the physicians each day lead to abandonment of attempting these processes.

Dr. McNeal is the division director of inpatient medicine at Baylor Scott & White Medical Center in Temple, Tex.

Choosing Wisely® and its impact on low-value care

Focus energy on 'low-hanging fruit'

By Moises Auron, MD, SFHM

It is a well-known fact that health care expenditure in the United States occupies a large proportion of its gross domestic product. In fact, it was 17.8% in 2016, almost twice what is expended in other advanced countries. However, this expenditure does not necessarily translate into optimal patient outcomes.

In 2012, the Institute of Medicine reported that the U.S. health care system wastes $750 billion per year in spending that does not provide any meaningful outcome to patients or the system; and patients can also suffer a financial impact from the delivery of low-value care.

In 2013, the Pediatrics Committee of the Society of Hospital Medicine published five recommendations through the Choosing Wisely® campaign aimed to decrease the use of low-value interventions. These recommendations were:

1. Do not order chest radiographs (CXR) in children with asthma or bronchiolitis.
2. Do not use systemic corticosteroids in children aged under 2 years with a lower respiratory tract infection.
3. Do not use bronchodilators in children with bronchiolitis.
4. Do not treat gastroesophageal reflux in infants routinely with acid suppression therapy.
5. Do not use continuous pulse oximetry routinely in children with acute respiratory illness unless they are on supplemental oxygen.

This publication led to the implementation of quality improvement initiatives across different hospitals and institutions nationally. Eventually, a team of hospitalists developed a report card that could help measure the utilization of these interventions in hospitals that were part of the Children's Hospital Association (CHA). The data stemming from the report card analysis would allow for benchmarking and comparing performance, as well as determining the secular trend in utilization of these procedures across the different institutions of the CHA.

Reyes et al. recently published the impact of utilization of these scorecards among all hospital members of the CHA in the Journal of Hospital Medicine, noting a positive impact of the SHM Choosing Wisely® recommendation in decreasing the utilization of low-value interventions. The

Continued on following page

Have lower readmission rates led to higher mortality for patients with COPD?

By Christopher Moriates, MD, SFHM

There is at least one aspect of "Obamacare" that my mother-in-law and I can agree on: Hospitals should not get paid for frequent readmissions.

The Hospital Readmission Reduction Program (HRRP), enacted by the Centers for Medicare & Medicaid Services in 2012 with the goal of penalizing hospitals for excessive readmissions, has great face validity and noble intentions. Does it also have a potentially disastrous downside?

The HRRP has been a remarkable success. It moved the national needle significantly on readmission rates. There are some caveats about increases in observation status patients and other shifts that could account for some of the difference, but it is fairly uncontroversial that, overall, there are fewer 30-day readmissions across the country following initiation of HRRP. That is encouraging evidence of the positive impact that policy can make to drive changes for specific targets.

However, there is also a more controversial side. A number of studies have suggested reductions in readmission rates may have been associated with an increase in mortality in some patient groups. You discharge a patient and hope they won't return to the hospital, but perhaps you should be more careful what you actually wish for.

Overall, the evidence of an association between readmissions and mortality has been conflicting. Headlines have alternately raised alarm about increased deaths and then reassured that there has been no change or perhaps even some concordant improvements in mortality. Not necessarily surprising: These studies are all of observational design and use different criteria, datasets, and analytic models, which drive their seemingly conflicting results.


Dr. Moriates

An article published recently in the *Journal of Hospital Medicine* examined the potential association between changes in rates of chronic obstructive pulmonary disease (COPD) readmissions and 30-day mortality following HRRP introduction. While the initial HRRP program and subsequent analyses included patients with heart failure, acute MI, and pneumonia, the program was extended in 2014 to include patients with COPD. So, what happened in this patient group?

The researchers seem to have found some important insights:

- The all-cause 30-day risk-standardized readmission rate declined from 2010 to 2017.
- The all-cause 30-day risk-standardized mortality rate increased from 2010 to 2017, and the rate of increase in mortality appears to be accelerating.
- Hospitals with higher readmission rates prior to COPD readmission penalties had a lower rate of increase in mortalities.
- Hospitals that had a larger decrease in readmission rates had a larger rate of increase in mortality.

These researchers could not evaluate data at the patient level and could not adjust for changes in disease severity. However, taken together, these findings suggest something bad may be happening here.

The authors note that the associations with increased mortality have largely been seen in patients with heart failure – and now COPD – which are chronic diseases characterized by exacerbations, as opposed to acute MI and pneumonia, which are episodic and treatable. Perhaps in those types of disease, efforts to avoid readmissions may be more universally helpful. Maybe.

I find it concerning that there is "biological plausibility" for this association. Hospitalists know exactly how this might have happened. Have you heard of pop-up alerts that fire in the ED to let physicians know that this patient was discharged within the past 30 days? That alert is not meant to tell you what to do, but you might want to consider trying to discharge them or place them in observation – use your clinical judgment, if you know what I mean.

Within the past decade, observation units quickly cropped up all over the country, often not staffed by hospitalists nor cardiologists, where patients with decompensated heart failure, chest pain, and/or COPD, can be given Lasix and/or nebulizer treatments – at least just enough to let them walk back out that door without an admission.

As Ashish Jha, MD, wrote in 2018, "Right now, a high-readmission, low-mortality hospital will be penalized at 6-10 times the rate of a low-readmission, high-mortality hospital. The signal from policy makers is clear – readmissions matter a lot more than mortality – and this signal needs to stop."

Dr. Moriates is the assistant dean for health care value at Dell Medical School at the University of Texas, Austin. This article first appeared on the Hospital Leader, SHM's official blog, at hospitalleader.org.

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authors compared the performance before and after the publication of the recommendations for a 9-year period (2008-2017). The most relevant impact occurred in children with bronchiolitis, with a decrease of 36% of bronchodilator use and of 31% in CXR utilization. In children with asthma, CXR utilization decreased by 20.8%. The authors found that, although there was a steady decrease in the utilization of low-value services, this was still limited.

What factors could impact the effectiveness of high-value quality initiatives? First of all, quality improvement requires a substantial investment of collective effort and time. It requires a change in culture that often involves changing longstanding paradigms. The Choosing Wisely® recommendations target a very specific, low-clinical-severity population – the focus is on "uncomplicated" disease. This is important as you don't want to pursue aggressive unnecessary intervention in children and potentially cause harm – for example, unnecessary use of steroids in a child with uncomplicated bronchiolitis who may improve with nasal suctioning alone. There is a need to appraise patients with more complex presentation of these diseases (for example, patients that require escalation of care to ICU), and this is beyond the scope of Choosing Wisely®. Further research is needed to see if higher-value care interventions can be implemented among these higher acuity and severity patients.


Dr. Auron

In our institution, we have created specific care paths that facilitate following these recommendations. Essentially, we have leveraged the EHR order sets to avoid the inclusion of low-value interventions; all stakeholders (respiratory therapy, nursing, etc.) are aware of the care path and ensure compliance. Even further, as a consequence of the change in culture toward high-value care, we have identified low-value interventions in settings where high-value quality improvement can be implemented – for example, we found that at least 20% of noncritically ill children undergoing an appendectomy receive unnecessary antacid prophylaxis treatment.

Changes always start small; quality improvement requires a lot of effort, and we must focus our energy on "low-hanging fruit," and also begin tackling higher complexity tasks. In the Choosing Wisely® manuscript cited above, the authors found that there was a change in performance with a tendency toward higher-value care, yet the change was not as substantial as originally thought.

How can we tackle higher complexity tasks if we find it difficult to implement solutions for those of lower complexity? My answer is simple. Maintain a consistent and continuous focus on high value, and ensure the message is iterative and redundant with feedback on performance, decrease in costs, and enhanced patient outcomes.

Dr. Auron is the quality improvement and patient safety officer in the department of hospital medicine at the Cleveland Clinic. He also serves as associate professor of medicine and pediatrics in the staff department of hospital medicine and department of pediatric hospital medicine. This article first appeared on the Hospital Leader, SHM's official blog, at hospitalleader.org.

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Palliative care

Continued from page 1

"unrepresented patient" – any source of information can be valuable. And health care providers should seek out this input, Dr. Frank said.

"When there is a visitor at the bedside, and as long as they know the person, and they can start giving the medical providers some information about what the patient would have wanted, most of us will talk with that person and that's actually a good habit," he said.

Thirty-nine states and the District of Columbia have regulations on whom health care providers should talk to when there is no obvious representative, Dr. Frank said, noting that most of these regulations follow a classic family-tree order. But in the discouraging results of many surveys of health care providers on the subject, most clinicians say that they do not know the regulations in their state, Dr. Frank said.

But he said such results betray a silver lining because clinicians say that they would be inclined to use a family tree–style hierarchy in deciding with whom they should speak about end-of-life decisions.

Hospitalists should at least know whether their hospital has a policy on unrepresented patients, Dr. Frank said.

"That's your road map on how to get through consenting this patient – what am I going to do with Mr. Smith?" he said. "You may ask yourself, 'Do I just keep treating him and treating him?' If you have a policy at your hospital, it will protect you from liability, as well as give you a sense of process."

> *"Words matter. Inappropriate language can inadvertently convey the feeling that, 'They're giving up on my dad – they think it's hopeless.' That can make families and the medical team dig in their heels further."*
>
> —Dr. Gundersen

Conflicts in communication

An even worse situation, perhaps, is one that many hospitalists have seen: A patient is teetering at the edge of life, and a spouse arrives, along with two daughters from out of state who have not seen their father in a year, said Elizabeth Gundersen, MD, director of the ethics curriculum at Florida Atlantic University, Boca Raton.

"The family requests that the medical team do everything, including intubation and attempts at resuscitation if needed," she said. "The family says he was fine prior to this admission. Another thing I hear a lot is, 'He was even sicker than this last year, and he got better.'"

Meanwhile, "the medical team consensus is that he is not going to survive this illness," Dr. Gundersen said.

The situation is so common and problematic that it has a name – the "Daughter from California Syndrome." (According to medical literature, it's called the "Daughter from Chicago Syndrome" in California.)

"This is one of the most agonizing things that happens to us in medicine," Dr. Gundersen said. "It affects us, it affects our nurses, it affects the entire medical team. It's agonizing when we feel like treatment has somehow turned to torture."

Dr. Gundersen said the medical staff should avoid using the word "futile," or similar language, with families.

"Words matter," she said. "Inappropriate language can inadvertently convey the feeling that, 'They're giving up on my dad – they think it's hopeless.' That can make families and the medical team dig in their heels further."

