

THE Hospitalist

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Pediatric hospitalist and researcher: Dr. Samir Shah

Stoking collaboration between adult and
pediatric clinicians

By Larry Beresford

Samir S. Shah, MD, MSCE, SFHM, director of the division of hospital medicine at Cincinnati Children's Hospital Medical Center, believes that pediatric and adult hospitalists have much to learn from each other. And he aims to promote that mutual education in his new role as editor in chief of the *Journal of Hospital Medicine*.

Dr. Shah is the first pediatric hospitalist to hold this position for *JHM*, the official journal of the Society of Hospital Medicine. He says his new position, which became effective Jan. 1, is primed for fostering interaction between pediatric and adult hospitalists. "Pediatric hospital medicine is such a vibrant community of its own. There are many opportunities for partnership and collaboration between adult and pediatric hospitalists," he said.

The field of pediatric hospital medicine has started down the path toward becoming recognized as a board-certified subspecialty.¹ "That will place a greater emphasis on our role in fellowship training, which is important to ensure that pediatric hospitalists have a clearly defined skill set," Dr. Shah said. "So much of what we learn in medical school is oriented to the medical care of adults. If you go into pediatrics, you've already had a fair amount of grounding in the healthy physiology and common diseases of adults. Pediatric hospital medicine fellowships offer an opportunity to refine clinical skill sets, as well

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A hospitalist must be
innovative, willing, even
daring

MIPS quality reporting for facility-based providers

By Joshua Lapps and Josh Boswell

A cornerstone of hospital medicine is the delivery of high-quality inpatient care by improving the performance of the systems and facilities in which hospitalists work. By extension, hospitalists are often held accountable, in varying ways, for improving the performance of facility metrics, such as those in the Hospital Value-Based Purchasing (HVBP), Inpatient Quality Reporting, and Hospital Readmissions Reduction programs.

Despite the work hospitalists were already doing to improve both efficiency and quality within their institutions, the 2010 Affordable Care Act introduced penalties for clinicians who did not submit qualifying provider-level data via the Physician Quality Reporting System program. Initially only an incentive program, PQRS was ultimately incorporated into the Physician Value-Based Payment (VBP) Modifier to make performance-based payment adjustments to Medicare physician payment. At this point, many hospitalists were not only accountable for helping to improve the metrics of their facilities, but also required to report individually or within their groups on provider-level measures, many of which were irrelevant to hospital medicine practice.

Who is eligible for facility-based measurement?

- Individual providers who bill more than 75% of their Medicare Part B professional services in Place of Service 21 (Emergency Department), 22 (Hospital Outpatient), and 23 (Inpatient Hospital), billing at least one service in POS 21 or 23, and work in a hospital with an HVBP score.
- Groups who have at least 75% of their individual clinicians who meet the eligibility criteria.
- Nearly all hospitalists should qualify for facility-based measurement as individuals, while group eligibility depends on the demographics of their staff.



Mr. Lapps is government relations senior manager and Mr. Boswell is government relations director at the Society of Hospital Medicine.

With this dual burden becoming evident, the Society of Hospital Medicine approached the Centers for Medicare & Medicaid Services with a possible solution. Could hospitalists elect to use their facilities' metrics as a stand-in for the provider level metrics? Not only would this reduce the burden of reporting irrelevant metrics, but it would also help alleviate some of the disadvantages hospitalists face within Physician VBP.

The CMS was initially very supportive of the concept, but informed the SHM such alignment was not possible under existing law. In brief, the law required Physician VBP to remain completely within the Physician Fee Schedule and its related metrics; facility level metrics from a different payment system could not be used.

Undeterred, the SHM sought opportunities to change the law. As Congress was developing the Medicare Access and Chip Reauthorization Act (MACRA), the SHM worked closely with lawmakers to include language that would permit measures in "other payment systems" to be used for physician performance assessment. This language was retained in the final version of MACRA that was signed into law on April 16, 2015.

The SHM continued its advocacy, working closely with the CMS and its new authority to shape an option to align Medicare's facility metrics and scores with provider reporting. Today that idea is a reality. Beginning this year, the CMS will have a new Merit-based Incentive Payment System (MIPS) reporting option

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The ever-evolving scope of hospitalists' services

More care 'beyond the walls' of the hospital

By Linda M. Kurian, MD,
FHM, FACP

The 2018 State of Hospital Medicine (SoHM) Report provides indispensable data about the scope of clinical services routinely provided by adult and pediatric hospitalists. This year's SoHM report reveals that a growing number of Hospital Medicine Groups (HMGs) serving adults are involved in roles beyond the inpatient medical wards, including various surgical comanagement programs, outpatient care, and post-acute care services.

The survey also compares services provided by academic and nonacademic HMGs, which remain markedly different in some areas. As the landscape of health care continues to evolve, hospitalists transform their scope of services to meet the needs of the institutions and communities they serve.

In the previous three SoHM re-

ports, it was well established that more than 87% of adult hospital medicine groups play some role in comanaging surgical patients. In this year's SoHM report, that role was further stratified to capture the various subspecialties represented, and to identify whether the hospitalists



generally served as admitting/attending physicians or consultants.

Hospitalists' roles in comanagement are most prominent for care of orthopedic and general surgery patients, but more than 50% of surveyed HMGs reported being involved in comanagement in some capacity with neurosurgery, obstetrics, and cardiovascular surgery. Additionally, almost 95% of surveyed adult HMGs reported that they pro-

vided comanagement services for at least one other surgical specialty that was not listed in the survey.

The report also displays comanagement services provided to various medical subspecialties, including neurology, GI/liver, oncology, and more. Of the medical subspecialties represented, adult HMGs comanaged GI/liver (98.2%) and oncology (97.7%) services more often than others.

Interestingly, more HMGs are providing care for patients beyond the walls of the hospital. In the 2018 SoHM report, over 17% of surveyed HMG respondents reported providing care in an outpatient setting, representing an increase of 6.5 percentage points over 2016. Most strikingly, from 2016 to 2018, there was a 12 percentage point increase in adult HMGs reporting services provided to post-acute care facilities (from 13.1% to 24.8%).

These trends were most notable in the Midwest region where nearly 28% of HMGs provide patient care in an outpatient setting and up to 34% in post-acute care facilities. In part, this trend may result from the increased emphasis on improving transitions of care, by providing prehospital preoperative services, postdischarge follow-up encounters, or offering posthospitalization extensivist care.

Within the hospital itself, there remain striking differences in certain services provided by academic



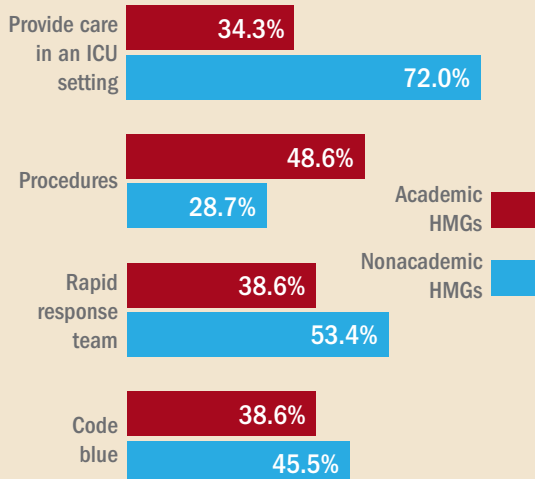
Dr. Kurian is chief of the academic division of hospital medicine at Northwell Health in New York. She is a member of the SHM Practice Analysis Committee.

and nonacademic HMGs serving adults. Nonacademic HMGs are far more likely to cover patients in an ICU than their academic counterparts (72.0% vs. 34.3%). In contrast, academic hospitalist groups were significantly more inclined to perform procedures. However, the report also showed that there was an overall downtrend of percentage of HMGs that cover patients in an ICU or perform procedures.

As the scope of hospitalist services continues to change over time, should there be concern for scope creep? It depends on how one might view the change. As health care becomes ever more complex, high-functioning HMGs are needed to navigate it, both within and beyond the hospital. Some might consider scope evolution to be a reflection of hospitalists being recognized for their ability to provide high-quality, efficient, and comprehensive care. Hospital medicine groups will likely continue to evolve to meet the needs of an ever-changing health care environment.

2018 SoHM: Roles beyond the inpatient medical wards

Services provided by HMGs serving adults



84% of adult HMGs are involved in comanagement of neurosurgery patients.

Outside the hospital

Adult HMGs that provide services to post-acute care facilities

Year	Percentage
2018	24.8%
2016	13.1%

MDedge News

Source: Society of Hospital Medicine's 2018 State of Hospital Medicine Report

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available for hospitalists: facility-based measurement.

Facility-based measurement enables clinicians to receive a score for the Quality and Cost categories of the MIPS, without the need to collect and report on measures separately. Eligible providers would receive the MIPS score in those categories associated with the same percentile as their hospital's score in HVBP. No more administrative work necessary to collect, clean, and report on data for quality measures in the MIPS. If you are eligible, the CMS will automatically calculate a Quality and Cost score and combine this with

your score from Improvement Activities and Promoting Interoperability (if you are not exempt) to give you a final MIPS score. If you decide to report on quality measures through the traditional MIPS pathway as well, the CMS will give you the higher of the scores.

There are certainly trade-offs associated with the facility-based measurement option. You do not have the burden of reporting measures on your own, but you do not get to pick what measures and what facility's score you receive. Facility-level measures may be more difficult to improve performance, particularly as an individual, but the automatic application of facility-based

measurement to eligible clinicians and groups serves as a backstop for MIPS reporting.

Aligning facility and clinician performance should encourage collaboration and innovation to meet these shared goals. As such, facility-based measurement represents a massive philosophical and practical shift in CMS measure reporting. As we enter these uncharted waters together, we hope to continue learning from your experiences and perspectives and working to refine facility-based measurement in the future.

For more information about facility-based reporting and the MIPS in general, visit www.macraforhm.org.

An unplanned career: How did this happen?

A focus on health system transformation

By Patrick H. Conway, MD, MSc, MHM

I have to admit that I am not sure I am a legacy in hospital medicine, and the term legacy throws me off a bit. I came to medical school after working at McKinsey & Co. consulting, and I chose pediatrics because of my love of working with children and families, as well as a vague notion that I wanted to work on “system” issues, and therefore, more generalist-type training seemed applicable.

I met Chris Landrigan, MD, MPH, and Vinny Chiang, MD, and learned what a hospitalist was, as an intern in 2002. We had a research elective and I was able to publish a couple of papers in Pediatrics on pediatric hospital medicine with Chris and Raj Srivastava, MD, MPH. In 2004, I went to my first Society of Hospital Medicine meeting and met Larry Wellikson, MD, MHM, and others. From there, I went to the Robert Wood Johnson Clinical

“Don’t listen to the people who say ‘you must do X before Y’ or ‘you must take this path.’ They are usually wrong. Take chances.”

Scholars Program, with Ron Keren, MD, MPH, and others, and along with faculty from the Cincinnati Children’s in hospital medicine.

In 2007, I applied for a White House Fellowship and told my wife that I didn’t think there was a chance that I would get it, so we should keep building our new home in Cincinnati. We were both surprised when I was selected. I served Michael Leavitt, the then-Secretary of the Department of Health & Human Services, as his White House fellow during the Bush administration, and then served as his chief medical officer. Exposure to health policy and leadership at that level was career shaping. Cincinnati Children’s was searching for a leader for the conversion of pediatric hospital medicine into a full division in 2009. So I returned to Cincinnati to take on leading pediatric hospital medicine, and a role leading quality measurement and improvement efforts for the entire health system. I loved the work and thought I would remain in that role, and our family would be in Cincinnati for a long time. Best laid plans ...

In early 2011, Don Berwick, MD, who was then the administrator of the Centers for Medicare & Medicaid Services, called and asked whether I “would come talk with him in D.C.” That talk quickly became a series of interviews, and he offered me the opportunity to be chief medical officer of CMS. He said “this platform is like no other to drive change.” He was right. I have been fortunate to have a few step-change opportunities in my life, and that was one.

On my first day at CMS, I looked around the table of senior executives reporting to me and realized they had more than 200 years of CMS

experience. I was a bit scared. Together, we led the implementation of Hospital Value-Based Purchasing, the Compare websites, and numerous quality measurement and improvement programs. Partnership for Patients works on patient safety and was associated with preventing more than 3 million infections and adverse events, over 125,000 lives saved, and more than \$26 billion in savings.

In early 2013, I was asked to lead the CMS Innovation Center. The goal was to launch new payment and service delivery models to improve quality and lower costs. We launched accountable care organizations, bundled payment programs, primary care medical homes, state-based innovation, and so much more. Medicare went from zero dollars in alternative payment models, where providers are accountable for quality and total cost of care, to more than 30% of Medicare payments, representing over \$200 billion through agreements with more than 200,000 providers in these alternative payment models. It was the biggest shift in U.S. history in how CMS paid for care. Later, I became principal deputy administrator and acting administrator of CMS, leading an agency that spends over \$1 trillion per year, or more than \$2.5 billion per day and insures over 130 million Americans. We also improved from being bottom quintile in employee engagement and satisfaction across the federal government to No. 2.

I had assumed that, after working at CMS, I would return to a hospital/health system leadership role. But then, a recruiter called about the CEO role at Blue Cross Blue Shield of North Carolina. It is one of the largest not-for-profit health plans in the country and insures most of the people in North Carolina, many for most of their lives. I met a 75-year-old woman the other day that we have insured every day of her life. I am almost a year into the role and it is a mission-driven organization that drives positive change. I love it so far.

We are going to partner with providers, so that more than half of our payments will be in advanced alternative payment models. No payer in the United States has done that yet. This allows us to innovate and decrease friction in the system (e.g., turn off prior authorization) and be jointly accountable with providers for quality and total cost of care. We insure people through the ACA (Affordable Care Act), commercial, and Medicare markets, and are competing to serve Medicaid as well. We have invested more than \$50 million to address social determinants of health across the state. We are making major investments in primary care, and mental and behavioral health. Our goal is to be a Model Blue – or a Model of Health Transformation for our state and nation – and achieve better health outcomes, lower costs, and best-in-class experience for all people we serve. I have learned that no physician leads a health plan of this size, and apparently, no practicing physician has ever led a health plan of this size.