Sometimes it can be hard to define the terms of decision making. Even if the family and the medical team can agree that no "nonbeneficial treatments" should be administered, Dr. Gundersen said, what exactly does that mean? Does it mean less than a 1% chance of working; less than a 5% chance?

If the medical staff thinks a mode of care won't be effective, but the family still insists, some states have laws that could help the medical team. In Texas, for example, if the medical team thinks the care they're giving isn't helping the patient, and the patient is likely going to have a poor outcome, there's a legal process that the team can go through, Dr. Gundersen said. But even these laws are seen as potentially problematic because of concerns that they put too much power in the hands of a hospital committee.

Dr. Gundersen strongly advised getting at the root causes of a family's apprehension. They might not have been informed early enough about the dire nature of an illness to feel they can make a decision comfortably. They also may be receiving information in a piecemeal manner or information that is inconsistent. Another common fear expressed by families is a concern over abandonment by the medical team if a decision is made to forgo a certain treatment. Also, sometimes the goals of care might not be properly detailed and discussed, she said.

But better communication can help overcome these snags, Dr. Gundersen said.

She suggested that sometimes it's helpful to clarify things with the family, for example, what do they mean by "Do everything"?

"Does it mean 'I want you to do everything to prolong their life even if they suffer,' or does it mean 'I want you do to everything that's reasonable to try to prolong their life but not at the risk of increased suffering,' or anywhere in between. Really just having these clarifying conversations is helpful."

She also emphasized the importance of talking about interests, such as not wanting a patient to suffer, instead of taking positions, such as flatly recommending the withdrawal of treatment.

"It's easy for both sides to kind of dig in their heels and not communicate effectively," Dr. Gundersen said.

'Emotional torture'

There are times when, no matter how skillfully the medical team communicates, they stand at an impasse with the family.

"This is emotional torture for us," Dr. Gundersen said. "It's moral distress. We kind of dread these situations. In these cases, trying to support yourself and your team emotionally is the most important thing."

SDI Productions/Getty Images

Ami Doshi, MD, director of palliative care inpatient services at Rady Children's Hospital in San Diego, described the case of a baby girl that touched on the especially painful issues that can arise in pediatric cases. The 2-month-old girl had been born after a pregnancy affected by polyhydramnios and had an abnormal neurological exam and brain MRI, as well as congenital abnormalities. She'd been intubated for respiratory failure and was now on high-flow nasal cannula therapy. The girl was intolerant to feeding and was put on a nasojejunal feeding tube and then a gastrostomy-jejunostomy tube.

But the baby's vomiting continued, and she had bradycardia and hypoxia so severe she needed bag mask ventilation to recover. The mother started to feel like she was "torturing" the baby.

The family decided to stop respiratory support but to continue artificial nutrition and hydration, which Dr. Doshi said, has an elevated status in the human psyche. Mentioning discontinuing feeding is fraught with complexity, she said.

"The notion of feeding is such a basic instinct, especially with a baby, that tackling the notion of discontinuing any sort of feeds, orally or tube feeds, is fraught with emotion and angst at times," Dr. Doshi said.

The girl had respiratory events but recovered from them on her own, but the vomiting and retching continued. Eventually the artificial nutrition and hydration was stopped. But after 5 days, the medical staff began feeling uncomfortable, Dr. Doshi said. "We're starting to hear from nurses, doctors, other people, that something just doesn't feel right about what's happening: 'She seems okay,' and, 'Is it really okay for us to be doing this?' and 'Gosh, this is taking a long time.' "

"When there is a visitor at the bedside, and as long as they know the person, and they can start giving the medical providers some information about what the patient would have wanted, most of us will talk with that person."

—Dr. Frank

The medical staff had, in a sense, joined the family on the emotional roller coaster.

Dr. Doshi said it's important to remember that there is no ethical or moral distinction between withdrawing a medical intervention and withholding one.

"Stopping an intervention once it has started is no different ethically or legally than not starting it in the first place," she said.

According to Dr. Doshi, there is a consensus among medical societies that artificial nutrition and hydration is a medical intervention just like any other and that it should be evaluated within the same framework: Is it overly burdensome? Are we doing harm? Is it consistent with the goal of care? In so doing, be sure to respect patient autonomy and obtain informed consent.

As with so much in medicine, careful communication is a must.

"Paint a picture of what the patient's trajectory is going to look like with and without artificial nutrition and hydration. At the end of the day, having done all of that, we're going to ultimately respect what the patient or the surrogate decision maker decides," Dr. Doshi said.

After assessment of the data and the chances of success, and still without clarity about how to proceed, a good option might be considering a "time-limited trial" in which the medical team sits with the family and agrees on a time frame for an intervention and chooses predetermined endpoints for assessing success or failure.

"This can be very powerful to help us understand whether it is beneficial, but also – from the family's perspective – to know everything was tried," Dr. Doshi said.

Hospitalists should emphasize what is being added to treatment so that families don't think only of what is being taken away, she said.

"Usually we are adding a lot – symptom management, a lot of psychosocial support. So what are all the other ways that we're going to continue to care for the patient, even when we are withdrawing or withholding a specific intervention?" Dr. Doshi noted.

Sometimes, the best healer of distress in the midst of end-of-life decision making is time itself, Dr. Gundersen said.

In a condolence call, she once spoke with a family member involved in an agonizing case in which the medical team and family were at odds. Yet the man told her: "I know that you all were telling us the entire time that this was going to happen, but I guess we just had to go through our own process."

The branching tree of hospital medicine

Diversity of training backgrounds

By Alan M. Hall, MD; Pallabi Sanyal-Dey, MD; Dennis Chang, MD, FHM; Brian Kwan, MD, FHM; Patricia Seymour, MD, MS, FAAFP, FHM


Dr. Hall


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Dr. Seymour

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You've probably heard of a "nocturnist," but have you ever heard of a "weekendist?"

The field of hospital medicine (HM) has evolved dramatically since the term "hospitalist" was introduced in the literature in 1996.[1] There is a saying in HM that, "if you know one HM program, you know one HM program," alluding to the fact that every HM program is unique. The diversity of individual HM programs combined with the overall evolution of the field has expanded the range of jobs available in HM.

The nomenclature of adding an -ist to the end of the specific roles (e.g., nocturnist, weekendist) has become commonplace. These roles have developed with the increasing need for day and night staffing at many hospitals secondary to increased and more complex patients, less availability of residents because of work hour restrictions, and the Accreditation Council for Graduate Medical Education (ACGME) rules that require overnight supervision of residents

Additionally, the field of HM increasingly includes physicians trained in internal medicine, family medicine, pediatrics, and medicine-pediatrics (med-peds). In this article, we describe the variety of roles available to trainees joining HM and the multitude of different training backgrounds hospitalists come from.

Nocturnists

The 2018 *State of Hospital Medicine* Report notes that 76.1% of adult-only HM groups have nocturnists, hospitalists who work primarily at night to admit and to provide coverage for admitted patients.[2] Nocturnists often provide benefit to the rest of their hospitalist group by allowing fewer required night shifts for those that prefer to work during the day.

Nocturnists may choose a nighttime schedule for several reasons, including the ability to be home more during the day. They also have the potential to work fewer total hours or shifts while still earning a similar or increased income, compared with predominantly daytime hospitalists, increasing their flexibility to pursue other interests. These nocturnists become experts in navigating the admission process and responding to inpatient emergencies often with less support when compared with daytime hospitalists.

> *"Internal medicine hospitalists may be the most common hospitalists encountered in many hospitals and at each Society of Hospital Medicine annual conference, but there has also been rapid growth in hospitalists from other specialties and backgrounds."*

In addition to career nocturnist work, nocturnist jobs can be a great fit for those residency graduates who are undecided about fellowship and enjoy the acuity of inpatient medicine. It provides an opportunity to hone their clinical skill set prior to specialized training while earning an attending salary, and offers flexible hours which may allow for research or other endeavors. In academic centers, nocturnist educational roles take on a different character as well and may involve more 1:1 educational experiences. The role of nocturnists as educators is expanding as ACGME rules call for more oversight and educational opportunities for residents who are working at night.

However, challenges exist for nocturnists, including keeping abreast of new changes in their HM groups and hospital systems and engaging in quality initiatives, given that most meetings occur during the day. Additionally, nocturnists must adapt to sleeping during the day, potentially getting less sleep then they would otherwise and being "off cycle" with family and friends. For nocturnists raising children, being off cycle may be advantageous as it can allow them to be home with their children after school.

Weekendists

Another common hospitalist role is the weekendist, hospitalists who spend much of their clinical time preferentially working weekends. Similar to nocturnists, weekendists provide benefit to their hospitalist group by allowing others to have more weekends off.

Weekendists may prefer working weekends because of fewer total shifts or hours and/or higher compensation per shift. Additionally, weekendists have the flexibility to do other work on weekdays, such as research or another hospitalist job. For those that do nonclinical work during the week, a weekendist position may allow them to keep their clinical skills up to date. However, weekendists may face intense clinical days with a higher census because of fewer hospitalists rounding on the weekends.

Weekendists must balance having more potential time available during the weekdays but less time on the weekends to devote to family and friends. Furthermore, weekendists may feel less engaged with nonclinical opportunities, including quality improvement, educational offerings, and teaching opportunities.

SNFists

With increasing emphasis on transitions of care and the desire to avoid readmission penalties, some hospitalists have transitioned to work partly or primarily in skilled nursing facilities (SNF) and have been referred to as "SNFists." Some of these hospitalists may split their clinical time between SNFs and acute care hospitals, while others may work exclusively at SNFs.

SNFists have the potential to be invaluable in improving transitions of care after discharge to post–acute care facilities because of increased provider presence in these facilities, comfort with medically complex patients, and appreciation of government regulations.[3] SNFists may face potential challenges of needing to staff more than one post–acute care hospital and of having less resourc-

es available, compared with an acute care hospital.

Specific specialty hospitalists

For a variety of reasons including clinical interest, many hospitalists have become specialized with regards to their primary inpatient population. Some hospitalists spend the majority of their clinical time on a specific service in the hospital, often working closely with the subspecialist caring for that patient. These hospitalists may focus on hematology, oncology, bone-marrow transplant, neurology, cardiology, surgery services, or critical care, among others. Hospitalists focused on a specific service often become knowledge experts in that specialty. Conversely, by focusing on a specific service, certain pathologies may be less commonly seen, which may narrow the breadth of the hospital medicine job.

Hospitalist training

Internal medicine hospitalists may be the most common hospitalists encountered in many hospitals and at each Society of Hospital Medicine annual conference, but there has also been rapid growth in hospitalists from other specialties and backgrounds.