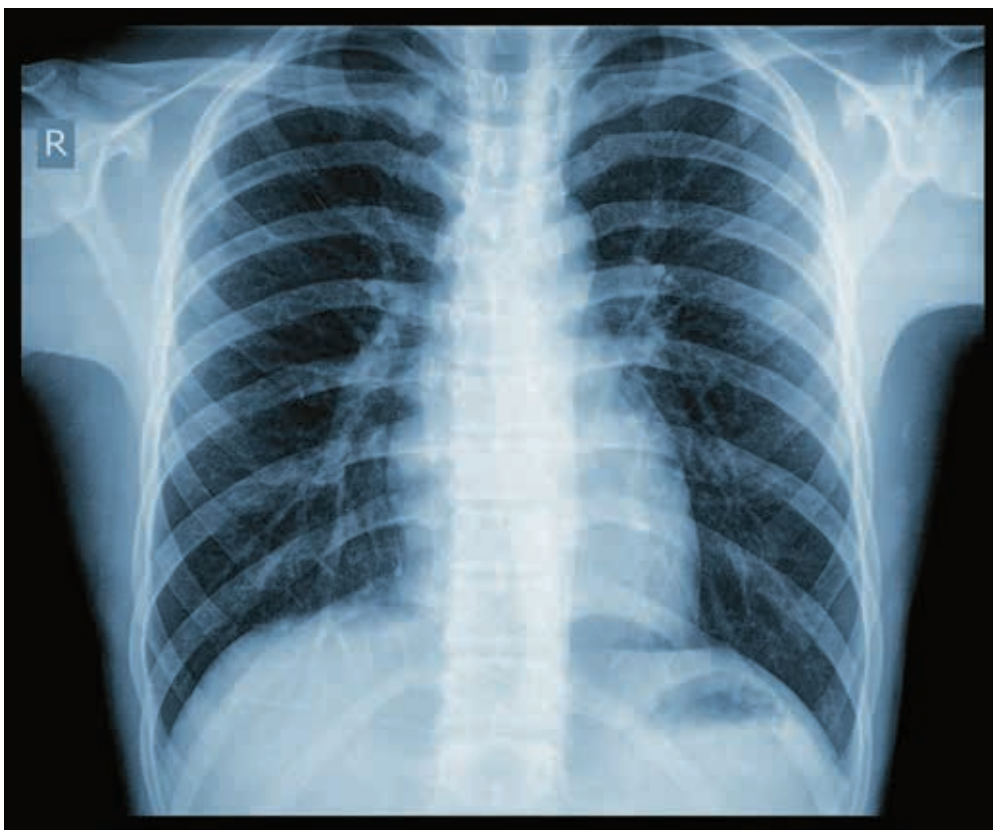
Dr. Conway is president and CEO of Blue Cross and Blue Shield of North Carolina. He is a hospitalist and former deputy administrator for innovation and quality at the Centers for Medicare & Medicaid Services.

What are some lessons learned over my career? I have had five criteria for all my career decisions: 1) family; 2) impact – better care and outcomes, lower costs, and exceptional experience for populations of patients; 3) people – mentors and colleagues; 4) learning; and 5) joy in work. If someone gives you a chance to lead people in your career as a physician, jump at the chance. We do a relatively poor job of providing this type of opportunity to those early in their careers in medicine, and learning how to manage people and money allows you to progress as a leader and manager.

Don’t listen to the people who say “you must do X before Y” or “you must take this path.” They are usually wrong. Take chances. I applied for many roles for which I was a long shot, and I didn’t always succeed. That’s life and learning. Hospital medicine is a great career. I worked in the hospital on a recent weekend and was able to help families through everything from palliative care decisions and new diagnoses, to recovering from illness. It is an honor to serve and help families in their time of need. Hospitalists have been – and should continue to be – primary drivers of the shift in our health system to value-based care.

As I look back on my career (and I hope I am only halfway done), I could not have predicted more than 90% of it. I was blessed with many opportunities, mentors, and teachers along the way. I try to pass this on by mentoring and teaching others. How did my career happen? I am not sure, but it has been a fun ride! And hopefully I have helped improve the health system some, along the way.

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Coherence: Your meta-leadership objective

Learn to balance organizational priorities

By Leonard J. Marcus, PhD

For the many people who expect you to lead, your role – among others – is to create coherence. That coherence characterizes the logic and consistency of what you do in your organization. It assembles the individual work of many different people into a whole that functions well. Coherence in your workplace helps people make sense of what they are doing and why it matters.

Our very rational brain craves coherence. We assemble facts, emotions, ambitions and our life stories into narratives that define who we are, what we are doing, and why it is im-

portant. Creating coherence is a complex meta-leadership process. A large health care center is a cacophony of priorities, of which advancing quality of care is but one. There are other objectives, some contradictory, that also absorb time and attention: achievement of financial benchmarks, promotion of professional careers, and the individual hopes and desires of patients. Systematically aligning those many priorities and objectives is a process of both design and leadership.

The meta-leadership model is a strategy for building coherence amid the complexity of health care operations. For those unfamiliar with meta-leadership: The prefix

as a hospitalist leader create coherence in what you are leading given the changing priorities, actions, and turbulence of current health policy and the market?

The answers lie in the communication you foster and clarify. That communication demands clarity and diplomacy. It is multidirectional such that messages and information in your leading down, up, across, and beyond complement and inform one another.

An illustration of one pathway: You learn from senior management about cuts in the budget. You reflect with them on the choices implicit in those cuts. Perhaps there are better ways to reduce expenditures and increase revenues that offer an alternative pathway to a balanced budget? When communicating with your subordinates, you open conversation on ways to enhance efficiencies and assure quality. You explore avenues to partner with other departments within your institution on how you can link and leverage services and capabilities. And you consider your marketplace and the actions you can take to reinforce your department and assure the volume necessary to achieve budget and quality objectives. And through it all, you monitor the situation.

What are the effects of the budget adjustments, and what can be done to sustain the coherence of the work and output of the department? It is a leadership process of constant situational awareness, personal commitment, and connectivity of effort.

An illustration of another pathway: Resist the change and argue forcefully for holding onto the current budget and workforce. Though you do not possess the authority to control larger budgetary decisions, you employ influence well beyond your authority. You recruit allies to your cause, advocates who believe in the purpose you are promoting. You build an alternative coherence, mindful of fostering friendship and minimizing alienation. You are recognized for the passion of your professional commitment and your capacity to uphold quality care and organizational balance.

Two very different pathways to crafting coherence. Leaders of each perceive their actions to advance priority coherence objectives. Apply this question to your own complex problem solving.

Meta-leaders forge coherence



Dr. Marcus is coauthor of *Renegotiating Health Care: Resolving Conflict to Build Collaboration*, 2nd Edition (San Francisco: Jossey-Bass Publishers, 2011) and is Director of the Program for Health Care Negotiation and Conflict Resolution, Harvard T.H. Chan School of Public Health, Boston. Dr. Marcus teaches regularly in the SHM Leadership Academy. He can be reached at ljmarcus@hsph.harvard.edu.



portant. An effective organizational “meta-leader” encourages that process for followers. It helps people make sense of the work side of their life.

When coherence is absent, the workplace is riddled with contradictions, unpredictability, and dissonance. People are expected to accomplish tasks for which the time, tools, and talent are missing. There is a perplexed swirl of high activity and low productivity. Expectations for high quality of care and patient satisfaction are contradicted by an overbearing workload, reams of paper\work, and the low morale that leaves the work force lethargic. “What we are doing here and how we are doing it doesn’t make sense,” exemplifies the exasperation of working amid incoherence. The department does not drive together toward success-oriented performance. Instead, different people, priorities, and opportunities will be positioned in conflict with one another. For people in your group and those surrounding it, morale and motivation suffer. There is the risk that people will descend into malaise.

“meta-” refers to a wider perspective on what is happening, the people involved, and the overall combination of objectives. The three dimensions of practice are: 1) the Person of the meta-leader – your own priorities, values and emotional intelligence; 2) the Situation – what is happening and what ought to be done about it; and 3) Connectivity of Effort, which leads down to subordinates, up to bosses, across to other internal departments, and beyond to external organizations and professionals.

In building connectivity of effort, the meta-leader links the many sides of the work being accomplished. The intent is to balance – purposefully – different organizational objectives into a combined whole that gets the jobs done. Furthermore, that coherence links and adapts what people are doing to the situation at hand. And in essence, the person of the leader cannot lead broader coherence if not coherent in her or his own thinking, attitudes, and behaviors, so achievement of personal and professional clarity of purpose is important.

The question for you: How do you

through the narratives they build and the consistency with those themes and priorities. When everyone on your staff, from physicians to housekeeping personnel, can say “I am here to help save lives,” you know that your followers are on board with a shared mission. They recognize that their efforts contribute to that overall mission. Each person has a role to play, and her or his work fits with the efforts of others, and the bottom line accomplishments of the department.

The coherence you forge assists your followers to make sense of what they are doing and how it fits with what others are doing. Work is fulfilling. Beyond that, in a turbulent health care system, you anticipate both problems and opportunities with strategies to meet them. You stay ahead of the game to ensure that people within and outside the department are aligned to maximize opportunities for success.

This is particularly important for the hospitalist. Your job is to fashion coherence on many levels. First, coherent patient care for the patient. Second, coherent interactions among professionals. Finally, organizational coherence, so one piece of the puzzle fits with others. And, when there is a need to recalculate, you adapt and develop solutions that fit the people and situation at hand.

Q&A

Shaping the future of hospital medicine

Dr. Therese Franco leads SHM's Pacific Northwest chapter

By Suzanne Bopp

Therese Franco, MD, SFHM, a hospitalist at the Virginia Mason Medical Center in Seattle, is the current president of SHM's Pacific Northwest chapter.

The Hospitalist recently sat down with her to learn about her background and discuss some of the initiatives that the Pacific Northwest chapter has been working on.

Can you tell us about your education and training on the way to becoming a hospitalist?

My undergraduate degree is in engineering from Michigan State University. I then went to the University of Michigan in Ann Arbor and did one degree at the School of Public Health in environmental and industrial health, and another degree in the College of Engineering in industrial and operations engineering. In my work with the safety department at an automotive company, I found I was spending a lot of time looking at data, and not talking to people. I got into a conversation with one of the occupational medicine physicians there, and he said, "You ought to try this." I spoke with a good friend, who was a medical student, and she agreed.

So then I went to medical school thinking that I would practice occupational medicine. I went to medical school at Wayne State University in Detroit and did a couple of rotations in occupational medicine. I wasn't sure that was the right fit, so I then went off to residency in internal medicine at the University of Connecticut, Farmington, and really enjoyed my wards experience. I liked the pace, I liked the variety, and just really liked all of hospital medicine. So that's what I decided to do.

What are your areas of research interest?

This year I'm doing a research fellowship through the Center for Healthcare Improvement Science, at Virginia Mason. Through SHM's mentored implementation program, I have done a lot of work on diabetes and glycemic control but never really published much of it. I think it is so important to share what you learn, so I'm working on publishing some of our results from the diabetes work.

Another area of interest is advanced-practice providers in hospital medicine, which I think is very important given all the issues that health care is facing. I think that medicine has gotten more complex and that we're going to have to look at working in a collaborative, interprofessional, multidisciplinary way. I think that advanced practice can really improve the care of hospitalized patients, if we practice appropriate skill-task alignment, develop a culture of mutual respect, and find the best ways to deploy our advanced-practice providers and our physicians.

Has your institution made any changes along these lines?

We're primarily using the fellowship as a tool to

recruit and retain some of the brightest and best. We've got three fellows that matriculated from our program and are currently working in the section of hospital medicine. Everyone's been really flexible and open to the idea that the job description is emerging. I think my colleagues are very appreciative of our advanced-practice providers. We've got two nurse practitioners and one physician assistant who is also a PhD-trained pharmacist. They've been great additions to our team.



Dr. Franco

What are some of the other issues that the Pacific Northwest chapter members are concerned about?

One of our most successful meetings was about telemedicine. There's a lot of interest in that, and it's very financially and technically complex. Some hospitals in the area are really doing novel things. One of the most interesting things is an addiction medicine teleconsult.

That's out of Swedish Medical Center, Seattle. Of course there's telestroke, which I think is picking up in popularity. We had speakers from Virginia Mason who presented on telestroke. Some institutions are even doing admissions this way. The University of Washington, Seattle, is doing some good antimicrobial stewardship work. They present cases and teleconference and have an infectious disease consultant. It's not a program directed at revenue generation, but is focused instead on sharing and spreading expertise.

Our chapter also hosted a presentation on burnout that was pretty well attended. And then, unfortunately, we did lose a hospitalist to suicide over the summer. That was the inspiration for offering the screening of the movie, "Do No Harm: Exposing the Hippocratic Hoax."

What was the program that you put together around the screening?

We had the filmmaker come for the screening, and we organized a panel discussion with a wellness officer from a local clinic and a psychiatrist who used to be on the board of the Physician

Health Program. John Nelson, MD, MHM, one of SHM's cofounders and a local hospitalist here, also participated as a panelist.

Overall, the event was well received. There were some things that I didn't really expect. I'm not sure that the film resonated with too many people in the room. It is very much directed at the educational process – med students and residents – and at times, the dialogue is a little inflammatory.

I think future conversations need to come from thoughtful, rational, respectful leaders who are willing to work with regulatory agencies, hospitals, and administrators. If we want to move forward, physicians, administrators, and the public need to come together in the best interest of the patient and of public health. And I don't know who leads that conversation.

What are some other issues that stand out as important to your chapter?

One key topic is the financial side of hospitalist practice, and dealing with issues that seem to create inefficiencies – regulatory issues, documentation issues, things that are important because we want to tell the story of what we're doing. We certainly want to be reimbursed for the value-added work that we're doing, but a lot of value-added work creates inefficiencies of practice, and I hear a lot of dissatisfaction around documentation, coding, billing, and other issues related to reimbursement. While people are concerned about these problems, nobody wants to talk about them. They just want somebody to fix it. So I'm not sure what to do with that, because I think if I had a meeting about coding and billing, I would have three attendees.

Our chapter is trying to diversify geographically and clinically. We were fortunate to receive a development funds grant to use technology to do streaming meetings. Our hope is that we can host streaming meetings and eventually transition hosting to rotate around the state. Once there's large enough attendance, the different delegates can develop their own leadership teams and, eventually, their own chapter.

What else is on the horizon for hospitalists in the Pacific Northwest?

I'd like to see more frequent meetings and a greater variety of meetings. I think there's interest in adding some kind of service element to the chapter. I think we'll also be focusing on students and residents and trying to create support for them. We held a student event around financial planning, and that was very well attended. Our chapter really needs to leverage our technology if we want to have the reach that I'm talking about. I'm looking forward to piloting the streaming meeting concept, and I hope to do some live polling of our meeting attendees to get them engaged. I hope we continue to grow and keep the dialogue going about what matters in hospital medicine, and do our part to shape the future in the way we want it.

Medicare's two-midnight rule

What hospitalists must know

By Charles Locke, MD, CHCQM-PHYADV,
and Edward Hu, MD, CHCQM-PHYADV

Most hospitalists' training likely included caring for patients in the ambulatory clinic, urgent care, and ED settings. One of the most important aspects of medical training is deciding which of the patients seen in these settings need to "be admitted" to a hospital because of risk, severity of illness, and/or need for certain medical services. In this context, "admit" is a synonym for "hospitalize."

However, in today's health care system, in which hospitalization costs are usually borne by a third-party payer, "admit" can have a very dif-

It is important for hospitalists to have a basic understanding of [inpatient vs. outpatient] rules because it can affect hospital billing, the hospitalist's professional fees, beneficiary liability, and payer denials of inpatient care.

ferent meaning. For most payers, "admit" means "hospitalize as inpatient." This is distinct from "hospitalize as an outpatient." ("Observation" or "obs" is the most common example of a hospitalization as an outpatient.) In the medical payer world, inpatient and outpatient are often referred to as "statuses." The distinction between inpatient versus outpatient status can affect payment and is based on rules that a hospital and payer have agreed upon. (Inpatient hospital care is generally paid at a higher rate than outpatient hospital care.) It is important for hospitalists to have a basic understanding of these rules because it can affect hospital billing, the hospitalist's professional fees, beneficiary liability, and payer denials of inpatient care.

For years, Medicare's definition of an inpatient hospitalization was primarily based on an expectation of a hospitalization of at least 24 hours and a physician's judgment of the beneficiary's need for inpatient hospital services. This judgment was to be based on the physician's assessment of the patient's severity of illness, the risk of an adverse outcome, and the hospital services required. (The exact definition by Centers for Medicare & Medicaid Services is much longer and can be found in the Medicare Benefit Policy Manual.¹) Under Medicare, defining a hospitalization as inpatient versus outpatient is especially important because they are billed to different Medicare programs (Part A for inpatient, Part B for outpatient), and both hospital reimbursement and the patient liability can vary significantly.

Not surprisingly, CMS found that how physicians were making status decisions for medically similar hospitalized patients varied greatly. CMS noted two major concerns: an overuse of inpa-

tient for patients hospitalized overnight leading to increased charges to CMS and multiday observation hospitalizations for lower-acuity patients leading to excessive liability for Medicare beneficiaries. (Observation stays are billed under Part B, under which the beneficiary generally has a 20% copay.)

To address these concerns, in October 2013, CMS adjusted the definition of inpatient to include "the two-midnight rule." Basically, CMS said that, in order to qualify for inpatient, the admitting physician should expect the beneficiary to require hospital care spanning at least two midnights, rather than the previous 24-hour benchmark, regardless of the severity of illness or risk of adverse outcome. (There are exceptions and exemptions to the two-midnight rule, which are discussed later in this article.)

The idea of the two-midnight rule was to address the two concerns noted above. Under this rule, most expected overnight hospitalizations should be outpatients, even if they are more than 24 hours in length, and any medically necessary outpatient hospitalization should be "converted" to inpatient if and when it is clear that a second midnight of hospitalization is medically necessary.

In January 2016, CMS amended the two-midnight rule to recognize, as it had done prior to October 2013, that some hospitalizations, based on physician judgment, would be appropriate for inpatient without an expectation of a hospitalization that spans at least two midnights. Unfortunately, CMS has not been forthcoming with guidance of examples of which hospitalizations would fall into this new category, other than to say they expect the use of this new provision would generally not be appropriate for a hospital stay of less than 24 hours.

As of today, physicians should order inpatient services under the following three situations:

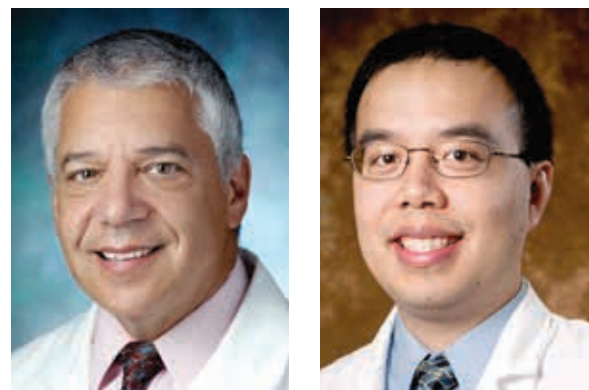
- The physician expects the beneficiary to require hospital care spanning at least two midnights.
- The physician provides a service on Medicare's inpatient-only list.
- The physician expects the beneficiary to require hospital care for less than two midnights but feels that inpatient services are nevertheless appropriate.

This most recently updated version of the two-midnight rule can be found in Section 42 CFR §412.3 of the Code of Federal Regulations.² Each of these three situations warrants additional discussion.

Care expected to span two midnights

The first situation is the one most applicable to hospitalists. In this circumstance there are three key points to remember.

The first point is that the two-midnight rule is based on a reasonable expectation of a need for hospitalization for at least 2 nights, not the actual length of hospitalization. Auditors, based on long-standing guidance from the CMS, should



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consider only the information known (or that should have been known) to the provider at the time the inpatient decision is made.

For example, if the expectation of the need for hospitalization of at least two midnights is well documented in the admission note, but the beneficiary improves more rapidly than expected and can be discharged before the second midnight, billing Medicare under Part A for inpatient admission remains appropriate. Auditors may look for provider documentation describing the unexpected improvement, and while such documentation is not an absolute requirement, its presence can be helpful in defending inpatient billing.

Other situations in which there can be an expectation of hospitalization of at least two midnights, but the actual length of stay does not meet this benchmark, are death, patients leaving against medical advice, or transfer to another hospital. For example, if a patient is hospitalized as an inpatient for bacterial endocarditis, and the documented plan of care includes at least 2 days of IV antibiotics and monitoring of cultures, inpatient remains appropriate even if the patient signs out against medical advice the following day.

The second key point to understand is that a night must be "medically necessary" to count toward the two-midnight benchmark. Hospital time spent receiving custodial care, because of excessive delays, or incurred because of the convenience of the beneficiary or provider does not count toward the two-midnight benchmark. For example, imagine a patient hospitalized with chest pain on Saturday evening and the attending physician determines that the patient requires serial cardiac isoenzymes and ECGs followed, most likely, by a noninvasive stress test. The attending physician, knowing that the hospital does not offer stress testing on Sunday, expects the patient to remain hospitalized at least until Monday, thus two midnights. However, in this situation, the

second midnight (Sunday night) was not medically necessary and does not count toward the two midnight expectation.

The third key point to know is that the clock for calculating the two-midnight rule begins when the beneficiary starts receiving hospital care, not when the inpatient order is placed. Further, care that starts in the ED or at another hospital counts, too. In contrast, care at an outpatient clinic, an urgent care facility, or waiting-room time in an ED does not count.

When CMS implemented the two-midnight rule in 2013, they said that they would be open to exceptions. The first and only exception to date to the two-midnight rule is newly initiated and unanticipated mechanical ventilation. (This excludes anticipated intubations related to other care, such as procedures.) For example, inpatient is appropriate for a patient who requires hospitalization for an anaphylactic reaction or a drug overdose and needs intubation and mechanical ventilation, even if discharge is expected before a second midnight of hospital care.

CMS's inpatient-only list

Each year, CMS publishes a list of procedures that CMS will pay only under Part A (that is, as inpatient). This list is updated quarterly (Addendum E) and can be found on the CMS website.³ Hospitalizations associated with the procedures on this list should always be inpatient, regardless of the expected length of stay.

It is important to note that the inpatient-only list is dynamic; it is revised annually, and procedures can come on or off the list. Notably, in Jan-

uary 2018, elective total knee replacements and laparoscopic radical prostatectomies came off the inpatient-only list. Most surgeons and proceduralists know whether the procedure they are

The clock for calculating the two-midnight rule begins when the beneficiary starts receiving hospital care, not when the inpatient order is placed. Further, care that starts in the ED or at another hospital counts, too.

performing is on this list, and they should advise hospitalists accordingly if the hospitalist is to be the attending of record and will be writing the admission order.

Inpatient services are nevertheless appropriate

The third situation, in which an inpatient admission is appropriate even when the admitting provider does not expect a two-midnight stay, was added to the two-midnight rule in January 2016. CMS states that the factors used in making this determination can be based on physician judgment and documented in the medical record.

At first reading, one might think that CMS is, in effect, returning to the definition of an inpatient prior to the two-midnight rule's implementation in 2013. However, CMS has not offered clear guid-

ance for its use, and they did not remove any of the previous two-midnight rule guidance. In the absence of clear guidance, hospitalists may be best served by not using this latest change to the two-midnight rule in determining which Medicare beneficiary hospitalizations are appropriate for inpatient designation.

A final, and critical, point about the two-midnight rule is that it only applies to traditional Medicare, and it does not apply to other payers, including commercial insurance and Medicaid. Medicare Advantage plans may or may not follow the two-midnight rule, depending on their contract with the hospital. Which patients are appropriate for inpatient designations are usually determined by the individual contract that the hospital has signed with that payer.

A better understanding of the two-midnight rule including to whom it applies, when it applies, and how to apply it will help you accurately determine which hospitalizations are appropriate for inpatient payment. With this understanding, you will quickly become the hero of your hospital's case managers and billing department.

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Dr. Samir Shah

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as develop new skills in domains such as research and leadership.”

An emphasis on diversity

Although he has praised the innovative work of his predecessors, Mark Williams, MD, MHM, and Andrew Auerbach, MD, MPH, MHM, in shepherding the journal to its current strong position, Dr. Shah brings ideas for new features and directions.

“We as a field really benefit from a diversity of skill sets and perspectives. I’m excited to create processes to ensure equity and diversity in everything we do, starting with adding more women and more pediatric hospitalists to the journal’s leadership team, as well as purposefully developing a diverse leadership pipeline for the journal and for the field,” he said.

“We are intentionally reaching out to pediatricians to emphasize the extent to which *JHM* is invested in their field. For example, we have increased by seven the number of pediatricians as part of the *JHM* leadership team.” But pediatric hospitalists have always seen *JHM* as a home for their work, and Dr. Shah himself has published a couple dozen research papers in the journal. “It has always felt to me like a welcoming place,” he said.

“The great thing for me is that I’m not doing this alone. We have a marvelous crew of senior deputy editors, deputy editors, associate editors, and advisors. The opportunity I have is to leverage the phenomenal expertise and enthusiasm of this exceptional team.”

The journal under Dr. Auerbach’s lead created an editorial fellowship program offering opportunities for 1-year mentored exposure to the publication of academic scholarship and to different aspects of how a medical journal works. “We’re excited to continue investing in this program and included an editorial about it and an application form in the January 2019 issue of the journal,” Dr. Shah said. He encourages editorial fellowship applications from physicians who historically have been underrepresented in academic medicine leadership.

“We’re also creating a column on leadership and professional development so that leaders in different fields can share their perspective and wisdom with our readers. We’ll be presenting a new, shorter review format; distilling clinical practice guidelines; and working on redesigning the journal’s web presence. We

believe that our readers interact with the journal differently than they did five years ago, and increasingly are leveraging social media,” he said.

“I’m eager to broaden the scope of the journal. In the past, we focused on quality, value in health care and transitions of care in and out of the hospital, which are important topics. But I’m also excited about the adoption of new technologies, how to evaluate them and incorporate them into medical practice – things like Apple Watch for measuring heart rhythm,” Dr. Shah.

He wants to explore other technology-related topics like alarm

“I have seen exceptional enthusiasm for increasing the presence of pediatric hospitalists in the society’s work.”

fatigue and the use of monitors. Another big subject is the management of health of populations under new, emerging, risk-based payment models, with their pressures on health systems to take greater responsibility for risk. *JHM* is a medical journal and an official society journal, Dr. Shah said. “But our readership and submitters are not limited to hospitalists. As editor in chief, I’m here to make sure the journal is relevant to our members and to our other constituencies.”

Dr. Shah joined *JHM*’s editorial leadership team in 2009, then he became its deputy editor in 2012 and its senior deputy editor in 2015. A founding associate editor of the *Journal of the Pediatric Infectious Diseases Society*, he has also served on the editorial board of *JAMA Pediatrics*. He is editor or coeditor of 12 books in the fields of pediatrics and infectious diseases, including co-authoring “The Philadelphia Guide: Inpatient Pediatrics for McGraw-Hill Education” while still a fellow in academic general pediatrics and pediatric infectious diseases at Children’s Hospital of Philadelphia (CHOP) and, more recently, “Pediatric Infectious Diseases: Essentials for Practice,” a textbook for the pediatric generalist.

Broad scope of activities

Dr. Shah started practicing pediatric hospital medicine in 2001 during his fellowship training. He joined the faculty at CHOP and the University of Pennsylvania, also in Philadelphia, in 2005. In 2011 he arrived at Cincinnati Children’s Hospital, a facility with more than 600 beds that’s affiliated with the University of Cincinnati, where he is professor in the

department of pediatrics and holds the James M. Ewell Endowed Chair, to lead a newly created division of hospital medicine. That division now includes more than 55 physician faculty members, 10 nurse practitioners, and nine 3-year fellows.

Collectively the staff represent a broad scope of clinical and research activities along with consulting and surgical comanagement roles and a unique service staffed by med/peds hospitalists for adult patients who have been followed at the hospital since they were children. “Years ago, those patients would not have survived beyond childhood, but

with medical advances, they have. Although they continue to benefit from pediatric expertise, these adults also require internal medicine expertise for their adult health needs,” he explained. Examples include patients with neurologic impairments, dependence on medical technology, or congenital heart defects.

Dr. Shah’s own schedule is 28% clinical. He also serves as the hospital’s chief metrics officer, and his research interests include serious infectious diseases, such as pneumonia and meningitis. He is studying the comparative effectiveness of different antibiotic treatments for community-acquired pneumonia and how to improve outcomes for hospital-acquired pneumonia.

Dr. Shah has tried to be deliberate in leading efforts to grow researchers within the field, both nationally and locally. He serves as the chair of the National Childhood Pneumonia Guidelines Committee of the Infectious Diseases Society of America and the Pediatric Infectious Diseases Society, and he also is vice chair of the Pediatric Research in Inpatient Settings (PRIS) Network, which facilitates multicenter cost-effectiveness studies among its 120 hospital members. For example, a series of studies funded by the Patient-Centered Outcomes Research Institute has demonstrated the comparable effectiveness of oral and intravenous antibiotics for osteomyelitis and complicated pneumonia.

Sustainable positions

When he was asked whether he felt pediatric hospitalists face particular challenges in trying to take their place in the burgeoning field of hos-

pital medicine, Dr. Shah said he and his colleagues don’t really think of it in those terms. “Hospital medicine is such a dynamic field. For example, pediatric hospital medicine has charted its own course by pursuing subspecialty certification and fellowship training. Yet support from the field broadly has been quite strong, and SHM has embraced pediatricians, who serve on its board of directors and on numerous committees.”

SHM’s commitment to supporting pediatric hospital medicine practice and research includes its cosponsorship, with the Academic Pediatric Association and the American Academy of Pediatrics, of an annual pediatric hospital medicine educational and research conference, which will next be held July 25-28, 2019, in Seattle. “In my recent meetings with society leaders I have seen exceptional enthusiasm for increasing the presence of pediatric hospitalists in the society’s work. Many pediatric hospitalists already attend SHM’s annual meeting and submit their research, but we all recognize that a strong pediatric presence is important for the society.”