Family medicine hospitalists are a part of 64.9% of HM groups and about 9% of family medicine graduates are choosing HM as a career path.[2,4] Most family medicine hospitalists work in adult HM groups, but some, particularly in rural or academic settings, care for pediatric, newborn, and/or maternity patients. Similarly, pediatric hospitalists have become entrenched at many hospitals where children are admitted. These pediatric hospitalists, like adult hospitalists, may work in a variety of different clinical roles including in EDs, newborn nurseries, and inpatient wards or ICUs; they may also provide consult, sedation, or procedural services.

Med-peds hospitalists that split time between internal medicine and pediatrics are becoming more commonplace in the field. Many work at academic centers where they often work on each side separately, doing the same work as their internal medicine or pediatrics colleagues, and then switching to the other side after a period of time. Some centers offer unique roles for med-peds hospitalists including working on adult consult teams in children's hospitals, where they provide consult care to older patients that may still receive their care at a children's hospital. There are also nonacademic hospitals that primarily staff med-peds hospitalists, where they can provide the full spectrum of care from the newborn nursery to the inpatient pediatric and adult wards.

Hospital medicine is a young field that is constantly changing with new and developing roles for hospitalists from a wide variety of backgrounds. Stick around to see which "-ist" will come next in HM.

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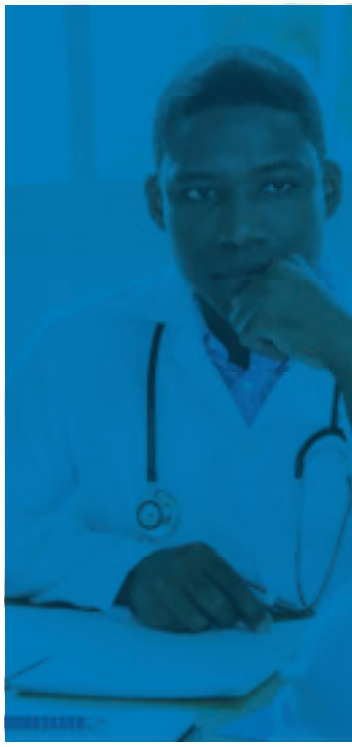
Key Clinical Question

A novel communication framework for inpatient pain management

Introducing the VIEW Framework

By Sarah Horman, MD, and Sarah Richards, MD



HISPANOLISTIC/GETTY IMAGES

Case

A 55-year-old male with a history of diabetes mellitus, lumbar degenerative disc disease, and chronic low back pain was admitted overnight with right lower extremity cellulitis. He reported taking oral hydromorphone for chronic pain, but review of the Prescription Drug Monitoring Program (PDMP) revealed multiple short-term prescriptions from various ED providers, as well as monthly prescriptions from a variety of primary care providers.

Throughout the EHR, he is described as manipulative and narcotic-seeking with notation of multiple ED visits for pain. Multiple discharges against medical advice were noted. He was given two doses of IV hydromorphone in the ED and requested that this be continued. He was admitted for IV antibiotics for severe leg pain that he rated 15/10.

Background

The Society of Hospital Medicine published a consensus statement in the Journal of Hospital Medicine in 2018 that included 16 clinical recommendations on the safe use of opioids for the treatment of acute pain in hospitalized adults.[1] In regard to communication about pain, clinicians are encouraged to set realistic goals and expectations of opioid therapy, closely monitor response to opioid therapy, and provide education about the side effects and potential risks of opioid therapy for patients and their families.

However, even when these strategies are employed, the social and behavioral complexities of individual patients can contribute to unsatisfactory interactions with health care staff. Because difficult encounters have been linked to provider burnout, enhanced communication strategies can benefit both the patient and physician.[2]

SHM's Patient Experience Committee saw an opportunity to provide complementary evidence-based best-practice tips for communication about pain. Specifically, the committee worked collectively to develop a framework that can be applied to more challenging encounters.

The VIEW Framework

VISIT *the patient's chart and your own mental state.*

First, visit the patient's chart to review information relevant to the patient's pain history. The EHR can be leveraged through filters and search functions to identify encounters, consultations, and notes relevant to pain management.

Look at the prior to admission medication list and active medication list and see if there are discrepancies. The medication administration record (MAR) can help identify adjunctive medications that the patient may be refusing. PDMP data should be screened for signs of aberrant use, including multiple pharmacies, multiple prescribers, short intervals between prescriptions, and serially prescribed, multiple, low-quantity prescriptions.

While documented pain scores can be a marker of patient distress, objective aspects of the patient's functional status can shed light on how much his/her discomfort impairs day-to-day living. Examples of these measures include nutritional intake, sleep cycle, out of bed activity, and participation with therapy. Lastly, assess for opioid-related side effects including constipation, decreased respiratory rate, and any notation of over sedation in narrative documentation from ancillary services.

Once this information has been accrued, it is important to take a moment of mindfulness before meeting with the patient. Take steps to minimize interruptions with electronic devices by silencing your pager/cell phone and disengaging from computers/tablets. Some examples of mindfulness-based practices include taking cycles of deep breathing, going for a short walk to appreciate hospital artwork or view points, or focusing on the sensory aspects of washing your hands prior to seeing the patient. Self-reflection on prior meaningful encounters can also help reset your state of mind. These activities can help clear prior subconscious thoughts and frustrations and prepare for the task ahead of you.[3]

Intense focus and awareness can enhance your recognition of patient distress, increase your ability to engage in active listening, and enable you to be more receptive to verbal and nonverbal cues.[2] Additionally, mindful behaviors have been shown to contribute to decreased burnout and improved empathy.[4,5]

INTERVIEW *the patient.*

Once you enter the room, introduce yourself to the patient and others who are present. Interview the patient by eliciting subjective information. Use open-ended and nonjudgmental language, and take moments to summarize the patient's perspective.

Inquire about the patient's home baseline pain scores and past levels of acceptable function. Further explore the patient's performance goals related to activities of daily living and quality of life. Ask about any prior history of addiction to any substance, and if needed, discuss your specific concerns related to substance misuse and abuse.

Dr. Horman

Dr. Richards

Dr. Horman is a hospitalist and assistant professor of medicine at UC San Diego Health. Dr. Richards is a hospitalist and assistant professor of medicine at the University of Nebraska Medical Center in Omaha. Dr. Horman and Dr. Richards note that they wrote this article in collaboration with the Society of Hospital Medicine Patient Experience Committee.

EMPATHIZE *with the patient.*

Integrate empathy into your interview by validating any frustrations and experience of pain. Identifying with loss of function and quality of life can help you connect with the patient and initiate a therapeutic relationship. Observe both verbal and nonverbal behaviors that reveal signs of emotional discomfort.[6] Use open-ended questions to create space and trust for patients to share their feelings.

Pause to summarize the patient's perspective while acknowledging and validating emotions that he or she may be experiencing such as anxiety, fear, frustration, and anger.[6] Statements such as " I know it is frustrating to ... " or "I can't imagine what it must feel like to ... " can help convey empathy. Multiple studies have suggested that enhanced provider empathy and positive messaging can also reduce patient pain and anxiety and increase quality of life.[7,8] Empathic responses to negative emotional expressions from patients have also been associated with higher ratings of communication.[9]

Finally, ***WRAP UP*** by aligning expectations with the patient for

pain control and summarize your management recommendations. Educate the patient and his/her family on the risks and benefits of recommended therapy as well as the expected course of recovery. Setting shared goals for functionality relevant to the patient's personal values and quality of life can build connection between you and your patient.

While handing over the patient to the next provider, refrain from using stereotypical language such as "narcotic-seeking patient." Clearly communicate the management plan and milestones to other team members, such as nurses, physical therapists, and oncoming hospitalists, to maintain consistency.

This will help align patients and their care team and may stave off maladaptive patient behaviors such as splitting.

The VIEW framework as it applies to the case

Visit

Upon visiting the medical chart, the physician realized that the patient's opioid use began in his 20s when he injured his back in a traumatic motor vehicle accident. His successful athletic career came to a halt after this injury and opioid dependence ensued.

While reviewing past notes and prescription data via the PDMP, the physician noted that the patient had been visiting many different providers in order to get more pain medications. The most recent prescription was for oral hydromorphone 4 mg every 4 hours as needed, filled 1 week prior to this presentation.

She reviewed his vital signs and found that he had been persistently hypertensive and tachycardic. His nurse mentioned that the patient appeared to be in severe pain because of facial grimacing with standing and walking.

Prior to entering the patient's room, the physician took a moment of mindfulness to become aware of her emotional state because she recognized that she was worried this could be a difficult encounter.

She considered how hard his life has been and how much emotional and physical pain he might be experiencing. She took a deep breath, silenced her mobile phone, and entered the room.

Interview

The physician sat at the bedside and interviewed the patient using a calm and nonjudgmental tone. It was quickly obvious to her that he was experiencing real pain. His cellulitis appeared severe and was tender to even minimal palpation. She learned that the pain in his leg had been worsening over the past week to the point that it was becoming difficult to ambulate, sleep, and perform his daily hygiene routine.

The patient was taking 4 mg tablets of hydromorphone every 2 hours, and he had run out a few days ago. He added that his mood was increasingly depressed, and he had even admitted to occasional suicidal thoughts because the pain was so unbearable.

When asked directly, he admitted that he was worried he was addicted to hydromorphone. He had first received it for low back pain after the motor vehicle accident, and it been refilled multiple times for ongoing pain over the course of a year. Importantly, she also learned that he felt he was often treated as an addict by medical professionals and felt that doctors no longer listened to him or believed him.

Continued on following page

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Empathize

As the conversation went on, the physician offered empathetic statements, recognizing the way it might feel to have your pain ignored or minimized by health care providers. She expressed how frustrating it is to not be able to perform basic functions and how difficult it must be to constantly live in pain.

The physician told the patient, "I don't want you to suffer in pain. I care about you and my goal is to treat your pain so that you can return to doing the things in life that you find meaningful." She also recognized the severity of the patient's depression and discussed with him the role and importance of psychiatric consultation.

Wrap Up

The physician wrapped up the encounter by summarizing her plan to treat the infection and work together with the patient to treat his pain with the goal that he could ambulate and perform activities of daily living.

She reviewed the side effects of both acute and long-term use of opioids and discussed the risks and benefits. Given the fact that the patient was on chronic baseline opioids and also had objective signs of acute pain, she started an initial regimen of hydromorphone 6 mg tablets every 4 hours as needed (a 50% increase over his home dose) and added acetaminophen 1,000 mg every 6 hours and ibuprofen 600 mg every 8 hours.