Dr. Shah credits Cincinnati Children’s Hospital for supporting a sustainable work schedule for its hospitalists and for a team-oriented culture that emphasizes both professional and personal development and encourages a diversity of skill sets and perspectives, skills development, and additional training. “Individuals are recognized for their achievements within and beyond the confines of the hospital. The mentorship structure we set up here is incredible. Each faculty member has a primary mentor, a peer mentor, and access to a career development committee. Additionally, there is broad participation in clinical operations, educational scholarship, research, and quality improvement.”

Dr. Shah’s professional interests in academics, research, and infectious diseases trace back in part to a thesis project he did on neonatal infections while in medical school at Yale University, New Haven, Conn. “I was working with basic sciences in a hematology lab under the direction of the neonatologist Dr. Patrick Gallagher, whose research focused on pediatric blood cell membrane disorders.” Dr. Gallagher, who directs the Yale Center for Blood Disorders, had a keen interest in infections in infants, Dr. Shah recalled.

“He would share with me inter-

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Hospitalists on the Hill

Advocating for HM in D.C.

By Suzanne Bopp

Another Hill Day is coming – the all-day advocacy event on Capitol Hill is scheduled in conjunction with the Society of Hospital Medicine’s Annual Conference whenever it is held in Washington, D.C. In 2019, Hill Day will take place on March 27, the final day of HM19.

This will be the fourth Hill Day, and the last for some time, said Ron Greeno, MD, FCCP, MHM, senior advisor for government affairs at SHM and the society’s immediate past president. For at least the next 5 years, SHM’s annual conferences won’t be held in Washington, so there will not be any opportunities to plan a Hill Day during that time. “Members may want to take advantage of this opportunity,” Dr. Greeno said. “The people who do this never forget it.”

How Hill Day works

Sign up for Hill Day and you’ll spend a day visiting legislators and their health care staffers to educate them on what hospital medicine is, what a hospitalist does, and some of the pressing issues that affect the profession, said Joshua Lenchus, DO, RPh, FACP, SFHM, chair of the SHM Public Policy Committee. “We try to leverage participants’ work and home addresses to pair them up with legislators from that area. Some hospitalists have personal or profes-



Dr. Lenchus

sional relationships with some of the legislators, and even if they’re not in their area, we’ll try to leverage that. And for people who have expertise in a particular topic, we try to arrange an audience with a member of Congress who may be promoting or sponsoring a bill related to that.”

Hill Day volunteers will attend an orientation to learn more about what the day will look like and what they’ll be talking about in their meetings. “We’ll only have time to cover one or two issues, and we’re in the process now of choosing the issues we want to address. We orient participants on those subjects so everybody is kind of saying the same thing,” Dr. Greeno said. “People shouldn’t be afraid of not being conversant with the issues because

we do sufficient orientation that everybody gets comfortable enough to do a good job.”

Registration for Hill Day is happening online now. HM19 attendees can register at https://sl.goeshow.com/shm/annual/2019/registration_form.cfm.

“We beg people: If you sign up, show up, because we have many more people trying to participate than we can accommodate,” Dr. Greeno said. “If you change your mind, that’s fine because we have a waiting list, but please let us know because somebody else wants to take your place.”

The purpose of Hill Day

Educating legislators and their health care staff is the goal of the day, and it’s an important job. “Hospital medicine is still a relatively new field,” Dr. Lenchus said. “There are a fair number of legislators who still don’t know what a hospitalist is or what hospital medicine is. Part of our visits is always to educate them about what we do and what our impact is on the health care landscape of the country.” He added that educating Hill staff about the most pressing issues is another primary goal.

“Finally, and this is what separates us from other organizations that do legislative advocacy, we try to leave them with the idea that we’re here to help,” Dr. Lenchus said. “If there’s an issue or a particular bill that we’re asking them to sponsor or cosponsor, that’s one part of a visit. But by and large, we are trying to leave them with the sense that SHM is a resource when it comes to health care–related issues. We want to be there for legislators so that they can understand our position accurately from the outset.”

In short, Hill Day offers a rare opportunity to have direct access to the people who are voting on new legislation affecting hospitalists and affecting the implementation of existing legislation. “This is where the rubber meets the road,” Dr. Lenchus said. Each time a Hill Day is held, he noted, attendance increases. “That’s a true testament to the level of involvement and the interest that hospitalists have across the country. If you’re at all interested, you should absolutely sign up. This will be an amazing experience.”

The lasting impact

Though it’s just one day, Hill Day’s effects are significant.

“Before I started doing this work, I often thought, ‘What impact could someone have going into a legislator’s office?’” Dr. Greeno said. “But the answer is ‘A lot.’ The members and staff really do listen – especially if an advocate is highly educated and represent what legislators consider an important constituency, like health care providers. Health care is a hot topic, and it’s probably going to be one of the hot topics in the next election. Hospitalists have good ideas, and as a result



Dr. Greeno

these meetings are extremely influential; we wouldn’t do it otherwise. It is fun, but we’re not doing it for fun. We’re doing it because we know we can make a difference.”

In fact, in terms of impact on Capitol Hill, SHM punches above its weight, he added.

“We’re a relatively new society; we’re not huge. There are lots of societies that are much bigger than us and have many more resources, but people on the Hill have told us they like talking with us because they know we’re not looking at things the same way,” Dr. Greeno revealed. “We’re trying to help, and the issues that we’re addressing are not necessarily self-serving. We’re not saying, ‘You need to do this because it will make more money for our doctors.’ Instead, we’re saying, ‘You need to do this because the way it’s being done now is hurting patients. It’s hurting the health care system, and we have ideas about how to make that better.’”

SHM’s impressive track record has earned the society a positive reputation that will underlie the Hill Day meetings. “When we first set up the policy shop at SHM, we wanted to be seen as providers who cared about the American health care system and our patients,” Dr. Greeno said. “We have established that reputation, and that has led members on Capitol Hill to recognize us as being well intentioned and knowledgeable. So we have an outsize influence in Congress for our age and our size. When 200 hospitalists go to Capitol Hill, it’s an important thing.”

For more information about Hill Day, including details about participation, visit shmannual.conference.org/hill-day/.

Continued from previous page

esting cases from his practice. What particularly captured my attention was realizing how the research I could do might have a direct impact on patients and families.” Thus inspired to do an additional year of medical school training at Yale before graduating in 1998, Dr. Shah used that year to focus on research,

including a placement at the Centers for Disease Control and Prevention to investigate infectious disease outbreaks, which offered real-world mysteries to solve.

“When I was a resident, pediatric hospital medicine had not yet been recognized as a specialty. But during my fellowships, most of my work was focused on the inpatient side of med-

icine,” he said. That made hospital medicine a natural career path.

Dr. Shah describes himself as a devoted soccer fan with season tickets for himself, his wife, and their three children to the Major League Soccer team FC Cincinnati. He’s also a movie buff and a former avid bicyclist who’s now trying to get back into cycling. He encourages readers of

The Hospitalist to contact him with input on any aspect of the *Journal of Hospital Medicine*. Email him at Samir.shah@cchmc.org and follow him on Twitter: @samirshahmd.

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Benefiting from an egalitarian hospital culture

Cultural change linked to improved outcomes

Health care experts have long known of a link between patient outcomes and a hospital's organizational culture, according to an article in the New York Times by Pauline W. Chen, MD.

"Heart attack patients who are treated at hospitals where nurses feel powerless and senior management is only sporadically involved in patient care tend to fare more poorly than patients hospitalized at institutions where nurses are asked regularly for their input and chief executives hold regular meetings with clinicians to review patient results," she wrote.

But there is hope for change, Dr. Chen noted, and it's demonstrable, citing a group of researchers that has written about strategies targeting hospital organizational culture called "Leadership Saves Lives." The researchers showed hospitals could create significant cultural changes, which could impact patient outcomes, in just 2 years.

"Leadership Saves Lives requires that each hos-

pital create a 'Guiding Coalition,' a group of staff members from across the entire institution. The coalition members participate in regular workshops, discussions, and national forums on ways hospitals might improve, then help their respective hospital translate newfound ideas and information into clinical practice," she wrote.

The researchers monitored heart attack patients to assess the effect of Leadership Saves Lives in 10 hospitals that had below-average patient outcomes. Over 2 years, all 10 hospitals changed significantly, but 6 hospitals experienced particularly profound cultural transformations.

"The staff of these hospitals spoke of an institutional shift from 'because I said so' to 'focusing on the why's,'" Dr. Chen wrote. "Instead of accepting that every heart attack patient had to undergo certain testing or take specific drugs because the chief of the department or administrator had previously established such clinical protocols, for example, it became more import-

ant to provide the data that proved such rituals were actually helpful. Staff members in these hospitals also said they received, and appreciated, increased support from senior management and a newfound freedom to voice opinions in 'more of an equal role, no matter what position you are.'"

The degree of an institution's cultural change was directly linked to patient outcomes, the researchers found. Indeed, hospitals that made more substantial changes in their work culture realized larger and more sustained drops in heart attack mortality rates.

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Helping quality improvement teams succeed

QI coaches may be the answer

Hospitalists understand the need for quality improvement (QI) as an important part of health care, and they take active roles in – or personally drive – many of the QI efforts at their own facilities. But too often the results are inconsistent and the adoption of new practices slow.

Help can come from a QI coach, according to a recent paper describing a model of successful coaching. "We wanted to be able to help novice QI teams to be successful," said the paper's lead author Danielle M. Olds, PhD. "Unfortunately, most QI projects are not successful for a variety of reasons including inadequate project planning, a lack of QI skills, a lack of leadership and stakeholder buy-in, and inappropriate measures and methods."

The coaching model outlined comes from the VAQS program, launched in 1998 to provide structured training around QI and the care of veterans. The seven-step process outlined in the paper provides a road map to overcoming typical QI stumbling blocks and create more successful projects.

"Improvement should be a part of everyone's practice, however most clinicians have not been trained in how to successfully lead a formal QI project," said Dr. Olds, who is based at the University of Kansas, Kansas City. "Hospitals can bridge this gap by providing QI coaches as a resource to guide teams through the process."

The model offers a new way for hospitalists to take the lead on QI. "Hospitalists who may have extensive experience in conducting QI could use a model, such as ours, to guide their coaching of teams within their facility," she said. "Because of the nature of hospitalist practice, they are in an ideal position to understand improvement needs at a systems level within their facility. I would strongly encourage hospitalists to engage in QI because of the wealth of knowledge and experience that they could bring."

Reference

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Improving interview skills for hospitalists

Standardized prep courses are helpful

Are residents generally prepared for fellowship interviews? Applications to the Fellowship Match through the National Residency Matching Program Specialties Matching Service are at an all-time high, but there is limited data regarding the preparedness of residents who go through the fellowship interview process, said Kelvin Wong, MD, a coauthor of research describing a new approach to fellowship interview preparation, which may be generalizable to hospitalists in applying for other positions.

"Applicants receive little to no feedback after their interviews and are thus likely to repeat the same mistakes throughout the process. Verbal feedback from our own fellowship directors indicated that residents as a whole are unprepared to interview," according to an abstract written by Dr. Wong and his colleagues.

Dr. Wong wanted to investigate the effects of a standardized fellowship interview preparation course on resident preparedness. He and his coauthors developed a formal preparation course for the applicants in the summer of 2017.

Precourse surveys showed that

only 17.65% of residents felt prepared to go on interviews; post-course surveys showed a rise in this number to 82.35%. Immediately after their mock interview, only 27.78% of residents rated their overall interview skills as "very good" or "excellent," whereas 87.50% of interviewers and 70.59% of observers rated their skills to be "very good" or "excellent."

A final survey will be given to the applicants and the fellowship program directors once the applicants have completed all of their actual interviews.

"This demonstrates the potential positive impact that mock interviews and standardized interview preparation courses can have, which may be generalizable to hospitalists applying for other positions," Dr. Wong said. "Specifically for teaching hospitalists in teaching hospitals, the institution of such fellowship interview preparation courses may improve resident preparedness for the fellowship application process."

Reference

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New handoff tool can improve safety

Standardization of process reduces variation

Hospitalists know all too well that a significant source of medical errors is miscommunication during transitions: By interrupting the continuity of care, handoffs can increase the risk of adverse events.

Yet the transfer of patients from the ED to the hospitalist inpatient service has not been well studied, said Carmen E. Gonzalez, MD, lead author of a recent paper that ex-



ANDREI MALOV/THINKSTOCK

amined the issue. “The scope of this study was to develop and test a handoff communication tool and a standardized process for transitioning patients from the ED to the hospitalist service at a comprehensive cancer center,” she explained.

In the study, the researchers found that the number of ICU transfers within 24 hours of admission and the number of rapid-response calls decreased after the implementation of a customized handoff tool. “The tool was named DE-PASS [DE-PASS: Decisive problem requiring admission, Evaluation time, Patient summary, Acute issues/action list, Situation unfinished/awareness,

Signed out to], which was a modification of the I-PASS, and adapted to our workflow,” reported Dr. Gonzalez, who is based at the University of Texas MD Anderson Cancer Center, Houston. DE-PASS stratifies patients as stable/urgent/emergent and establishes requirements for communications between providers.

Results from the 1-month pilot revealed that, within a 24-hour period, DE-PASS reduced the number of intensive care unit transfers by 58%, the number of rapid-response team calls by 39%, and time to inpatient order by 31%.

“The standardization of the language and format of the handoff process of admission from the ED to the hospitalist service reduced handoff variations, increased provider satisfaction, and improved patient safety,” she noted.

The hospitalists expressed satisfaction with the tool. “This handoff tool helps stratify newly admitted patients based on their illness acuity, hence, assists the busy admitting hospitalist in prioritizing which patient needs to be attended first,” said study coauthor Norman Brito-Del-lan, MD, also of MD Anderson Cancer Center. “In this study, DE-PASS reduced admission-to-evaluation times for unstable patients. These patients tend to be evaluated earlier, improving safety.”

Reference

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Quick Byte: Needle-free injections

A start-up operating out of MIT in Cambridge, Mass., called Portal Instruments has developed a needleless injection system.

The device, called PRIME, delivers medication into the bloodstream in a high-pressure stream that travels at Mach 0.7 – the speed of a jet. The makers signed a commercial deal in

December 2017, and the device is expected to be available soon.

Reference

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Q&A

Advanced practice providers in HM

Building a collaborative practice

By Suzanne Bopp

Emilie Thornhill Davis, PA-C, is the assistant vice president for advanced practice providers at Ochsner Health System in New Orleans. She is the former chair of SHM's Nurse Practitioner and Physician Assistant (NP/PA) Committee, and has spoken multiple times at the SHM Annual Conference.