She informed the patient that she would check on him in the afternoon and that the ultimate plan would be to taper down on his hydromorphone dose each day as his cellulitis improved. She also communicated that bidirectional respect between the patient and care team members was critical to a successful pain management.

Finally, she explained that there was going to be a different doctor covering at night and major changes to the prescription regimen would be deferred to daytime hours.

When she left the room, the physician summarized the plan with the patient's nurse and shared a few details about the patient's difficult past. At the end of the shift, the physician signed out to the overnight team that the patient had objective signs of pain and recommended a visit to the bedside if the patient's symptoms were reported as worsening.

During his hospital stay, she monitored the patient's nonverbal responses to movement, participation in physical therapy, and ability to sleep. She tapered the hydromorphone down each day as the patient's cellulitis improved.

At discharge, the patient was prescribed a 3-day supply of his home dose of hydromorphone and the same acetaminophen and ibuprofen regimen he had been on in the hospital with instructions for tapering. Finally, after coming to an agreement with the patient, the physician arranged for follow-up in the opioid taper clinic and communicated the plan with the patient's primary care provider.

Key points

- Spend adequate time to fully **visit** patients' history as it relates to their current pain complaints.
- Review notes and prescription data to better understand past and current pain regimen.
- Be vigilant about taking a mindful moment to **visit** your thoughts and potential biases.
- **Interview** patients using a calm tone and nonjudgmental, reassuring words.
- **Empathize** with patients and validate any frustrations and experience of pain.
- **Wrap up** by summarizing your recommendations with patients, their families, the care team, and subsequent providers.

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Previously healthy patients hospitalized for sepsis show increased mortality

By Mitchel L. Zoler
MDedge News

WASHINGTON / Although severe, community-acquired sepsis in previously healthy U.S. adults is relatively uncommon, it occurs often enough to strike about 40,000 people annually, and when previously healthy people are hospitalized for severe sepsis, their rate of in-hospital mortality was double the rate in people with one or more comorbidities who have severe, community-acquired sepsis, based on a review of almost 7 million Americans hospitalized for sepsis.

The findings "underscore the importance of improving public awareness of sepsis and emphasizing early sepsis recognition and treatment in all patients," including those without comorbidities, Chanu Rhee, MD, said at an annual scientific meeting on infectious diseases. He hypothesized that the increased sepsis mortality among previously healthy patients may have stemmed from factors such as delayed sepsis recognition resulting in hospitalization at a more advanced stage and less aggressive management.

In addition, "the findings provide context for high-profile reports about sepsis death in previously healthy people," said Dr. Rhee, an infectious diseases and critical care physician at Brigham and Women's Hospital in Boston. Dr. Rhee and associates found that, among patients hospitalized with what the researchers defined as "community-acquired" sepsis, 3% were judged previously healthy by having no identified major or minor comorbidity or pregnancy at the time of hospitalization, a percentage that – while small – still translates into roughly 40,000 such cases annually in the United States. That helps explain why every so often a headline appears about a famous person who died suddenly and unexpectedly from sepsis, he noted.

MITCHEL L. ZOLER/MDEDGE NEWS

Dr. Chanu Rhee

The study used data collected on hospitalized U.S. patients in the Cerner Health Facts, HCA Healthcare, and Institute for Health Metrics and Evaluation databases, which included about 6.7 million people total including 337,983 identified as having community-acquired sepsis, defined as patients who met the criteria for adult sepsis advanced by the Centers for Disease Control and Prevention within 2 days of their hospital admission.

The researchers looked further into the hospital records of these patients and divided them into patients with one or more major comorbidities (96% of the cohort), patients who were pregnant or had a "minor" comorbidity such as a lipid disorder, benign neoplasm, or obesity (1% of the study group), or those with no chronic comorbidity (3%; the subgroup the researchers deemed previously healthy).

In a multivariate analysis that adjusted for patients' age, sex, race, infection site, and illness severity at the time of hospital admission, the researchers found that the rate of in-hospital death among the previously healthy patients was exactly twice the rate of those who had at least one major chronic comorbidity, Dr. Rhee reported.

Differences in the treatment received by the previously healthy patients or in their medical status compared with patients with a major comorbidity suggested that the previously healthy patients were sicker. They had a higher rate of mechanical ventilation, 30%, compared with about 18% for those with a comorbidity; a higher rate of acute kidney injury, about 43% in those previously healthy and 28% in those with a comorbidity; and a higher percentage had an elevated lactate level, about 41% among the previously healthy patients and about 22% among those with a comorbidity.

Fewer bloodstream infections with FMT for *C. difficile*

Patients also had shorter hospital stays

By Bianca Nogrady
MDedge News

Treating *Clostridioides difficile* infection with fecal microbiota transplantation is associated with a lower risk of bloodstream infection and recurrence than treatment with antibiotics, new research has found.

A paper published in Annals of Internal Medicine presents outcomes of a prospective cohort study in 290 inpatients with recurrent *C. difficile* infection, 109 of whom were treated with fecal microbiota transplantation (FMT); the remaining patients in the study were treated with antibiotics including metronidazole, vancomycin, and fidaxomicin.

While the FMT group had a higher mean number of previous *C. difficile* infections than the antibiotics group (2.82 vs. 1.23, respectively), a sustained cure was achieved in 97% of the FMT group, compared with 38% in the antibiotics group.

Blood cultures were done if patients developed a temperature above 30° C or showed symptoms that might be attributable to sepsis. Bloodstream infections were diagnosed in 5% (5 patients) of those treated with FMT, and 22% (40 patients) in the antibiotics group.

The patients in the FMT group with bloodstream infections all had bacterial infections – one of which was polymicrobial – and there were no cases of fungal bloodstream infections. In the antibiotics group, 28 patients (15%) had bacterial bloodstream infections – 11 of which were polymicrobial – and 12 (7%) had fungal bloodstream infections.

Bloodstream infections were particularly evident among the 11 inpatients whose *C. difficile* infection was treated with fidaxomicin, 4 of whom developed a bloodstream infection.

Overall, 27% of patients died during the 90-day follow-up, with 7% dying because of bloodstream infections, all of whom were in the antibiotic-treated cohort. Three patients in the FMT group died because of overwhelming *C. difficile* infection, compared with 12 in the antibiotic cohort.

Nearly three-quarters of deaths occurred within 30 days of the end of treatment; 5 of these deaths were in the FMT group, and 53 were in the antibiotics group.

"These findings suggest that the longer 90-day [overall survival] of patients in the FMT group is attributable to cure of [*C. difficile* infection] leading to an improvement in clinical condition," wrote Gianluca Ianiro, MD, from the Catholic University of the Sacred Heart in Rome, and coauthors.

The 90-day overall survival rate was 92% in the FMT group and 61% in the antibiotic group. Patients treated with FMT also showed significantly shorter mean duration of hospital stay at 13.3 days, compared with 29.7 days in patients treated with antibiotics.

The authors noted the results should be interpreted with caution because of baseline differences between the two groups that were not entirely accounted for by using propensity matching.

However, even in the propensity-matched cohort of 57 patients from each group, there was still a significantly higher overall survival at 90 days among patients treated with FMT.

One author declared grants from the pharmaceutical sector outside the submitted work. No funding or other conflicts of interest were reported by the coauthors.

Aligning scheduling and satisfaction

Research reveals counterintuitive results

Hospitalist work schedules have been the subject of much reporting – and recent research. Studies have shown that control over work hours and schedule flexibility are predictors of clinicians' career satisfaction and burnout, factors linked to quality of patient care and retention.


Dr. Anstett

Starting in January 2017, an academic hospital medicine group at the University of Colorado at Denver, Aurora, undertook a scheduling redesign using improvement methodology, combined with purchased scheduling software. Tyler Anstett, DO, a hospitalist and assistant professor at the university, and colleagues presented the results in an abstract published during the SHM 2019 annual conference last March.

"We wrote this abstract as a report of the work that we did over several years in our hospital medicine group to improve hospitalist satisfaction with their schedules," said Dr. Anstett. "We identified that, despite not following the traditional 7-on, 7-off model and 100% fulfillment of individual schedule requests, the majority of clinicians were dissatisfied with the scheduling process and their overall clinical schedules. Further, building these complex, individualized schedules resulted in a heavy administrative burden. We strove to provide better alignment of schedule satisfaction and the administrative burden of incorporating individualized schedule requests."

Prior to January 2017, service stretches had ranged from 5 to 9 days, and there were few limits on time-off requests.

"Through sequential interventions, we standardized service stretches to 7 days (Tuesday-Monday), introduced a limited number of guaranteed 7-day time-off requests (Tuesday-Monday), and added a limited number of nonguaranteed 3-day flexible time-off requests," according to the authors. "This simplification improved the automation of the scheduling software, which increased the schedule release lead time to an average of 16 weeks. Further, despite standardizing service stretches to 7 days and limiting time-off requests, physicians surveyed reported improved satisfaction with both their scheduling process (34% of participants 'satisfied' in 2017 to 67% in 2018) and their overall clinical schedules (50% of participants 'satisfied' in 2017 to 75% in 2018)."

So counterintuitively, creating individualized schedules may not result in improved satisfaction and likely results in heavy administrative burden, Dr. Anstett said. "Standardization of schedule creation with allowance of a 'free-market' system, allowing clinicians to self-individualize their schedules may also result in less administrative burden and improved satisfaction."

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Cultivating patient activation through tech

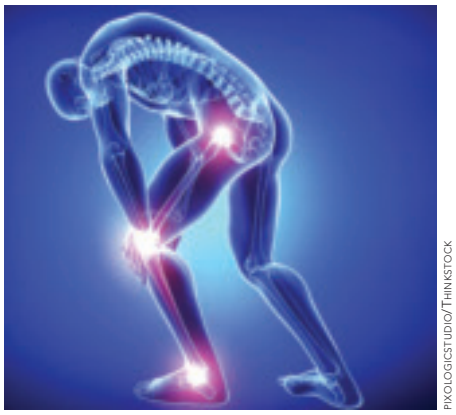
Tech alone is not enough

Patient activation refers to an individual's knowledge, skill, and confidence in managing their health and health care, according to a recent BMJ editorial. It's recognized as a critical aspect of high-quality, patient-centered health care – patient activation has the potential to improve patient outcomes while reducing costs.

Total knee replacement offers a great opportunity to study patient activation, said editorial lead author Jesse I. Wolfstadt, MD, MS, FRCSC, of the University of Toronto. "It may help address the one in five patients who are unsatisfied with their knee replacement despite an otherwise technically sound procedure."