In honor of the inaugural National Hospitalist Day, to be held on Thursday, March 7, 2019, *The Hospitalist* spoke with Ms. Davis about the unique contributions of NP and PA hospitalists to the specialty of hospital medicine.

Where did you get your education?

I got my undergraduate degree from Mercer University and then went on to get my prerequisites for PA school, and worked clinically for a year prior to starting graduate school in Savannah, Georgia, at South University.

Was your intention always to be a PA?

During my sophomore year of college, Mercer was starting a PA program. Having been taken care of by PAs for most of my life, I realized that this was a profession I was very interested in. I shadowed a lot of PAs and found that they had extremely high levels of satisfaction. I saw the versatility to do so many types of medicine as a PA.

How did you become interested in hospital medicine?

When I was in PA school, we had small groups that were led by a PA who practiced clinically. The PA who was my small group leader was a hospitalist and a fantastic role model. I did a clinical rotation with her team, and then went on to do my elective with her team in hospital medicine. When I graduated, I got my first job with the hospital medicine group that I had done those clinical rotations with in Savannah. And then in 2013, after about a year and a half, life brought me to New Orleans and I started working at Ochsner in the department of hospital medicine. I was one of the first two PAs that this group had employed.

What is your current role and title at Ochsner?

From 2013 to 2018, I worked in the department of hospital medicine, and for the last 2 years I functioned as the system lead for advanced practice providers in the department of hospital medicine. In September 2018, I accepted the role of assistant vice president of advanced practice providers for Ochsner Health System.

What are your areas of interest or research?

I've had the opportunity to speak at the annual Society of Hospital Medicine Conference for 3 years in a row on innovative models of care, and nurse practitioner and PA utilization in hospital medicine. I was the chair for the NP/PA committee, and during that time we developed a toolkit aimed at providing a resource to hospital medicine groups around nurse practitioner and PA integration to practice in full utilization.

What has your experience taught you about how NPs and PAs can best fit into hospital medicine groups?

Nurse practitioners and PAs are perfectly set up to integrate into practice in hospital medicine. Training for PAs specifically is based on the medicine model, where you have a year of didactic and a year of clinical work in all the major disciplines of medicine. And so in a clinical year as a PA, I would rotate through primary care, internal medicine, general surgery, ob.gyn., psychiatry, emergency medicine, pediatrics. When I come out of school, I'm generalist trained, and depending on where your emphasis was during clinical rotations, that could include a lot of inpatient experience.

I transitioned very smoothly into my first role in hospital medicine as a PA, because I had gained that experience while I was a student on clinical rotations. PAs and nurse practitioners are – when they're utilized appropriately and at the top of their experience and training – able to provide services to patients that can improve quality outcomes, enhance throughput, decrease length of stay, and improve all the

different areas that we focus on as hospitalists.

What roles can a PA occupy in relation to physicians and nurse practitioners in hospital medicine?

When you're looking at a PA versus a nurse practitioner in hospital medicine, you'll notice that there are



Ms. Davis

differences in the way that PAs and nurse practitioners are trained. All PAs are trained on a medical model and have a very similar kind of generalist background, whereas a nurse practitioner is typically schooled with nursing training that includes bedside experience that you can't always guarantee with PAs. But once we enter into practice, our scope and the way that we take care of patients over time becomes very similar. So a PA and a nurse practitioner for the most part can function in very similar capacities in hospital medicine.

The only thing that creates a difference for PAs and NPs are federal and state rules and regulations, as well as hospital policies that might create "scope of practice" barriers. For instance, when I first moved to Louisiana, PAs were not able to prescribe Schedule II medications. That created a barrier whenever I was discharging patients who needed prescriptions for Schedule II. That has since changed in the state of Louisiana; now both PAs and NPs have full prescriptive authority in the state.

I would compare the work of PAs and NPs with that of physicians like this: Once you have NPs or PAs who

are trained and have experience in the specialty that they are working in, they are able to provide services that would otherwise be provided by physicians.

How does a hospitalist PA work differently from a PA in other care settings?

The scope of practice for a PA is defined by the physician they're working with. So my day-to-day work as a PA in hospital medicine looked very similar to a physician's day-to-day work in hospital medicine. In cardiology, for example, the same would likely hold true, but with tasks unique to that specialty.

How does SHM support hospitalist PAs?

SHM is the home where you have physicians, nurse practitioners, and PAs all represented by one society, which I think is really important whenever we're talking about a membership organization that reflects what things truly look like in practice. When I am a member of SHM and the physician I work with is a member of SHM, we are getting the same journals and are both familiar with the changes that occur nationally in our specialty; this really helps us to align ourselves clinically and to understand what's going on across the country.

What kind of resources do hospitalist PAs need to succeed, either from SHM or from their own institutions?

I think the first thing we have to do is make sure that we're getting the nomenclature right, that we're referring to nurse practitioners and physician assistants by their appropriate names and recognizing their role in hospital medicine. Every year that I spoke at the SHM Annual Conference, I had many hospital medicine leaders come up to me and say they needed help with incorporating NPs and PAs, not only clinically, but also making sure they were represented within their hospital system. That's why we developed the toolkit, which provides resources for integrating NPs and PAs into practice.

There is an investment early on

Continued on following page

New AAN position statement on brain death

By Erik Greb

MDedge News

FROM NEUROLOGY / In a position statement published in *Neurology*, the American Academy of Neurology urges uniformity in the laws, policies, and practices related to brain death. Such uniformity would reduce uncertainty and improve patient care, according to the authors. The statement, which was drafted by the AAN's Brain Death Working Group, also supports the development of uniform policies regarding brain death and its determination within American medical institutions.

Finally, the document provides neurologists with guidance for responding to requests for accommodation, including objections to the determination of brain death and to the withdrawal of organ-sustaining technology.

The AAN defines brain death as death resulting from irreversible loss of function of the entire brain. The Uniform Determination of Death Act of 1981 held that brain death and circulatory death (that is, death resulting from irreversible loss of function of the circulatory system) are equivalent, and the AAN acknowledges this equivalence.

The two current medical stan-

dards for brain death are the AAN's 2010 Evidence-Based Guideline Update: Determining Brain Death in Adults and the 2011 Guidelines for the Determination of Brain Death in Infants and Children, which was published by the pediatric section of the Society of Critical Care Medicine, the sections of neurology and critical care of the American Academy of Pediatrics, and the Child Neurology Society. "The AAN is unaware of any cases in which compliant application of the brain death guidelines led to inaccurate determination of death with return of any brain function, including consciousness, brainstem reflexes, or ventilatory effort," according to their 2019 statement.

The only jurisdiction with laws that specifically defer to these standards, however, is Nevada. The vagueness of most states' laws has contributed to divergent legal interpretations and idiosyncratic standards for determining brain death.

"The AAN believes that a specific, uniform standard for the determination of brain death is critically important to provide the highest quality patient-centered neurologic and end-of-life care," said James Russell, DO, MS, a neurologist at Lahey Hospital and Medical Center in Burlington, Mass., and lead author of the position statement.

"The AAN supports the development of legislation in every state modeled after the Nevada statute, which specifically defers to these current adult and pediatric brain death guidelines and any future updates."

In addition to uniform institutional policies for determining brain death within U.S. medical facilities, the AAN calls for the development of training programs and credentialing mechanisms for physicians who determine brain death, regardless of their specialties.

While expressing respect for requests for limited accommodation, the AAN says these requests "must be based on the values of the patient, and not those of loved ones or other surrogate decision makers." The AAN further observes that physicians have no ethical obligation to provide medical treatment to a deceased patient. New Jersey is the only state that legally obliges physicians to provide indefinite accommodation and continued application of organ-sustaining technology.

"The AAN believes that its members have both the moral authority and professional responsibility, when lawful, to perform a brain death evaluation, including apnea testing, after informing a patient's loved ones or lawful surrogates of that intention, but without obligation to obtain informed consent," according to the statement. "This position is analogous to the authority and responsibility historically granted to the medical profession to determine circulatory death without the requirement for additional informed consent."

If a dispute about indefinite accommodation cannot be resolved, it is acceptable for a physician to withdraw organ-sustaining technology unilaterally over the objection of loved ones when legally permitted, according to the AAN. Such unilateral action is a measure of last resort and does not apply when the patient is a pregnant woman, wrote the authors. In the latter case, the ethical analysis should focus mainly on the welfare of the fetus.

Continued from previous page

when you bring PAs into your group to train them. We often use the SHM core competencies when we are referring to a training guide for PAs or NPs as a way to categorize the different materials that they would need to know to practice efficiently, but I do think those could be expanded upon.

What's on the horizon for NPs and PAs in hospital medicine?

One national trend I see is an increase in the number of NPs and PAs entering hospital medicine. The other big trend is the formal development of postgraduate fellowships for PAs in hospital medicine. As the complexity of our health systems continues to grow, the feeling is that, to get a nurse practitioner and PA the training they need, there are benefits to having a protected post-grad year to learn.

One unique thing about nurse practitioners and PAs is their ver-

satility and their ability to move among the various medical specialties. As a PA or a nurse practitioner, if I'm working in hospital medicine and I have a really strong foundation, there's nothing to say that I couldn't then accept a job in cardiovascular surgery or cardiology and bring those skills with me from hospital medicine.

But this is kind of a double-edged sword, because it also means that you may have a PA or NP leave your HM group after 1-2 years. That kind of turnover is a difficult thing to address, because it means dealing with issues such as workplace culture and compensation. But that shows why training and engagement is important early on in that first year – to make sure that NPs and PAs feel fully supported to meet the demands that hospital medicine requires. All of those things really factor into whether an NP or PA will choose to continue in the field.



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Non-TB mycobacteria infections rising in COPD patients

By Jennie Smith

MDedge News

FROM FRONTIERS IN MEDICINE / Veterans with chronic obstructive pulmonary disease (COPD) have seen a sharp increase since 2012 in rates of non-TB mycobacteria infections, which carry a significantly higher risk of death in COPD patients, according to findings from a nationwide study.

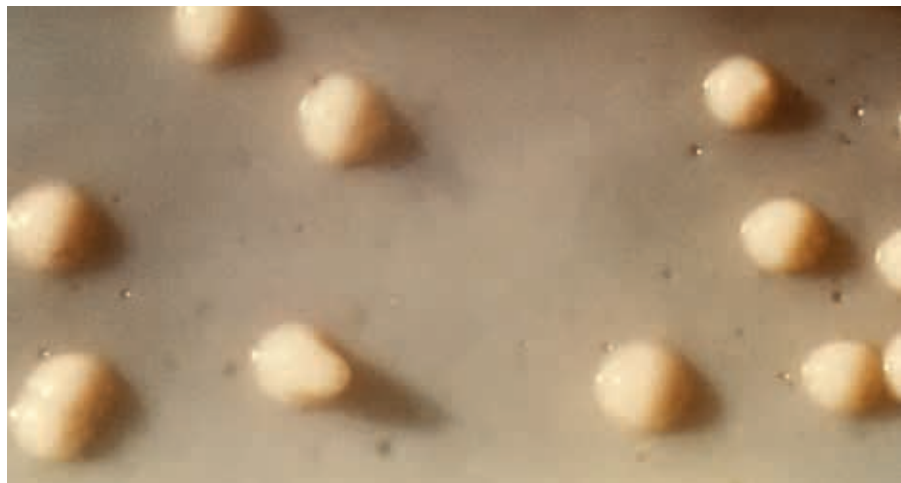
For their research, published in *Frontiers of Medicine*, Fahim Pyarali, MD, and colleagues at the University of Miami, reviewed data from Veterans Affairs hospitals to identify non-TB mycobacteria (NTM) infections among more than 2 million COPD patients seen between 2000 and 2015. Incidence of NTM infections was 34.2 per 100,000 COPD patients in 2001, a rate that remained steady until 2012, when it began climbing sharply through 2015 to reach 70.3 per 100,000 ($P = .035$). Dr. Pyarali and colleagues also found that, during the study period, prevalence of NTM

climbed from 93.1 infections per 100,000 population in 2001 to 277.6 per 100,000 in 2015.

Hotspots for NTM infections included Puerto Rico, which had the highest prevalence seen in the study at 370 infections per 100,000 COPD population; Florida, with 351 per 100,000; and Washington, D.C., with 309 per 100,000. Additional hotspots were identified around Lake Michigan, in coastal Louisiana, and in parts of the Southwest.

Dr. Pyarali and colleagues noted that the geographical concentration of cases near oceans and lakes was “supported by previous findings that warmer temperatures, lower dissolved oxygen, and lower pH in the soils and waters provide a major environmental source for NTM organisms,” however, the study is the first to identify Puerto Rico as having exceptionally high prevalence. The reasons for this should be extensively investigated, the investigators argued.

The mortality risk was 43% higher among NTM-infected patients than



Dr. GEORGE KUBICA/CDC

Petri culture plate that had been used to cultivate colonies of the saprotrophic bacteria, *Mycobacterium avium*, which is commonly found in water and soil.

in COPD patients without an NTM diagnosis (95% confidence interval, 1.31-1.58; P less than .001), independent of other comorbidities.

Though rates of NTM infection were seen rising steeply in men and women alike, Dr. Pyarali and colleagues noted as a limitation of their study its use of an overwhelmingly male population, writing that this

may obscure “the true reach of NTM disease and mortality” in the general population. The average age of NTM diagnosis remained steady throughout the study period, suggesting that rising incidence is not attributable to earlier diagnosis.

Dr. Pyarali and colleagues reported no outside sources of funding or financial conflicts of interest.



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Digital alerts reduced AF-related stroke, MI rates

By Richard Mark Kirkner

MDedge News

REPORTING FROM THE AHA SCIENTIFIC SESSIONS / CHICAGO / High-risk hospitalized patients with atrial fibrillation (AF) whose doctors monitored them with a computerized alert system were more than twice as likely to be on anticoagulation and had significantly lower rates of death and other cardiovascular events, compared with patients on a standard admissions protocol, according to results of a randomized, controlled trial presented at the American Heart Association Scientific Sessions.

"Alert-based computerized decision support [CDS] increased the prescription of anticoagulation for stroke prevention in atrial fibrillation during hospitalization, at discharge, and at 90 days after randomization in high-risk patients," said Gregory Piazza, MD, of Brigham and Women's Hospital, Boston, in presenting results of the AF-ALERT trial. "The reductions in major cardiovascular events was attributable to reductions in MI and stroke/transient ischemic attack at 90 days in patients whose physicians received the alert."

The trial evaluated 458 patients hospitalized for AF or flutter and with CHA₂DS₂-VASc scores of 1-8 randomly assigned to the alert (n = 258) or no-alert (n = 210) groups.

Dr. Piazza explained that, for those in the alert group, the CDS system notified physicians when the patient's CHA₂DS₂-VASc score increased. From there, the physician could choose to open an order template to prescribe evidence-based medications to prevent stroke, to elect to review evidence-based clinical practice guidelines, or to

continue with the admissions order with an acknowledged reason for omitting anticoagulation (such as high bleeding risk, low stroke risk, high risk for falls, or patient refusal of anticoagulation).