The authors considered some patient activation studies that have shown positive results for cultivating activation through technology. In one, patients engaging with a bedside multimedia intervention on a tablet after undergoing knee replacement reported better pain scores, length of stay, knee function, and satisfaction with care. Another study showed patients who received automated text messages after joint replacement improved time spent on home exercises, decreased their use of narcotics, and had fewer calls to the surgeon's office.

But "negative mobile app studies seem to suggest that when technologies are used as a passive educational intervention, patient activation may suffer," according to the editorial. "One possible key ingredient to successful patient activation is the engagement of the health care team that is facilitated through mobile technology. … Mobile apps and other technological interventions also must have clear goals if they are to be used successfully; and these goals are likely to differ for different patient populations and disease processes."


PIXOLOGICSTUDIO/THINKSTOCK

Technology alone is not enough to affect patient activation, Dr. Wolfstadt said. "The key to success will likely involve facilitating increased engagement with the health care team. You can't just give a patient an app or other form of technology and expect it to replace the function of patient-clinician communication."

Reference

Wolfstadt JI et al. Improving patient outcomes following total joint arthroplasty: Is there an app for that? BMJ Qual Saf. 2019 May 2019. doi: 10.1136/bmjqs-2019-009571.

Improving sepsis-related outcomes

Performance data provided a key goal

Sepsis is a leading cause of death and disease among patients in hospitals, and it's the subject of a recent quality improvement study in the Journal for Healthcare Quality.

"The number of cases per year has been increasing in the U.S., and it is the most expensive condition treated in U.S. hospitals," said lead author M. Courtney Hughes, PhD, of Northern Illinois University.

Dr. Hughes

But early identification of symptoms can be difficult for clinicians, meaning there's a continuing need for studies examining sepsis identification and prevention. "The purpose of this study was to examine a QI project that consisted of clinical alerts, audit and feedback, and staff education at an integrated health system," she said.

In a retrospective analysis, the researchers examined data from three health systems to determine the impact of a 10-month sepsis QI program that consisted of clinical alerts, audit and feedback, and staff education. The results showed that, compared with the control group, the intervention group significantly decreased length of stay and costs per stay.

"One way to improve sepsis health outcomes and decrease costs may be for hospitals to implement a sepsis quality improvement program," Dr. Hughes said. "Providing sepsis performance data and education to hospital providers and administrators can arm staff with the knowledge and tools necessary for improving processes and performance related to sepsis."

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Treating pain with virtual reality

Pilot studies are underway

Physicians may soon have another tool to help patients deal with pain: virtual reality (VR) therapy. A New York Times article earlier this year described the way immersive VR experiences seem to crowd pain sensations out of the brain.

Jeffrey I. Gold, PhD, director of the Children's Outcomes, Research, and Evaluation program at Children's Hospital Los Angeles, told the newspaper that VR was "like an endogenous narcotic providing a physiological and chemical burst that causes you to feel good."

So far, VR has been most successfully used in cases of acute pain. "But it can also enhance the effectiveness of established techniques like physical therapy, hypnosis and cognitive behavioral therapy to treat debilitating chronic pain," the New York Times reported.

"Using VR as an adjunct, we can teach coping skills, techniques patients can use on their own that will help diminish chronic pain," said Hunter Hoffman, PhD, principal investigator at the Human Photonics Laboratory of the University of Washington, Seattle. "Learning changes the brain and gives patients something that continues to work when they take the helmet off. When patients realize their pain isn't inevitable, they're more receptive to physical therapy."

Others with experience in VR say the technique can foster mindfulness, which teaches the mind how to quiet the body and nervous system through breathing.

Pilot studies of VR and pain management are underway, and software companies are developing programs that create therapeutic VR environments.

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In the Literature

ITL: Clinician reviews of HM-centric research

By Kathryn Brouillette, MDCM; Nicholas Dupuis, DO; Lesley B. Gordon, MD, MS; Elizabeth Herrle, MD; and Emily Zarookian, MD

Maine Medical Partners Hospital Medicine, Maine Medical Center, Portland

IN THIS ISSUE

By Kathryn Brouillette, MDCM

1 Complications and death within 30 days after noncardiac surgery

CLINICAL QUESTION: What is the frequency and timing of perioperative complications associated with death after noncardiac surgery?
BACKGROUND: There have been advances in perioperative care and technology for adults, but at the same time the patient population is increasingly medically complex. We do not know the current mortality risk of noncardiac surgery in adults.
STUDY DESIGN: Prospective cohort study.
SETTING: Twenty-eight academic centers in 14 countries in North America, South America, Asia, Europe, Africa, and Australia. At least four academic centers represented each of these continents, except Africa, with one center reporting there.
SYNOPSIS: The VISION study included 40,004 inpatients, aged 45 years and older, followed for 30-day mortality after noncardiac surgery. One-third of surgeries were considered low risk. A startling 99.1% of patients completed the study. Mortality rate was 1.8%, with 71% of patients dying during the index admission and 29% dying after discharge.

Nine events were independently associated with postoperative death, but the top three – major bleeding, myocardial injury after noncardiac surgery (MINS), and sepsis – accounted for 45% of the attributable fraction. These, on average, occurred within 1-6 days after surgery. The other events (infection, kidney injury with dialysis, stroke, venous thromboembolism, new atrial fibrillation, and congestive heart failure) constituted less than 3% of the attributable fraction. Findings suggest that closer monitoring in the hospital and post discharge might improve survival after noncardiac surgery.


Dr. Brouillette

Limitations for hospitalists include that patients were younger and less medically complex than our typically comanaged patients: More than half of patients were aged 45-64, less than 10% had chronic kidney disease stage 3b or greater, and only 20% had diabetes mellitus.
BOTTOM LINE: Postoperative and postdischarge bleeding, myocardial injury after noncardiac surgery, and sepsis are major risk factors for 30-day mortality in adults undergoing noncardiac surgery. Closer postoperative monitoring for these conditions should be explored.
CITATION: The Vision Study Investigators (Spence J et al.) Association between complications and death within 30 days after noncardiac surgery. CMAJ. 2019 Jul 29;191(30):E830-7.

Dr. Brouillette is a med-peds hospitalist at Maine Medical Center in Portland.

By Nicholas Dupuis, DO

2 Eosinophilia-guided treatment cuts corticosteroid exposure in COPD exacerbations

CLINICAL QUESTION: Is eosinophilia-guided therapy in the setting of a chronic obstructive pulmonary disease (COPD) exacerbation a safe way to reduce total systemic steroid exposure?
BACKGROUND: Corticosteroids in the setting of an acute exacerbation of improve COPD symptoms but do not affect the decline in lung function, rate of repeat exacerbations after a month, or mortality. There is concern regarding the cumulative adverse effects over time. Limited prior research suggests that a patient's blood eosinophil count may be useful for determining the necessity of steroids for treatment of exacerbation.
STUDY DESIGN: Randomized, controlled, open-label trial.
SETTING: Respiratory departments of three university hospitals in Denmark.
SYNOPSIS: A total of 318 patients admitted for COPD exacerbation were randomized to standard or eosinophilia-guided therapy. On day 1, all patients received 80 mg of IV methylprednisolone. The standard-therapy group then received 37.5 mg of oral prednisolone for 4 more days. In contrast, the eosinophilia-guided group received prednisolone only if their blood eosinophil count was 300 cells/mcL or greater.

The primary outcome of days alive and out of the hospital within 14 days after recruitment was similar between groups (9 days; $P = .34$), along with the secondary outcome of treatment failure (26%; $P = .90$). Importantly, the cumulative steroid dose in the eosinophilia-guided group was lower than that of the control group at days 5, 30, and 90 (P less than or equal to .0002). Additionally, the control arm had worsening of baseline diabetes within 30 days and was more likely to require antibiotics for infections within 90 days.

Although not statistically significant, a trend was noted toward increased readmission for COPD exacerbations or death at 30 days in the eosinophilia-guided group (25% vs. 17% of control; $P = .10$). Future work will need to further study this trend.


Dr. Dupuis

BOTTOM LINE: Eosinophilia-guided treatment of COPD exacerbations reduced the cumulative exposure of steroid therapy, thereby decreasing side effects, although further study of safety profile is warranted.
CITATION: Sivapalan P et al. Eosinophil-guided corticosteroid therapy in patients admitted to hospital with COPD exacerbation (CORTICO-COP): A multicenter, randomized, controlled, open-label, non-inferiority trial. Lancet Respir Med. 2019 Aug;7(8): 699-709.

Dr. Dupuis is a hospitalist at Maine Medical Center in Portland.

By Lesley B. Gordon, MD, MS

3 A standardized approach to postop management of DOACs in AFib

CLINICAL QUESTION: Is it safe to adopt a standardized approach to direct oral anticoagulant (DOAC) interruption for patients with atrial fibrillation (AFib) who are undergoing elective surgeries/procedures?
BACKGROUND: At present, perioperative management of DOACs for patients with AFib has significant variation, and robust data are absent. Points of controversy include: The length of time to hold DOACs before and after the procedure, whether to bridge with heparin, and whether to measure coagulation function studies prior to the procedure.
STUDY DESIGN: Prospective cohort study.
SETTING: Conducted in Canada, the United States, and Europe.
SYNOPSIS: The PAUSE study in-

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cluded adults with atrial fibrillation who were long-term users of either apixaban, dabigatran, or rivaroxaban and were scheduled for an elective procedure (n = 3,007). Patients were placed on a standardized DOAC interruption schedule based on whether their procedure had high bleeding risk (held for 2 days prior; resumed 2-3 days after) or low bleeding risk (held for 1 day prior; resumed 1 day after).

Dr. Gordon

The primary clinical outcomes were major bleeding and arterial thromboembolism. Authors determined safety by comparing to expected outcome rates derived from research on perioperative warfarin management.

They found that all three drugs were associated with acceptable rates of arterial thromboembolism (apixaban 0.2%, dabigatran 0.6%, rivaroxaban 0.4%). The rates of major bleeding observed with each drug (apixaban 0.6% low-risk procedures, 3% high-risk procedures; dabigatran 0.9% both low- and high-risk procedures; and rivaroxaban 1.3% low-risk procedures, 3% high-risk procedures) were similar to those in the BRIDGE trial (patients on warfarin who were not bridged perioperatively). However, it must still be noted that only dabigatran met the authors' predetermined definition of safety for major bleeding.

Limitations include the lack of true control rates for major bleeding and stroke, the relatively low mean CHADS2-Va2Sc of 3.3-3.5, and that greater than 95% of patients were white.