"In patients for whom their providers were alerted, 35% elected to open the stroke-prevention order set, a very tiny percentage elected to read the AF guidelines, and about 64% exited but provided a rationale for omitting anticoagulation," Dr. Piazza noted.



Dr. Piazza

The alert group was far more likely to be prescribed anticoagulation during the hospitalization (25.8% vs. 9.5%; *P* less than .0001), at discharge (23.8% vs. 12.9%; *P* = .003), and at 90 days (27.7% vs. 17.1%; *P* = .007) than the control group. The alert resulted in a 55% relative risk reduction in a composite outcome of death, MI, cerebrovascular event, and systemic embolic event at 90 days (11.3% vs. 21.9%; *P* = .002). The alert group had an 87% lower incidence of MI at 90 days (1.2% vs. 8.6%, *P* = .0002) and 88% lower incidence of cerebrovascular events or systemic embolism at 90 days (0% vs. 2.4%; *P* = .02). Death at 90 days occurred in 10.1% in the alert group and 14.8% in the control group (*P* = .13).

One of the limitations of the study, Dr. Piazza noted, was that the most dramatic finding – reduction of major cardiovascular events – was a secondary, not a primary, endpoint. "CDS has the potential to be a powerful tool in prevention of cardiovascular events in patients with atrial fibrillation."

Moderator Mintu Turakhia, MD, of Stanford (Calif.) University, questioned the low rate of anticoagulation in the study's control arm – 9.5% – much lower than medians reported in many registries. He also asked Dr. Piazza to describe the mechanism of action for prescribing anticoagulation in these patients.

Dr. Piazza noted the study population was hospitalized patients whose providers had decided prior to their admissions not to prescribe anticoagulation; hence, the rate of anticoagulation in these patients was actually higher than expected.

Regarding the mechanism of action, "the electronic alert seems to preferentially increase the prescription of [direct oral anticoagulants] over warfarin, and that may have been one of the mechanisms," Dr. Piazza said. Another explanation he offered were "off-target" effects whereby, if providers have a better idea of a patient's risk for a stroke or MI, they'll be more aggressive about managing other risk factors.

"There are a number of interventions that could be triggered if the alert prompted the provider to have a conversation with patients about their risk of stroke from AF," he said. "This may have impact beyond what we can tell from this simple [Best Practice Advisory in the Epic EHR system]. I think we don't have a great understanding of the full mechanisms of CDS."

Dr. Piazza reported ties with BTG, Janssen, Bristol-Myers Squibb, Daiichi Sankyo, Portola, and Bayer. Daiichi Sankyo funded the trial. Dr. Turakhia reported relationships with Apple, Janssen, AstraZeneca, VA, Boehringer Ingelheim, Cardiva Medical, Medtronic, Abbott, Precision Health Economics, iBeat, iRhythm, MyoKardia, Biotronik, and an ownership interest in AliveCor.

In-hospital blood-saving strategy appears safe with anemia

By Andrew D. Bowser

MDedge News

FROM THE ANNALS OF INTERNAL MEDICINE / A blood management initiative that reduced RBC transfusions in the hospital did not adversely impact long-term outcomes after discharge, a retrospective analysis of an extensive patient database suggested.

Tolerating moderate in-hospital anemia did not increase subsequent RBC use, readmission, or mortality over the next 6 months, according to the study, which drew on nearly half a million patient records.

In fact, modest mortality decreases were seen over time for patients with moderate anemia, perhaps because of concomitant initiatives that targeted infectious and circulatory conditions, reported Nareg H. Roubinian, MD, of Kaiser Permanente Northern California in Oakland

and the University of California, San Francisco, and coinvestigators.

"These data support the efficacy and safety of practice recommendations to limit red blood cell transfusion in patients with anemia during and after hospitalization," they wrote. The report is in *Annals of Internal Medicine*. Additional studies are needed to guide anemia management, they wrote, particularly since persistent anemia has impacts on quality of life that are "likely substantial" and linked to the severity of that anemia.

Dr. Roubinian and colleagues sought to evaluate the impact of blood management programs – initiated starting in 2010 – that included blood-sparing surgical and medical techniques, increased use of hemostatic and cell salvage agents, and treatment of suboptimal iron stores before surgery.

In previous retrospective cohort

studies, the researchers had found that the blood conservation strategies did not impact in-hospital or 30-day mortality rates, which was consistent with short-term safety data from clinical trials and other observational studies.

Their latest report on longer-term outcomes was based on data from Kaiser Permanente Northern California for 445,371 adults who had 801,261 hospitalizations with discharges between 2010 and 2014. In this cohort, moderate anemia (hemoglobin between 7 g/dL and 10 g/dL) at discharge occurred in 119,489 patients (27%) and 187,440 hospitalizations overall (23%).

Over the 2010-2014 period, RBC transfusions decreased by more than 25% in the inpatient and outpatient settings; in parallel, the prevalence of moderate anemia at hospital discharge increased from 20% to 25%. However, the risks of

subsequent RBC transfusions and rehospitalization after discharge with anemia decreased during the study period and mortality rates stayed steady or decreased slightly.

Among patients with moderate anemia, the proportion with subsequent RBC transfusions within 6 months decreased from 18.9% in 2010 to 16.8% in 2014 (*P* less than .001), while the rate of rehospitalization within 6 months decreased from 36.5% to 32.8% over that same time period (*P* less than .001). The adjusted 6-month mortality rate likewise decreased from 16.1% to 15.6% (*P* = .004) over that time period among patients with moderate anemia.

The National Heart, Lung, and Blood Institute supported the study. Dr. Roubinian and several coauthors reported grants during the conduct of the study from the National Institutes of Health.

ITL: Clinician reviews of HM-centric research

By Gopi Astik, MD; Maya V. Defoe, MD; Joshua M. Lennon, MD; Aditi Puri, MD, MS;
and Marion V.N. Stanley, MD

Division of Hospital Medicine, Northwestern Memorial Hospital, Chicago

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By Gopi Astik, MD

1 Increased daily water intake benefits premenopausal women with recurrent UTIs

CLINICAL QUESTION: Does increased water intake have any measurable effect on the occurrence of cystitis in premenopausal women?
BACKGROUND: Acute cystitis is a common condition in women and associated with morbidity. A commonly recommended preventative measure is increased oral hydration, but there is limited evidence to support this claim.

STUDY DESIGN: Open-label, randomized, controlled study.

SETTING: Clinical research center based in Sofia, Bulgaria.

SYNOPSIS: A 12-month trial done at a clinical research center including healthy women with recurrent cystitis who drank less than 1.5 L of fluid daily. One group was instructed to drink 1.5 L of water/day in addition to their normal fluid intake, and the

other was advised not to drink any additional fluid. The mean number of cystitis episodes in the intervention group was 1.7 (95% confidence interval, 1.5-1.8), compared with 3.2 (95% CI, 3.0-3.4) in the control group, which was a statistically significant difference of 1.5 (95% CI, 1.2-1.8; P less than .01).

Though antibiotic prophylaxis is more effective at reducing cystitis, increased daily water intake is a safe and inexpensive method to

prevent cystitis without increasing exposure to antimicrobial therapy. This study did rely on information obtained from phone calls with patients. It is also an open-label study design in which patients were not blinded to their assigned group. This would be less of an issue if episodes of cystitis were confirmed with culture. Another limitation of this study is that it included only ambulatory patients and excluded patients with pyelonephritis, so it may be less applicable to our hospitalized patients.

BOTTOM LINE: This study shows a benefit in recurrent cystitis by increased water intake in premenopausal women.

CITATION: Hooton TM et al. Effect of increased daily water intake in premenopausal women with recurrent urinary tract infections. *JAMA Intern Med.* 2018 Nov;178(11):1509-15.

Dr. Astik is medical director, clinical documentation, at Northwestern University Feinberg School of Medicine and a hospitalist at Northwestern Memorial Hospital, both in Chicago.

By Maya V. Defoe, MD

2 Use of antipsychotics to treat delirium in the ICU

CLINICAL QUESTION: Does management of ICU delirium with either typical or atypical antipsychotic medications result in a shorter duration of delirium?

BACKGROUND: Delirium is commonly seen in the ICU and has been associated with increased morbidity and mortality. While haloperidol, as well as atypical antipsychotics,

often are used to manage ICU delirium, evidence has been mixed as to whether these medications shorten the duration of either hyperactive or hypoactive delirium.

STUDY DESIGN: Randomized, controlled trial.

SETTING: 16 medical centers in the United States.

SYNOPSIS: 566 adult patients with respiratory failure or shock who experienced delirium in medical or surgical ICUs in participating hospitals were randomly assigned to receive either IV haloperidol, ziprasidone, or placebo. The median exposure to the trial medication or placebo

was 4 days. The median number of days without delirium was not significantly different among the three groups ($P = .26$) with a median length of delirium of 8.5 days in the placebo group,

compared with 7.9 days in the haloperidol group and 8.7 days in the ziprasidone group. The study was powered to detect a 2-day difference.

Only 11% of patients experienced hyperactive delirium, which makes these results less generalizable to patients whose delirium presents as agitation.

BOTTOM LINE: The use of antipsychotics in ICU delirium does not affect the duration of delirium in patient with respiratory failure or shock.

CITATION: Girard TD et al. Haloperidol and ziprasidone for treatment of delirium in critical illness. *N Eng J Med.* 2018 Dec 27;379(26):2506-16.

Dr. Defoe is an instructor of medicine at Northwestern University Feinberg School of Medicine and a hospitalist at Northwestern Memorial Hospital, both in Chicago.

By Joshua M. Lennon, MD

3 Shorter vs. longer DAPT following coronary stent placement

CLINICAL QUESTION: Is 6 months of dual antiplatelet therapy (DAPT) therapy noninferior to 12 months

following ST-elevation myocardial infarction (STEMI) with placement of second-generation drug-eluting stents?

BACKGROUND: DAPT has been the standard of care to prevent abrupt thrombotic closure of vessels following percutaneous coronary intervention (PCI) and placement of stents. The recommended duration of DAPT was lengthened from at least 30 days in bare metal stents to at least 12 months in earlier-generation drug-eluting stents after observation of high rates of in-stent thrombosis of drug-eluting stents.

Trials have shown that there is no difference in outcomes comparing 6 month vs. 12 months in DAPT for PCI in the cases of non-ST-elevation MI and unstable angina. However, there are no randomized controlled studies comparing 6 vs. 12 months of DAPT with newer drug-eluting stents following STEMI. Newer drug-eluting stents are made of biocompatible polymers with thinner struts and are thought to be fully absorbed by 3 months. International guidelines still recommend 12 months of DAPT following drug-eluting stent placement following STEMI.

STUDY DESIGN: Prospective, unblinded, randomized, multicenter noninferiority trial.

SETTING: The study was performed at 17 sites in the Netherlands, Norway, Poland, and Switzerland.

SYNOPSIS: This study enrolled 1,100 patients with STEMI started on DAPT during December 2011–June 2015. Overall, 870 patients were randomized to continue DAPT or to change to single antiplatelet therapy (SAPT) at 6 months. Exclusions included embolic events, cardiogenic shock, revascularization, bleeding, or being on anticoagulation. Patients were followed for 24 months.

The primary endpoint was a composite of all-cause mortality, any MI, any revascularization, stroke, or thrombolysis. Incidence of the composite endpoint was 4.8% of SAPT cases and 6.6% of DAPT cases. Noninferiority was met ($P = .004$)



Dr. Astik



Dr. Defoe

because the upper 95% confidence interval of 1.27 was smaller than the prespecified noninferiority margin of 1.66. The secondary endpoint of safety and bleeding at 18 months was 3.2% for SAPT and 4.3% for DAPT, with a hazard ratio of 0.75.

Medtronic's new stent was used in 92% of the cases of this industry-sponsored study. Despite usage of



Dr. Lennon

a composite endpoint, there was no difference in the individual elements of the composite in subgroup analyses. There was a low event rate in both arms, likely because of the exclusions

that led to a lower-risk population. The individual operators were able to choose the P2Y12 inhibitor.

BOTTOM LINE: This industry-sponsored, randomized, open-label trial showed noninferiority of 6 months of DAPT to 12 months of therapy following STEMI to prevent in-stent thrombosis with newer second-generation drug-eluting stents. However, the study's results may be limited to lower-risk patients, without need for revascularization, oral anticoagulation, or with stroke or cardiogenic shock.

CITATION: Kedhi E et al. Six months versus 12 months of dual antiplatelet therapy after drug-eluting stent implantation in ST-elevation myocardial infarction (DAPT-STEMI): Randomised, multicenter, noninferiority trial. *BMJ*. 2018;363:k3793.

4 Amitriptyline for chronic low back pain

CLINICAL QUESTION: Is a low-dose tricyclic antidepressant effective in the treatment of chronic low back pain?

BACKGROUND: Lower back pain is the leading cause of disability globally and effective treatments are limited. Furthermore, opioid usage for lower back pain is a large contributor to the current opioid epidemic. A recent Cochrane review showed no clear evidence that antidepressant use in the treatment of back pain is effective, but it did note a lack of high-quality trials of sufficient rigor or length.

STUDY DESIGN: Double-blind, randomized, controlled trial.

SETTING: Single center trial in Melbourne.

SYNOPSIS: Overall, 146 patients aged 18-75 years with chronic lower back pain of no specific cause for more than 3 months were included. Exclusions included pathological cause, major coexisting illness, psychosis, or diagnosed depression. Patients were given amitriptyline 25 mg daily or benzotropine mesylate 1 mg daily. Benzotropine has similar anticholinergic side effects, without the antidepressant effect. Participants were assessed and followed by calls at 2 weeks, 1-2 months, 3 months, 4-5 months, and 6 months. Adherence was noted by the return of empty medication bottles at 6 months. Six-month surveys were completed by 81% and found that 70% of each group was adherent and 12% in each group withdrew because of adverse effects.

The primary outcome was level of pain at 6 months using a visual analog and descriptor scales. Secondary outcomes were measurement of disability, work missed, global improvement, general health, fear of movement, and depression.

The primary outcome was reduction in pain intensity of 12.6 (standard error, 2.7) with amitriptyline at 6 months, compared with 4.8 (SE 2.9) with benzotropine, which did not meet statistical significance. There was a statistically significant difference in disability at 3 months, but not at 6 months.

BOTTOM LINE: This trial suggests that there may be a place for prescribed amitriptyline for chronic lower back pain, but it failed to show statistical significance. The study may not have been sufficiently powered to detect the difference.

CITATIONS: Urquhart DM et al. Efficacy of low-dose amitriptyline for chronic low back pain: A randomized clinical trial. *JAMA Intern Med*. 2018;178(11):1474-81.