BOTTOM LINE: For patients with moderate-risk atrial fibrillation, a standardized approach to DOAC interruption in the perioperative period that omits bridging along with coagulation function testing appears safe in this preliminary study.

CITATION: Douketis JD et al. Perioperative management of patients with atrial fibrillation receiving a direct oral anticoagulant. JAMA Intern Med. 2019 Aug 5. doi: 10.1001/jamainternmed.2019.2431.

4 Overdiagnosis and overtreatment of COPD appears rampant

CLINICAL QUESTION: How frequently is chronic obstructive pulmonary disease (COPD) overdiagnosed and overtreated in the general population?

BACKGROUND: COPD is a highly morbid disease, and there is a need for a better understanding of the true prevalence. Little is known regarding overdiagnosis of COPD. According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD), airflow limitation by spirometry is a key criteria for diagnosis.

STUDY DESIGN: Population-based survey.

SETTING: Altogether, 23 sites in 20 countries worldwide were included.

SYNOPSIS: The Burden of Obstructive Lung Disease (BOLD) study recruited community-dwelling adults who underwent questionnaires, as well as spirometry. Of the 16,717 participants, 919 self-reported a COPD diagnosis. Of these, more than half were found to not meet obstructive lung disease criteria on spirometry, and therefore were misdiagnosed: 62% when defined as forced expiratory volume in 1 second to forced vital capacity (FEV_1/FVC) ratio less than the lower limit of normal and 55% when using the GOLD definition of FEV_1/FVC less than 0.7. After patients with reported asthma were excluded, 34% of participants with false-positive COPD were found to be treated with respiratory medications as outpatients.

Overdiagnosis of COPD was noted to be more prevalent in high-income countries than they were in low- to middle-income countries (4.9% versus 1.9% of the participants sampled).

The self-reporting of the diagnosis of COPD is a limitation of the study because it may have artificially inflated the rate of false positives.

BOTTOM LINE: Patient-reported diagnoses of COPD should be taken with a degree of caution because of high rates of overdiagnosis and overtreatment.

CITATION: Sator L et al. Overdiagnosis of COPD in subjects with unobstructed spirometry. Chest. 2019 Aug;156(2):277-88.

Dr. Gordon is a hospitalist at Maine Medical Center in Portland.

By Elizabeth Herrle, MD

5 DOACs show safety benefit in early stages of CKD

CLINICAL QUESTION: In terms of efficacy and bleeding risk, what is known about anticoagulation in patients with chronically impaired renal function?

BACKGROUND: Chronic kidney disease (CKD) is both a prothrombotic state and a condition with an elevated bleeding risk that increases in a linear fashion as estimated glomerular filtration rate (eGFR) decreases. These features of the disease along with the exclusion of patients with CKD from most anticoagulation trials have resulted in uncertainty about overall risks and benefits of anticoagulant use in this population.

STUDY DESIGN: Systematic review and meta-analysis.

SETTING: Variable across included trials.

SYNOPSIS: Forty-five randomized, controlled trials of anticoagulation covering a broad range of anticoagulants, doses, indications, and methodologies were included in this meta-analysis, representing 34,082 patients with CKD or end-stage kidney disease.

Dr. Herrle

The most compelling data were seen in the management of atrial fibrillation in early-stage CKD (five studies representing 11,332 patients) in which high-dose DOACs were associated with a lower risk for stroke or systemic embolism (risk ratio, 0.79; 95% confidence interval, 0.66-0.92), hemorrhagic stroke (RR, 0.48; 95% CI, 0.30-0.76), and all-cause death (RR, 0.88; 95% CI, 0.78-0.99). Overall stroke reduction was primarily hemorrhagic, and DOACs were equivalent to vitamin K antagonists (VKAs) for ischemic stroke risk.

The analysis also suggests that, in CKD, DOACs may reduce major bleeding when compared with VKAs across a variety of indications, though that finding was not statistically significant.

Efficacy of DOACs, compared with VKAs, in treatment of venous thromboembolism was uncertain, and patients with end-stage kidney disease and advanced CKD (creatinine clearance, less than 25 mL/min) were excluded from all trials comparing DOACs with VKAs, with limited overall data in these populations.

BOTTOM LINE: For patients with atrial fibrillation and early-stage CKD, direct oral anticoagulants show a promising risk-benefit profile when compared with vitamin K antagonists. Very few data are available on the safety and efficacy of anticoagulants in patients with advanced CKD and end-stage kidney disease.

CITATION: Ha JT et al. Benefits and harms of oral anticoagulant therapy in chronic kidney disease. Ann Intern Med. 2019 Aug 6;171(3):181-9.

6 Covert stroke after noncardiac surgery linked with cognitive decline

CLINICAL QUESTION: Does covert stroke increase the risk of cognitive decline after noncardiac surgery in patients older than 65 years?

BACKGROUND: Prior studies have established an increased risk of overt stroke after noncardiac surgery, with significant associated morbidity and mortality. Similarly, covert stroke in the nonsurgical population is well described and has been shown to be associated with cognitive decline.

STUDY DESIGN: Prospective cohort study.

SETTING: Academic centers in nine countries.

SYNOPSIS: This study evaluated 1,114 patients older than 65 years who were hospitalized for noncardiac surgery, excluding patients with carotid and neurosurgical procedures. All enrolled participants completed diffusion-weight MRI of the brain within 9 days of surgery. Follow-up rates for clinical outcomes (1,112; greater than 99%) were excellent, and the primary outcome measure, follow-up Montreal Cognitive Assessment (MOCA) at 1 year, was defined in 1,001 (90%) of the study subjects.

Covert stroke was detected in 78 (7%) of the study participants. Those with covert stroke had a higher incidence of cognitive decline at 1 year (adjusted odds ratio, 1.98; 95% confidence interval, 1.22-3.2) with an absolute risk increase of 13%. Patients with covert stroke also had a higher rate of delirium within 3 days of surgery (hazard ratio, 2.24; 95% CI, 1.06-4.73) and a higher rate of overt stroke and transient ischemic attack at 1 year (HR, 4.13; 95% CI, 1.14-14.99).

This study helps to establish the incidence of covert stroke after noncardiac surgery and provides support for covert stroke as a risk factor for cognitive impairment.

BOTTOM LINE: Covert stroke following noncardiac surgery is common, affecting 1 in 14 patients in this study, and it is associated with an increased risk of cognitive decline, perioperative delirium, and subsequent overt stroke.

CITATION: The NeuroVISION Investigators (Mrkobrada M et al.). Perioperative covert stroke in patients undergoing noncar-

diac surgery (NeuroVISION): a prospective cohort study. Lancet. 2019;394(10203):1022-9.

Dr. Herrle is a hospitalist at Maine Medical Center in Portland and at Stephens Memorial Hospital in Norway, Maine.

By Emily Zarookian, MD

7 Think twice before intensifying BP regimen in older hospitalized patients

CLINICAL QUESTION: Does intensifying antihypertensive regimens in older patients hospitalized for noncardiac conditions lead to better long-term blood pressure control or does this practice potentially cause harm?

BACKGROUND: It is common practice for providers to intensify antihypertensive regimen during admission for noncardiac conditions even if a patient has a history of well-controlled blood pressure as an outpatient. Many providers have assumed that these changes will benefit patients; however, this outcome had never been studied.

STUDY DESIGN: Retrospective cohort study.

SETTING: Veterans Affairs hospitals.

SYNOPSIS: The authors analyzed a well-matched retrospective cohort of 4,056 adults aged 65 years or older with hypertension who were admitted for noncardiac conditions including pneumonia, urinary tract infection, and venous thromboembolism. Half of the cohort was discharged with intensification of their antihypertensives, defined as a new antihypertensive medication or an increase of 20% of a prior medication.

Dr. Zarookian

Patients discharged with regimen intensification were more likely to be readmitted (hazard ratio, 1.23; 95% confidence interval, 1.07-1.42; number needed to harm = 27), experience a medication-related serious adverse event (HR, 1.42; 95% CI, 1.06-1.88; NNH = 63), and have a cardiovascular event (HR, 1.65; 95% CI, 1.13-2.4) within 30 days of discharge. At 1 year, no significant difference in mortality, cardiovascular events, or systolic BP were noted between the two groups.

A subgroup analysis of patients with poorly controlled blood pressure as outpatients (defined as systolic blood pressure greater than 140 mm Hg) who had their antihypertensive medications intensified did not show significant difference in 30-day readmission, severe adverse events, or cardiovascular events.

Limitations of the study include observational design and majority male sex (97.5%) of the study population.

BOTTOM LINE: Intensification of antihypertensive regimen among older adults hospitalized for noncardiac conditions with well-controlled blood pressure as an outpatient can potentially cause harm.

CITATION: Anderson TS et al. Clinical outcomes after intensifying antihypertensive medication regimens among older adults at hospital discharge. JAMA Intern

Continued on following page

SHORT TAKES

Staying alive: Compression rate and depth affects survival

Employing 107 compressions per minute with a depth of 4.7 cm is associated with improved outcomes for out-of-hospital cardiac arrest. A cohort study of 3,643 patients with out-of-hospital cardiac arrest showed that survival was higher when CPR was performed within 20% of the above values (6% vs 4.3% outside of range; P = .02).

CITATION: Duval S et al. Optimal combination of compression rate and depth during cardiopulmonary resuscitation for functionally favorable survival. JAMA Cardiol. 2019;4(9):900-8.

Dose of ibuprofen may not affect analgesia

A randomized, double-blind, equivalency trial of 225 patients found no difference in analgesic effect among ibuprofen doses of 400 mg, 600 mg, and 800 mg within 1 hour of administration. The study did not examine anti-inflammatory effect and did not examine effect after 1 hour.

CITATION: Motov S et al. Comparison of oral ibuprofen at three single-dose regimens for treating acute pain in the emergency department: A randomized controlled trial. Ann Emerg Med. 2019;74(4):530-7.

Continued from previous page

Med. 2019 Aug 19. doi: 10.1001/jamainternmed.2019.3007.

8 Limiting antibiotic therapy after surgical drainage for native joint bacterial arthritis

CLINICAL QUESTION: Is 2 weeks of antibiotic therapy after surgical drainage for native joint bacterial arthritis noninferior to 4 weeks of antibiotic therapy?

BACKGROUND: Currently the recommended duration of antibiotic therapy for native joint bacterial arthritis is 3-6 weeks based on expert opinion.

STUDY DESIGN: Prospective, unblinded, randomized, noninferiority.

SETTING: Single center in Geneva.

SYNOPSIS: In total, 154 patients were randomized to either 2 weeks or 4 weeks of antibiotic regimen selected in consultation with infectious disease specialists after surgical drainage of native joint bacterial arthritis.