Dr. Lennon is an instructor of medicine at Northwestern University Feinberg School of Medicine and a hospitalist at Northwestern Memorial Hospital, both in Chicago.

By Aditi Puri, MD, MS

5 Do prophylactic PPIs improve mortality in critically ill patients?

CLINICAL QUESTION: Does the use of prophylactic proton pump inhibitors improve mortality or cause more adverse events in critically ill ICU patients at high risk of gastrointestinal bleeding?

BACKGROUND: Prophylactic proton pump inhibitors (PPIs) are used frequently in an ICU setting for acid suppression, but this is an off-label use and the evidence in support of using PPI prophylactically is limited. In fact, PPIs have been associated with adverse effects in recent literature including *Clostridium difficile* infection, myocardial ischemia, and pneumonia.

STUDY DESIGN: Multicenter, parallel group, blinded clinical trial that compared PPI with placebo.

SETTING: 78 sites in the United States and Canada.

SYNOPSIS: Among 3,298 total participants, 90-day mortality was 31.1% in the pantoprazole group and 30.4% in the placebo group, which is a relative risk of 1.02 (95% confidence interval, 0.91-1.13; $P = .76$).

The researchers also used a com-

Continued on following page

Short Takes

Comparison of the number of major complications of laparoscopic cholecystectomy versus percutaneous catheter drainage in the treatment of acute cholecystitis

This randomized, controlled trial showed that 65% of high-risk patients (APACHE II score of at least 7) with acute cholecystitis experienced major complications after undergoing percutaneous catheter drainage, compared with 12% of patients who underwent laparoscopic cholecystectomy. Major complications included reintervention and recurrent biliary disease. The rate of death was the same in both groups.

CITATION: Loozen CS et al. Laparoscopic cholecystectomy versus percutaneous catheter drainage for acute cholecystitis in high-risk

patients (CHOCOLATE): Multicenter randomized clinical trial. *BMJ*. 2018 Aug 28;363:k3965.

Food and Drug Administration approves new drug to treat influenza

Two randomized, controlled trials showed that Xofluza (baloxavir marboxil) taken as a single dose decreased symptoms in uncomplicated influenza, compared with placebo. The medication also was associated with a lower viral load on day 1 after administration, compared with both placebo and oseltamivir, the most commonly used medication to treat influenza.

CITATION: Hayden FG et al. Baloxavir marboxil for uncomplicated influenza in adults and adolescents. *N Eng J Med*. 2018 Sep 6;379:913-23.

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Continued from previous page

posite outcome comprising clinically important gastrointestinal bleeding, *Clostridium difficile* infection, new onset pneumonia, and acute myocardial ischemia. Overall, 21.9% in the pantoprazole group and 22.6% participants in the placebo group had the composite outcome – a relative risk of 0.96 (95% CI, 0.83-1.11). Clinically important gastrointestinal bleeding was the only component of the composite outcome that was significantly different between groups, occurring less often in the pantoprazole group – the relative risk was 0.58 (95% CI, 0.40-0.86).

BOTTOM LINE: Pantoprazole does not differ significantly, compared with placebo, with regard to 90-day mortality and a composite outcome of clinically significant events.

CITATION: Krag M et al. Pantoprazole in patients at risk of gastrointestinal bleeding in the ICU. *N Eng J Med*. 2018 Dec 6;379(23):2199-208.

6 Efficacy of DOACs vs. warfarin in high-risk atrial fibrillation patients

CLINICAL QUESTION: Are the direct-acting anticoagulants (DOACs) rivaroxaban and dabigatran efficacious and safe, compared with

warfarin, in elderly atrial fibrillation patients with new-onset atrial fibrillation and multiple major comorbidities?

BACKGROUND: DOACs have been shown to be efficacious in randomized, controlled trials, but these



Dr. Puri

trials did not include high-risk patients. This trial studies the efficacy and safety of DOACs in elderly patients with new-onset atrial fibrillation who are at high risk of both ischemic stroke and major bleeding.

STUDY DESIGN: Retrospective comparative effectiveness analysis.

SETTING: Data from a population-based Medicare beneficiaries database.

SYNOPSIS: Data from 213,705 Medicare beneficiaries with new-onset atrial fibrillation on rivaroxaban, dabigatran, or warfarin were analyzed. The investigators calculated CHA₂DS₂-VASc, HAS-BLED, and Gagne Index comorbidity scores for each participant to assess comorbidity burden and categorize patients into low-, medium-, and

high-morbidity categories.

Researchers then used three-way propensity matching, accounting for each morbidity category and anticoagulation medication to compare outcomes. Cox proportion regression models were used to adjust for risk and compare outcomes of ischemic stroke and major hemorrhage in matched participants in each anticoagulant group.

Primary outcomes of the study were ischemic stroke and major hemorrhage, which were determined based on ICD-9 codes. The investigators did not find a significant difference among anticoagulants regardless of the morbidity level for risk-adjusted ischemic stroke rates. Participants in the dabigatran group had lower rates of risk-adjusted major hemorrhage, compared with the warfarin group, regardless of morbidity category. The dabigatran group also had lower major hemorrhage risk, compared with the rivaroxaban group, especially in moderate- and high-morbidity category. Lastly, risk-adjusted rates of mortality were lower in the dabigatran and rivaroxaban groups, compared with the warfarin group, and there was no difference between the dabigatran and rivaroxaban groups with regards to mortality.

BOTTOM LINE: Rivaroxaban and dabigatran are each equally effective, compared with warfarin, in preventing ischemic strokes in elderly patients with new-onset atrial fibrillation and multiple comorbidities. However, patients on dabigatran appear to be at less risk of major bleeding, compared with warfarin and rivaroxaban.

CITATION: Mentias A et al. Assessment of outcomes of treatment with oral anticoagulants in patients with atrial fibrillation and multiple chronic conditions. *JAMA Netw Open*. 2018 Sep 28;1(5):e182870.

Dr. Puri is assistant professor of medicine at Northwestern University Feinberg School of Medicine and a hospitalist at Northwestern Memorial Hospital, both in Chicago.

By Marion V.N. Stanley, MD

7 NSAID use in high-risk patients not linked with short-term, safety-related adverse events

CLINICAL QUESTION: In patients with hypertension, chronic kidney disease, or heart failure presenting with a musculoskeletal disorder, how frequently are prescription NSAIDs dispensed and are there associated short-term (between 7

Short Takes

Effects of missed hemodialysis treatments

Researchers used a prospective cohort of 8,501 patients from hemodialysis (HD) centers in 20 countries to identify patients who missed one or more HD sessions in 4 months. In the United States, 24% of HD patients missed one or more sessions in 4 months, compared with 10% in Canada and 9% in the United Kingdom. Moreover, 12.2% of U.S. HD patients missed at least one session per month. All-cause mortality was 68% higher in patients who missed one or more sessions in 4 months. Risk factors associated with missing dialysis treatments were travel time of more than 1 hour to the facility, depression, younger age, being on dialysis for a shorter vintage, lower perceived burden of kidney disease, and shorter treatment times.

CITATION: Al Salmi I et al. Missed hemodialysis treatments: International variation, predictors, and outcomes in the Dialysis Outcomes and Practice Patterns Study (DOPPS). *Am J Kidney Dis*. 2018 Nov;72(5):634-43.

and 38 days of visit) safety-related outcomes?

BACKGROUND: Multiple expert panels recommend against the use of NSAIDs in patients with hypertension (HTN), chronic kidney disease (CKD), or heart failure (HF). Previous studies have demonstrated an increased risk of cardiovascular events and renal injury with long-term NSAID use.

STUDY DESIGN: Retrospective cohort study.

SETTING: Population-based administrative claims database identified primary care visits in Ontario between April 1, 2012, and March 31, 2016.

SYNOPSIS: Among 814,049 patients aged 65 years and older with high-risk medical conditions, 9.3% were prescribed NSAIDs. Of those prescribed NSAIDs, a vast majority had only HTN (90.8%). There was substantial variation in NSAID prescriptions among physicians (range, 0.9%-69.2%; median, 11%). During the study period, there was a decline in the frequency of NSAID prescriptions. Those patients with reduced odds to receive an NSAID prescription had CKD, HF, hospitalization in the past year, or prior opiate use. Of

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35,552 matched patient pairs either exposed or not exposed to NSAIDs (not controlled for disease severity), there was a similar rate of cardiac complications (288 vs. 279), renal complications (34 vs. 33), and death (27 vs. 30).

Patients with current opiate prescriptions were excluded. This study did not capture those patients taking acetylsalicylic acid, over-the-counter formulations, or topical NSAIDs.

BOTTOM LINE: NSAIDs are frequently prescribed among older adults with high-risk conditions, and short-term use of NSAIDs was not associated with increased cardiovascular or renal safety-related outcomes in this study. In otherwise healthy patients with HTN and musculoskeletal pain, it might be reasonable to trial a short course of NSAIDs with close monitoring.

CITATION: Bouck Z et al. Frequency and associations of prescription nonsteroidal anti-inflammatory drug use among patients with a musculoskeletal disorder and hypertension, heart failure, or chronic kidney disease. *JAMA Intern Med.* 2018 Nov;178(11):1516-25.

8 Older adults' interested in conversations about deprescribing

CLINICAL QUESTION: Among older adults, what attitudes exist toward deprescribing?

BACKGROUND: Polypharmacy in older adults is common and can be associated with increased hospitalizations and reduced quality of life.

SETTING: Medicare beneficiaries in the United States.

SYNOPSIS: The investigators used data from the National Health and Aging Trends Study (NHATS), which collects information annually on a nationally representative sample of Medicare beneficiaries ages 65 years and older. Of 1,981 responses on the NHATS Medication Attitudes module, 92% of older adults expressed willingness to stop a medication if their doctor said it was possible. While 89% agreed that all their medications were necessary, 66.6% also agreed that they would like to reduce the number of their medications. Greater odds of willingness to stop a medication were seen in patients taking more than six medications, compared with those taking fewer than six (adjusted odds ratio, 2.9; 95% confidence interval, 1.74-4.82), and those with three or more medical conditions, compared with

Short Takes

Do in situ mock codes affect in-hospital cardiac arrest mortality?

This ecological study included multiple hospital systems and showed that hospitals with a higher proportion of in situ mock codes had an in-hospital cardiac arrest survival rate of 42.8% versus 31.8% in hospitals with fewer mock codes (*P* greater than .0001).

CITATION: Josey K et al. Hospitals with more-active participation in conducting standardized in-situ mock codes have improved survival after in-hospital cardiopulmonary arrest. *Resuscitation.* 2018 Dec;133:47-52.

New oxygen guidelines

In patients admitted with acute stroke or MI, an international expert panel made a strong recommendation against initiating supplemental oxygen when the SpO₂ is greater than 92% and a weak recommendation against initiating supplemental oxygen when the SpO₂ is 90%-92%. In acutely ill medical patients receiving supplemental oxygen, the panel makes a strong recommendation to maintain an upper limit oxygen saturation of less than 96%.

CITATION: Siemieniuk RAC et al. Oxygen therapy for acutely ill medical patients: A clinical practice guideline. *BMJ.* 2018 Oct 24;363:k4169.

patients with fewer than two (aOR 2.87; 95% CI 1.53-5.37). Importantly, the study did not collect data about specific medications.

BOTTOM LINE: A vast majority of older adults would be willing to stop one or more of their medications if considered possible by their physician, and two-thirds want to reduce the number of their medications. If appropriate, hospitalists should consider having a conversation about deprescribing with their older patients.

CITATION: Reeve E et al. Assessment of attitudes toward deprescribing in older Medicare beneficiaries in the United States. *JAMA Intern Med.* 2018;178(12):1673-180.

Dr. Stanley is assistant professor of medicine at Northwestern University Feinberg School of Medicine and a hospitalist at Northwestern Memorial Hospital, both in Chicago.

Imaging in nonvalvular heart disease

By Christopher Palmer

MDedge News

FROM JACC / The American College of Cardiology, the American Heart Association, and other groups have jointly released an appropriate use criteria (AUC) document regarding the use of imaging modalities in diagnosing nonvalvular (that is, structural) heart disease.

Imaging plays an important role in diagnosing both valvular and nonvalvular heart diseases, so the goal of the document was to help clinicians provide high-quality care by standardizing the decision-making process. To do so, a committee was formed to devise scenarios that reflected situations in real-world practice; these scenarios were considered within categories to prevent the list from being too exhaustive. The scenarios were then reviewed by a rating panel in terms of how appropriate certain modalities were in each situation. The panel members first evaluated the scenarios

independently then face to face as a panel before giving their final scores (from 1 to 9) independently.

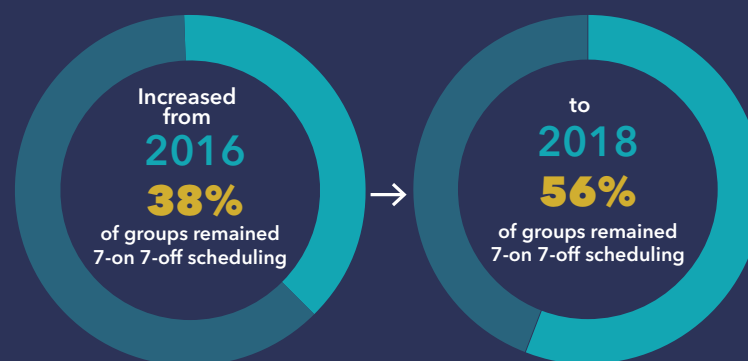
For example, for the indication of nonsustained ventricular tachycardia, the panelists rated transthoracic echocardiography with or without 3-D and with contrast as needed as an 8, which means it's an "appropriate test," whereas they gave CT for the same indication a 3, which means "rarely appropriate." For sustained ventricular tachycardia or ventricular fibrillation, they gave a 9 and a 6, respectively; this latter score indicates the test "may be appropriate." These scenarios and the respective scores for any given test are organized into tables, such as initial evaluation or follow-up.

This AUC document "signals a shift from documents evaluating a single modality in various disease states to documents evaluating multiple imaging modalities." The full document can be viewed in JACC at www.onlinejacc.org/content/early/2019/01/02/j.jacc.2018.10.038.

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ICU Hospitalist/Nocturnist CHA Everett Hospital

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CHA is recruiting for an ICU Hospitalist/Nocturnist to cover Everett Hospital.

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Chief of Hospitalist Medicine Opportunity in Northeast Pennsylvania



Job description:

Guthrie Clinic, a non-profit, physician-led, integrated health care delivery system is seeking candidates for Chief, Section of Hospitalist Medicine. The Chief will oversee 24 Hospitalists and 9 Advanced Practice Providers, located in 4 regional hospitals. The Chief has responsibility for quality, leadership, scheduling and overall program strategy.

Position details and requirements:

- Ensures the Section functions in an integrated system of care, improving performance, growing depth of clinical programs, and enhancing quality outcomes.
- Serves as mentor, guide and support for Hospitalists system wide.
- Leads recruitment/retention of physicians and APPs to actively grow the Section.
- Position is 50% Administrative and 50% clinical.