The study population was 38% women with a median age of 51 years. Sites of infection were majority hand and wrist arthritis (64%). The most frequent pathogen was *Staphylococcus aureus* (31%) with no methicillin-resistant strains. There was a low incidence of patients with bacteremia (4%) and chronic immune compromise (10%). Antibiotic regimen varied with 13 different initial intravenous regimens and 11 different oral regimens.

The primary study outcome was rate of recurrent infection within 2 years, which was low with only one recurrence in the 2-week arm and two recurrences in the 4-week arm. This difference was well within the 10% noninferiority margin selected by the authors.

The study was underpowered for nonhand and nonwrist cases, limiting generalizability.

BOTTOM LINE: Consider a shorter duration of antibiotic therapy after surgical drainage for native joint bacterial arthritis of the hand and wrist in an otherwise healthy patient.

CITATION: Gjika E et al. Two weeks versus four weeks of antibiotic therapy after surgical drainage for native joint bacterial arthritis: a prospective, randomized, non-inferiority trial. Ann Rheum Dis. 2019 Aug;78(8):1114-21.

Dr. Zarookian is a hospitalist at Maine Medical Center in Portland and Stephens Memorial Hospital in Norway, Maine.

Smokers with PE have higher readmission rate

By Jennifer Smith
MDedge News

Smokers with pulmonary embolism (PE) are more likely to be readmitted to the hospital within 30 days of their index admission, according to a retrospective study.

The rate of readmission was significantly higher among patients with tobacco dependence, and tobacco dependence was independently associated with an increased risk of readmission.

"This is the first study to quantify the increased rate of hospital readmission due to smoking," said study investigator Kam Sing Ho, MD, of Mount Sinai St. Luke's and Mount Sinai West, New York.

Dr. Ho and colleagues described this study and its results in a poster presented at the annual meeting of the American College of Chest Physicians.

The researchers analyzed data on 168,891 hospital admissions of adults with PE, 34.2% of whom had tobacco dependence. Patients with and without tobacco dependence were propensity matched for baseline characteristics (n = 24,262 in each group).

The 30-day readmission rate was significantly higher in patients with tobacco dependence than in those without it – 11.0% and 8.9%, respectively (*P* less than .001). The most common reason for readmission in both groups was PE.

Dr. Ho said the higher readmission rate among patients with tobacco dependence might be explained by the fact that smokers have a higher level of fibrinogen, which may affect blood viscosity and contribute to thrombus formation (Proc Am Thorac Soc. 2005;2[1]:71-7).

The investigators also found that tobacco dependence was an independent predictor of readmission (hazard ratio, 1.43; *P* less than .001). And the mortality rate was significantly higher after readmission than after index admission – 6.27% and 3.15%, respectively (*P* less than .001).

The increased risk of readmission and death among smokers highlights the importance of smoking cessation services.

Recommendations to fight clinician burnout

NAM generates six-goal approach

By Kerry Dooley Young

WASHINGTON / The practice of medicine needs a major reset to address the stresses that lead to clinician burnout, a condition now estimated to affect a third to a half of clinicians in the United States, according to a report from an influential federal panel.

The National Academy of Medicine (NAM) released a report, "Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being." The report calls for a broad and unified approach to tackling the root causes of burnout.

There must be a concerted effort by leaders of many fields of health care to create less stressful workplaces for clinicians, Pascale Carayon, PhD, cochair of the NAM committee that produced the report, said during the NAM press event.

"This is not an easy process," said Dr. Carayon, a researcher into patient safety issues at the University of Wisconsin–Madison. "There is no single solution."

The NAM report assigns specific tasks to many different participants in health care through a six-goal approach, as described below.

• **Create positive workplaces.** Leaders of health care systems should consider how their business and management decisions will affect clinicians' jobs, taking into account the potential to add to their levels of burnout. Executives need to continuously monitor and evaluate the extent of burnout in their organizations, and report on this at least annually.

• **Address burnout in training and in clinicians' early years.** Medical, nursing, and pharmacy schools should consider steps such as monitoring workload, implementing pass-fail grading, improving access to scholarships and affordable loans, and creating new loan repayment systems.

• **Reduce administrative burden**. Federal and state bodies and organizations such as the National Quality Forum should reconsider how their regulations and recommendations contribute to burnout. Organizations should seek to eliminate tasks that do not improve the care of patients.

• **Improve usability and relevance of health information technology (IT).** Medical organizations should develop and buy systems that are as user-friendly and easy to operate as possible. They also should look to use IT to reduce documentation demands and automate nonessential tasks.

Dr. Washington

• **Reduce stigma and improve burnout recovery services.** State officials and legislative bodies should make it easier for clinicians to use employee assistance programs, peer support programs, and mental health providers without the information being admissible in malpractice litigation. The report notes the recommendations from the Federation of State Medical Boards, American Medical Association, and the American Psychiatric Association on limiting inquiries in licensing applications about a clinician's mental health. Questions should focus on current impairment rather than reach well into a clinician's past.

• **Create a national research agenda on clinician well-being.** By the end of 2020, federal agencies – including the Agency for Healthcare Research and Quality, the National Institute for Occupational Safety and Health, the Health Resources and Services Administration, and the U.S. Department of Veterans Affairs – should develop a coordinated research agenda on clinician burnout, the report said.

In casting a wide net and assigning specific tasks, the NAM report seeks to establish efforts to address clinician burnout as a broad and shared responsibility. It would be too easy for different medical organizations to depict addressing burnout as being outside of their responsibilities, Christine K. Cassel, MD, the cochair of the NAM committee that produced the report, said during the press event.

"Nothing could be farther from the truth. Everyone is necessary to solve this problem," said Dr. Cassel, who is a former chief executive officer of the National Quality Forum.

Darrell G. Kirch, MD, chief executive of the Association of American Medical Colleges, described the report as a "call to action" at the press event.

Previously published research has found between 35% and 54% of nurses and physicians in the United States have substantial symptoms of burnout, with the prevalence of burnout ranging between 45% and 60% for medical students and residents, the NAM report said.

Leaders of health organizations must consider how the policies they set will add stress for clinicians and make them less effective in caring for patients, said Vindell Washington, MD, chief medical officer of Blue Cross Blue Shield of Louisiana and a member of the NAM committee that wrote the report.

"Those linkages should be incentives and motivations for boards and leaders more broadly to act on the problem," Dr. Washington said at the NAM event.

Dr. Kirch said he experienced burnout as a first-year medical student. He said a "brilliant aspect" of the NAM report is its emphasis on burnout as a response to the conditions under which medicine is practiced. In the past, burnout has been viewed as being the fault of the physician or nurse experiencing it, with the response then being to try to "fix" this individual, Dr. Kirch said at the event.

The NAM report instead defines burnout as a "work-related phenomenon studied since at least the 1970s," in which an individual may experience exhaustion and detachment. Depression and other mental health issues such as anxiety disorders and addiction can follow burnout, he said. "That involves a real human toll."

Joe Rotella, MD, MBA, chief medical officer at American Academy of Hospice and Palliative Medicine, said in an interview that this NAM paper has the potential to spark the kind of transformation that its earlier research did for the quality of care. Then called the Institute of Medicine (IOM), NAM in 1999 issued a report, "To Err Is Human," which is broadly seen as a key catalyst in efforts in the ensuing decades to improve the quality of care. IOM then followed up with a 2001 report, "Crossing the Quality Chasm."

"Those papers over a period of time really did change the way we do health care," said Dr. Rotella, who was not involved with the NAM report.

In Dr. Rotella's view, the NAM report provides a solid framework for what remains a daunting task, addressing the many factors involved in burnout.

"The most exciting thing about this is that they don't have 500 recommendations. They had six and that's something people can organize around," he said. "They are not small goals. I'm not saying they are simple."

The NAM report delves into the factors that contribute to burnout. These include a maze of government and commercial insurance plans that create "a confusing and onerous environment for clinicians," with many of them juggling "multiple payment systems with complex rules, processes, metrics, and incentives that may frequently change."

Clinicians face a growing field of measurements intended to judge the quality of their performance. While some of these are useful, others are duplicative and some are not relevant to patient care, the NAM report said.

The report also noted that many clinicians describe electronic health records as taking a toll on their work and private lives. Previously published research has found that, for every hour spent with a patient, physicians spend an additional 1-2 hours on the EHR at work, with additional time needed to complete this data entry at home after work hours, the report said.

In an interview, Cynda Rushton, RN, PhD, a Johns Hopkins University researcher and a member of the NAM committee that produced the report, said this new publication will support efforts to overhaul many aspects of current medical practice. She hopes it will be a "catalyst for bold and fundamental reform.

"It's taking a deep dive into the evidence to see how we can begin to dismantle the system's contributions to burnout," she said. "No longer can we put Band-Aids on a gaping wound."

DIVISION CHIEF, HOSPITAL MEDICINE

DEPARTMENT OF MEDICINE

Hershey, Pennsylvania

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- Dedicated RN and Social Work Clinical Care Coordinators
- Community based academic appointment
- The only Louisiana Hospital recognized by US News and World Report Distinguished Hospital for Clinical Excellence award in 3 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

Ochsner Health System is Louisiana's largest non-profit, academic, healthcare system. Driven by a mission to **Serve, Heal, Lead, Educate and Innovate,** coordinated clinical and hospital patient care is provided across the region by Ochsner's 40 owned, managed and affiliated hospitals and more than 100 health centers and urgent care centers. Ochsner is the only Louisiana hospital recognized by U.S. News & World Report as a "Best Hospital" across three specialty categories caring for patients from all 50 states and more than 70 countries worldwide each year. Ochsner employs more than 25,000 employees and over 4,500 employed and affiliated physicians in over 90 medical specialties and subspecialties, and conducts more than 700 clinical research studies. For more information, please visit **ochsner.org** and follow us on Twitter and Facebook.

Interested physicians should click here to apply online.

Visit ochsner.org/physician Job Number 00022186

Ochsner Health System

Sorry, no opportunities for J1 applications.

Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, protected veteran status, or disability status.

Hospitalist Opportunities with Penn State Health

Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. We are seeking IM/FM trained physicians interested in joining the Penn State Health family in various settings within our system.