Clinical

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

Administrative

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

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

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

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

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

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Sweet Hospitalist Opportunity with Penn State Health

Penn State Health is a multi-hospital health system serving patients across central Pennsylvania seeking exceptional physicians to join our Penn State Health family to provide patient care as a Hospitalist.

What we're offering:

- Faculty positions as well as non-teaching hospitalist positions within our multi-hospital system as well as our outpatient practices;
- Network with experienced hospitalist colleagues and collaborative leadership;
- Ability to develop quality improvement projects in transition of care and other scholarly pursuits of interest;
- Commitment to patient safety in a team approach model;
- Potential for growth into leadership roles;
- Competitive salary, comprehensive benefit package, relocation, and so much more!

What we're seeking:

- Collaborative individual to work with diverse population and staff;
- Medical degree - MD, DO, or foreign equivalent;
- Completion of an accredited Internal Medicine or Family Medicine program;
- BC/BE in Internal or Family Medicine;
- Must have or be able to acquire a license to practice in the Commonwealth of Pennsylvania;
- No J1 visa waiver sponsorships available.

What the area offers:

Located in a safe family-friendly setting 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 communities are rich in history and offers 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 Peffley, Physician Recruiter at: hpeffley@pennstatehealth.psu.edu



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



Physician-Led Medicine in Montana Internal Medicine/Family Medicine Hospitalist

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Contact: Rochelle Woods
1-888-554-5922
physicianrecruiter@billingsclinic.org
billingsclinic.com



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HOSPITALISTS/ NOCTURNISTS NEEDED IN SOUTHEAST LOUISIANA



Ochsner Health System is seeking physicians to join our hospitalist team. BC/BE Internal Medicine and Family Medicine physicians are welcomed to apply. Highlights of our opportunities are:

- Hospital Medicine was established at Ochsner in 1992. We have a stable 50+ member group
- 7 on 7 off block schedule with flexibility
- Dedicated nocturnists cover nights
- Base plus up to 45K in incentives
- Average census of 14-18 patients
- E-ICU intensivist support with open ICUs at the community hospitals
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- Community based academic appointment
- The only Louisiana Hospital recognized by US News and World Report Distinguished Hospital for Clinical Excellence award in 4 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

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

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

Reference # SHM2017.



Sorry, no opportunities for J1 applications.

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

Where Quality of Life and Quality of Care Come Together

Hospitalist Opportunity Available
Join the Healthcare Team at
Berkshire Health Systems!

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

- Day, Evening and Nocturnist positions
- Previous Hospitalist experience is preferred

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

- 302-bed community teaching hospital with residency programs
- A major teaching affiliate of the University of Massachusetts Medical School and UNECOM
- Geographic rounding model
- A closed ICU/CCU
- A full spectrum of Specialties to support the team
- 7 on/7 off 10 hour shift schedule

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

- Located just 2½ hours from Boston and New York City
- Small town New England charm
- Excellent public and private schools
- World renowned music, art, theater, and museums
- Year round recreational activities from skiing to kayaking, this is an ideal family location.

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



Interested candidates are invited to contact:

Liz Mahan, Physician Recruitment Specialist, Berkshire Health Systems
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Applications accepted online at www.berkshirehealthsystems.org

To learn more, visit www.the-hospitalist.org and click "Advertise" or contact

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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. We are currently seeking exceptional physicians to join our highly regarded team. 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.



Natasha Durham, D.A.S.P.R.
natasha.durham@osumc.edu
hospitalmedicine@osumc.edu
<http://go.osu.edu/hospitalmedicine>

We are an Equal Opportunity/Affirmative Action Employer. Qualified women, minorities, Vietnam-era and disabled Veterans, and individuals with disabilities are encouraged to apply. This is not a J-1 opportunity.



UNIVERSITY OF MICHIGAN DIVISION OF HOSPITAL MEDICINE



The University of Michigan, Division of Hospital Medicine seeks board certified/board eligible internists to join our growing and dynamic division. Hospitalist duties include teaching of medical residents and students, direct patient care in our non-resident and short-stay units and involvement in quality improvement and patient safety initiatives. Novel clinical platforms that feature specialty concentrations (hematology/oncology service, renal transplant service and bone marrow transplant teams) as well as full-time nocturnist positions are also available. Our medical short stay unit provides care for both observation and inpatient status patients and incorporates advanced practice providers as part of the medical team.

The ideal candidate will have trained at, or have clinical experience at a major US academic medical center. Sponsorship of H1B and green cards is considered on a case-by-case basis for outstanding individuals. Research opportunities and hospitalist investigator positions are also available for qualified candidates.

The University of Michigan is an equal opportunity/affirmative action employer and encourages applications from women and minorities.

HOW TO APPLY

Interested parties may apply online at www.medicine.umich.edu/hospital-medicine or email cover letter and CV to Vineet Chopra, MD, MSc, Chief, Division of Hospital Medicine at kcreed@umich.edu.

WWW.MEDICINE.UMICH.EDU/HOSPITAL-MEDICINE



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Hospitalist & Nocturnist Opportunities in SW Virginia & NE Tennessee



Ballad Health, located in Southwest Virginia and Northeast Tennessee, is currently seeking Full Time, BE/BC, Day Shift Hospitalists and Nocturnist Hospitalists to join its team.

Qualified candidates will work within Ballad Health Facilities and will need an active Virginia and/or Tennessee license, depending on facility location.

Facilities:

Ballad Health Southwest Virginia

Johnston Memorial Hospital, Russell County Medical Center, Smyth County Community Hospital, Norton Community Hospital, Mountain View Regional Medical Center, Lonesome Pine Hospital

Ballad Health Northeast Tennessee

Johnson City Medical Center, Holston Valley Medical Center, Bristol Regional Medical Center and Hawkins County Memorial Hospital

Please Contact:

Ballad Health Physician Recruitment

800-844-2260

docjobs@balladhealth.org



Full time positions with the following incentives:

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CONTACT:

Heather Gonroski

973.290.8259

hgonroski@mdedge.com

or

Linda Wilson

973.290.8243

lwilson@mdedge.com

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:

- Community Setting Hospitalist opportunities (Lancaster and Berks County positions)
- 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



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





Hospitalist Opportunities in Eastern PA — Starting Bonus and Loan Repayment —

We have day positions at our Miners Campus in beautiful Schuylkill County and at our newest hospital in Monroe County set in the Pocono Mountains. Both campuses offer you an opportunity to make a difference in a Rural Health Community yet live in your choice of family friendly, thriving suburban areas. In addition, you'll have access to our network's state of the art technology and Network Specialty Support Resources. We also have opportunities at our Quakertown campus, where a replacement hospital will open in 2019.

We offer:

- Starting bonus and up to \$100,000 in loan repayment
- 7 on/7 off schedules
- Additional stipend for nights
- Attractive base compensation with incentive
- Excellent benefits, including malpractice, moving expenses, CME
- Moonlighting Opportunities within the Network

SLUHN is a non-profit network comprised of physicians and 10 hospitals, providing care in eastern Pennsylvania and western NJ. We employ more than 800 physician and 200 advanced practitioners. St. Luke's currently has more than 220 physicians enrolled in internship, residency and fellowship programs and is a regional campus for the Temple/St. Luke's School of Medicine. Visit www.sluhn.org.

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

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

Great Opportunity for a Hospitalist in the Southwest

San Juan Regional Medical Center in Farmington, NM is recruiting for a hospitalist. This opportunity offers a great place to live, a caring community and hospital environment with a team committed to offering personalized, compassionate care.

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- Wide variety of critical care
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- Excellent Benefits



Interested candidates should contact
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Boston

Come join our well established hospitalist team of dedicated hospitalist at Emerson Hospital located in historic Concord, Massachusetts. Enjoy living in the suburbs with convenient access to metropolitan areas such as Boston, New York and Providence as well as the mountains, lakes and coastal areas. Opportunities available for hospitalist and nocturnists; full time, part time, per diem and moonlighting positions, just 25 minutes from Boston. A great opportunity to join a well established program.

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Emerson Hospital provides advanced medical services to more than 300,000 people in over 25 towns. We are a 179 bed hospital with more than 300 primary care doctors and specialists. Our core mission has always been to make high-quality health care accessible to those that live and work in our community. While we provide most of the services that patients will ever need, the hospitals strong clinical collaborations with Boston's academic medical centers ensures our patients have access to world-class resources for more advanced care. For more information please contact: Diane M Forte, Director of Physician Recruitment and Relations 978-287-3002, dforte@emersonhosp.org

Not a J-1 or H1B opportunity



Where Quality of Life and Quality of Care Come Together

Med/Peds Hospitalist
Opportunities Available
Join the Healthcare Team at
Berkshire Health Systems

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

- Day and Nocturnist positions
- Previous Med/Peds Hospitalist experience is preferred
- Leadership opportunities available

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

- Comprehensive care for all newborns and pediatric inpatients including:
 - Level Ib nursery
 - 7 bed pediatrics unit
 - Care for pediatric patients admitted to the hospital
- Comprehensive adult medicine service including:
 - 302-bed community teaching hospital with residency programs
 - Geographic rounding model
 - A closed ICU/CCU
 - A full spectrum of Specialties to support the team
 - A major teaching affiliate of the University of Massachusetts Medical School and University of New England College of Osteopathic Medicine
- 7 on/7 off 12 hour shift schedule

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

- Located just 2½ hours from Boston and New York City
- Small town New England charm
- Excellent public and private schools
- World renowned music, art, theater, and museums
- Year round recreational activities from skiing to kayaking, this is an ideal family location.

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



Interested candidates are invited to contact:

Liz Mahan, Physician Recruitment Specialist, Berkshire Health Systems
725 North St. • Pittsfield, MA 01201 • (413) 395-7866.

Applications accepted online at www.berkshirehealthsystems.org

The amazing work we get to do

Serving people, connecting, and improving care

By Rachel E. Thompson, MD, MPH, SFHM

Stories are told of the first meeting, 20 years ago, where a hat was passed to collect donations to develop a fledgling organization of inpatient physicians. Today, 90% of hospitals with 200+ beds operate with a hospitalist model. Today, we are the Society of Hospital Medicine.

In the early 1900s, health care in many ways was simple. It was a doctor with a shingle hung. It was house calls. Remedies were limited. In the 1940s, companies developed insurance benefits to lure workers during World War II; this third party, the payer, added complexity. Meanwhile, treatment options began to diversify. Then, in the 1960s, Medicare was passed, and the government came into the mix, further increasing this complexity. Diagnostic and treatment options continued to diversify, seemingly exponentially. Some would say it took 30 years for our country to recognize that it had created the most advanced and expensive, as well as one of the least quality-controlled, health systems in the world. Thus, as hospital medicine was conceived in the 1990s, our national health system was awakening to the need – the creative niche – that hospitalists would fill.

When I began my career, I was unaware that I was a hospitalist. The title didn't exist. Yes, I was working solely in the hospital. I was developing programs to improve care delivery. I was rounding, teaching, collaborating, connecting – everything that we now call hospital medicine. That first job has evolved into my career, one that I find both honorable and enjoyable.

As health care changes with the passing years, being a hospitalist continues to be about serving people, connecting, and improving care. Being a hospitalist is being innovative, willing, and even daring. Dare to try, dare to fail, dare to redesign and try again. Hospital medicine is thinking outside of the box while knowing how to color between the lines. In the coming decades, health care will continue to evolve, and hospital medicine will too. We now encompass surgical comanagement and perioperative care, palliative care, postacute care, and transitions of care services. In corners, hospital medicine is already experimenting

with telecare, virtual health, and hospital at home. Our hospital medicine workforce is innovative, diverse, tech savvy, and poised for leading.

We are ready and willing to face the pressures affecting health care in the United States today: the recognition of an overwhelming expense to society, the relative underperformance with regard to quality, the increasing complexity of illness and treatment options, the worsening health of the average American citizen, the aging population, the role of medical error in patient harm, the increasing engagement of people in their own care, and the desire to make care better. What our country is facing is actually a phenomenal opportunity, no matter what side of the political aisle you live on. Being in hospital medicine today is being at the center front of this evolutionary stage.

Since joining the SHM board of directors, I continue to find examples of the stellar work of our staff and our members across the country. Having the privilege as a board member to join several Chapter meetings, I have witnessed firsthand the camaraderie, the compassion, the team that makes our Society work. From Houston to San Francisco and from St. Louis to Seattle, I have been honored to work with SHM members that create and nurture local and regional networks with the support of SHM's Chapters program – a program that now houses more than 50 chapters and has launched regional districts to further support networking and growth. SHM's chapter venues allow our larger hospital medicine team – yes, the national one – to connect and collaborate.

Take the Pacific Northwest Chapter. In its early years hospitalists from various and competing health systems would convene at a restaurant and just talk. They spoke of how to staff, how to pay, and how to negotiate with hospital leadership. As I have joined chapter meetings in recent years, meetings continue to be the place to share ideas – how to develop new programs; what is the most recent approach to glycemic control, sepsis care, or antibiotic stewardship; how best to approach diagnosis without “anchoring”; and even how to care for each other in the time of loss of a colleague to suicide. It is here in our community that we share experiences, knowl-

edge, new ideas – and this sharing makes us all stronger.

Our hospital medicine community also comes together through areas of shared interest. There are 18 Special Interest Groups (SIGs), focused on specific topic areas. I have been privileged as a board member to work with our Perioperative/Comanagement SIG as it launched in 2017 and has grown rapidly. Currently, the community hosts a “case of the month” hospital medicine discussion as well as a regular journal club webinar that allows participants to review recent literature and interact directly with the authors. As this SIG has grown, shared resources and ideas have allowed for diffusion of knowledge, providing our nation with infrastructure for improving perioperative care. It is networks like this that support our national hospital medicine team to build strength through sharing.

It is our society, our people, that have taken us from the passing of a hat to developing our national community and network. This March, we get to celebrate our field in a new way – Thursday, March 7, 2019, marks the inaugural National Hospitalist Day. Then, March 24-27, our annual conference, Hospital Medicine 2019, will bring thousands of our national team to National Harbor, Maryland. Join your colleagues. Find your niche and your community. Be a part of the change you want to see. While you are there, come introduce yourself to me and let me thank you for the amazing work you are doing.

We are all a part of this movement transforming patient care both on a local and national level. As we move to the future, our innovative, diverse, and connected network of hospital medicine will continue to create and guide health care advances in our country.



Dr. Thompson is professor and chief of the section of hospital medicine at University of Nebraska Medical Center, and medical director of clinical care transitions at Nebraska Medicine, Omaha.

“As health care changes with the passing years, being a hospitalist continues to be about serving people, connecting, and improving care. Being a hospitalist is being innovative, willing, and even daring. Dare to try, dare to fail, dare to redesign and try again.”



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