What We're Offering:

- Opportunities for both Community based and Academic settings
- We'll foster your passion for patient care and cultivate a collaborative environment rich with diversity
- Commitment to patient safety in a team approach model
- Experienced hospitalist colleagues and collaborative leadership
- Salary commensurate with qualifications
- Relocation Assistance

What We're Seeking:

- Internal Medicine or Family Medicine trained
- Ability to acquire license in the State of Pennsylvania
- Must be able to obtain valid federal and state narcotics certificates
- Current American Heart Association BLS and ACLS certification required
- BE/BC in Family Medicine or Internal Medicine (position dependent)

No J1 visa waiver sponsorships available

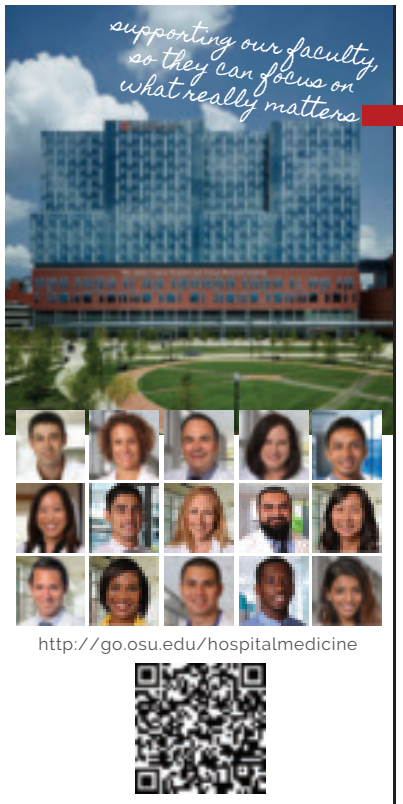
What the Area Offers:

Penn State Health is located in Central Pennsylvania. Our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Our surrounding communities are rich in history and offer an abundant range of outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

For more information please contact:
Heather J. Peffley, PHR FASPR, Penn State Health Physician Recruiter
hpeffley@pennstatehealth.psu.edu

PennState Health

Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.



http://go.osu.edu/hospitalmedicine

NOW INTERVIEWING COMPETITIVE APPLICANTS
HospitalMedicine@osumc.edu

The Ohio State University Wexner Medical Center

Join a Leader in Hospital Medicine

As one of the nation's largest academic hospitalist programs, we lead a variety of teaching and non-teaching inpatient and consultative services. OSUWMC Division of Hospital Medicine is dedicated to the health and well-being of our patients, team members, and our OSUWMC community. Our mission is to improve the lives of our patients and faculty by providing personalized, patient-centered, evidence-based medical care of the highest quality. Our clinical practice meets rigorous standards of scholarship, and we are devoted to serving as expert educators and mentors to the next generation of physicians.

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

OSUWMC is an equal opportunity/affirmative action employer and encourages applications from women and minorities. This is not a J-1 opportunity.

Our Faculty Enjoy:

- Competitive salary & bonus including a rich benefit package
- Manageable clinical workload with flexible scheduling options
- Faculty appointment commensurate with experience
- Opportunities for leadership & professional development, research & quality improvement, and resident and medical student teaching in partnership with the College of Medicine
- Robust onboarding and mentoring program
- Ongoing education and development programs
- Relocation allowance
- Sign on bonus

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

The Ohio State University Wexner Medical Center

ICU Hospitalist/Nocturnist – Everett Hospital Cambridge Health Alliance (CHA)

Cambridge Health Alliance is a well-respected, nationally recognized and award-winning public healthcare system, which receives recognition for clinical and academic innovations. CHA is comprised of three hospital campuses with additional outpatient clinic locations throughout Boston's Metro North Region. CHA is an academic affiliate of both Harvard Medical School and Tufts University School of Medicine. We are a clinical affiliate of Beth Israel Deaconess Medical Center.

- Position requires PM (7p-7a) and weekend day shifts
- Work collaboratively with intensivist MDs to round on inpatients within the ICU
- Cross coverage of med/surg inpatient unit included in clinical responsibility (10% of FTE)
- Applicants comfortable with central lines, vent management, intubation, etc.
- Internal training/maintenance program exists to assist in certification of skills
- Academic appointment is available commensurate with medical school criteria

Applicants should be Board Certified in Internal Medicine or Family Medicine, possess clinical and communication skills, and show commitment to CHA's unique patient population.

We have a supportive and collegial clinical environment with strong leadership. CHA has a fully integrated electronic medical record system (Epic) throughout. We offer a competitive, guaranteed base salary and comprehensive benefits package.

Please visit **www.CHAproviders.org** to learn more and apply through our secure candidate portal. CV and cover letter may be also be submitted confidentially to Kasie Marchini at **ProviderRecruitment@challiance.org**. CHA's Department of Provider Recruitment may be reached at (617) 665-3555.

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

Envisioning the future of hospital medicine

By Leslie Flores, MHA, SFHM

I have written frequently over the last few years on topics related to the sustainability of the hospital medicine practice model. I continue to be concerned by what I see as a confluence of significant trends that are conspiring to challenge hospital medicine's status quo.

On one hand, the financial pressures on U.S. hospitals are unrelenting, and their willingness or even ability to continue providing significant funding to support their hospital medicine groups is in question. Combine this with hospitalists' rapidly evolving clinical scope and the ever-increasing demands of physicians in other specialties for hospitalist support, and the result is hospital medicine groups that will continue to grow in size, complexity, and the demand for ever more financial support.

On the other hand, the hospitalists I interact with in my work all over the country seem more stressed out than ever, and many are questioning whether this is a job that can be satisfying and sustainable for a career. Increasing patient complexity, productivity pressures, a lack of resources to address patients' social issues, a systole-diastole schedule, the frustration of EHRs and other documentation responsibilities, and feeling "dumped on" by physicians in other specialties all contribute to hospitalist job stress.

A quick look at the literature confirms that in 2019 hospitalist burnout is definitely "a thing." Interestingly, it's been a thing for a while; the risk of hospitalist burnout was first identified by Hoff et al., in 2002 (doi: 10.2307/30902462002). My colleague, John Nelson, MD, MHM, has written a number of times about strategies for preventing or mitigating hospitalist burnout.

As these trends converge, the hospital medicine practice model as we know it may be facing an existential crisis. If that sounds overly dramatic, let me say instead that the hospital medicine practice model will need to evolve significantly over the next decade in order to continue to meet patient and institutional needs while remaining both affordable and sustainable for the clinicians who work in it.

In September 2019, SHM's Multi-Site Leaders Special Interest Group met in Chicago for their second annual Multi-Site Leaders Summit to explore the theme of sustainability in hospital medicine. The participants held robust discussions about coping with our changing practice environment, issues relating to hospitalist burnout and resiliency, innovative staffing models, the role of technology in HM sustainability, and financial sustainability

At the end of the meeting, the group engaged in a visioning exercise designed to move beyond what we are doing today by envisioning what the future of hospital medicine will look like and what interventions will be necessary for us to get from here to there. I'd like to share this visioning exercise with you and encourage you to "play along" by thinking seriously about the questions it poses.

Visioning exercise

Feel free to jot down some thoughts as we go through this exercise. But otherwise, just close your eyes and come along for the ride. Imagine yourself sitting at your desk looking at a desk calendar showing today's date. Watch the pages flip from today, to tomorrow, to the next day, then to next month, and the next, and then to the next year and so on, until we arrive at December 2029.

Imagine that you look up from your desk, and suddenly realize that you aren't in your office at all, but instead in a huge auditorium where someone is speaking about an award that is going to be announced. People around you are whispering to each other with an air of eager anticipation, their eyes glued to the stage. You realize that the person being introduced up on the podium is the President of the United States, and the award is the Presidential Medal of Freedom, which is awarded to people or groups who have made "an especially meritorious contribution to the security or national interests of the United States, world peace, culture, or other significant public or private endeavors."

Today, the Medal is being awarded to the Society of Hospital Medicine on behalf of all hospital medicine leaders nationally, for their collective accomplishments in saving the specialty of hospital medicine and, by doing so, ensuring that sick people are able to continue receiving the care they need in our nation's hospitals – and that the hospitals themselves have become reliably safe, efficient, and effective in achieving high-quality outcomes.

The President says, "At no time in the history of this award until now have we given this, the highest civilian award in the land, to a whole group of physician leaders across an entire specialty. But the achievements of this group of people in preserving and even enhancing the presence of highly energized, dedicated, capable clinicians in our nation's hospitals against the significant odds they have faced over the last 10 years is nothing short of extraordinary." There is a standing ovation, as people jump up out of their chairs to cheer and applaud. When the applause finally dies down, the President goes on to list all the accomplishments that made this group of leaders deserving. Listen to what she is saying. What is it that this group has accomplished?

Up on a huge screen beside the stage, a video starts. In it, there are several hospital and physician executives in a focus group, and one exec says, "The thing that is great about what these leaders have accomplished in the field of hospital medicine is …" Fill it in – what did that executive say?

The video then moves on to show a focus group of recent hospital patients. One patient says, "10 years ago when my mom was in the hospital, the poor hospitalists caring for her seemed completely overwhelmed and burnt out, and the whole care system seemed fragmented and inefficient; but my own recent hospital experience was so different because …" Additional patients chime in, talking about how confident they felt about the care they received in the hospital and the reasons for that. What is it these patients are describing?

SHM's CEO gets up to accept the award and explains that 10 years ago, a group of multi-site hospital medicine leaders from across the country came together to begin addressing the issue of sustainability; this led to a formal process for developing a vision and a plan for the future of hospital medicine, and the execution of that plan eventually resulted in the outcomes recognized by this award. She acknowledges that over the years many people questioned whether the hospital medicine model should even continue to exist or whether some other model for inpatient care should be adopted. She talks about all the compelling reasons that supported the continued existence of the specialty of hospital medicine. What are some of the reasons she listed? The SHM CEO goes on to describe some of the key things that were done to address the issues associated with sustainability of the hospital medicine practice model. Listen to what she says; what was it that SHM and the leaders it represents did?

As you leave the auditorium, you overhear a group of mid-career staff hospitalists talking. They are saying that they didn't originally believe the specialty would actually change, and they weren't sure if they could do this job for a career – but that it did change. They begin talking about what it feels like to work as a hospitalist, and how these changes have improved their lives. Listen to what they are saying. How does it feel to work as a hospitalist?

Take a minute to jot down the specifics that came to mind as you read through this exercise. If you are willing to share your thoughts about sustainability in hospital medicine, I'd love to hear from you. Feel free to email me directly at Leslie.Flores@nelsonflores.com.

Let's build the foundation for a sustainable future for our specialty.

Ms. Flores is a partner at Nelson Flores Hospital Medicine Consultants, La Quinta, Calif. She serves on SHM's Practice Analysis Committee, and helps to coordinate SHM's bi-annual State of Hospital Medicine Survey. This article appeared originally in SHM's official blog The Hospital Leader.

The Hospitalist