

HOSPITAL MEDICINE ANNUAL CONFERENCE

HM2019 PREVIEW

MARCH 24-27, 2019 ★ NATIONAL HARBOR, MD

THE Hospitalist

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Crafting a 'well-rounded' program

New tracks, interactive programs highlight HM19

By Larry Beresford

As course director for the Society of Hospital Medicine's 2019 annual conference – Hospital Medicine 2019 (HM19) – to be held March 24-27 in National Harbor, Md., Dustin T. Smith, MD, SFHM, hospitalist and associate professor of medicine at Emory University, Atlanta, tried his best to apply democratic processes to the work of the annual conference committee.

"We created numerous email surveys to go out to the 20

committee members for their vote. So many great topics were proposed for HM19, with so many great faculty, that we had to make hard choices – although we see that as a good problem. It was my job to make sure that we had a process that works," Dr. Smith explained. "We have planned what we believe will be another well-attended and well-received hospital medicine conference. Every year it's been great, but every year we try something to make it a little better."

The SHM annual conference committee meets in person

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Hospitalist Movers and Shakers

By Matt Pesyna

Flora Kisuule, MD, SFHM, has been awarded the 2018 Excellence in Service and Professionalism Award by Johns Hopkins Bayview Medical Center, Baltimore. Dr. Kisuule is associate director of the division of hospital medicine at Johns Hopkins Bayview, assistant professor at Johns Hopkins University School of Medicine, and assistant professor in the Johns Hopkins Bloomberg School of Public Health.

Dr. Kisuule codeveloped a hospitalist fellowship program for Johns Hopkins University, and has served on several SHM committees and consulted on hospitalist programs around the world. Dr. Kisuule is joining the SHM Board of Directors in March 2019.

Paul Hain, DO, was promoted recently to chief medical officer and senior vice president of market delivery for Blue Cross/Blue Shield of Texas. Dr. Hain has a wealth of experience in leadership, including helping create the pediatric hospitalist program at Vanderbilt Children's Hospital in Nashville, Tenn.

With BC/BS, Dr. Hain will oversee the region's public relations, community investments, government relations, and lobbying.

Laura M. Rosch, DO, recently was selected by Kansas City University

as the new campus dean in the Joplin (Mo.) College of Osteopathic Medicine.



Dr. Rosch

Dr. Rosch is a practicing hospitalist in Illinois, where she was chair of internal medicine at the Chicago College of Osteopathic Medicine.

Suzan Lowry, MD, has been named health officer for Charles County, Md., by the county Department of Health and Charles County Commissioners. A longtime pediatrician with 20 years' experience, Dr. Lowry has served as a pediatric hospitalist educator at Children's National Medical Center in Washington.

Dr. Lowry has spent most of her career working on behalf of public health. Most recently, she has worked at the U.S. Marine Corps Quantico Health Clinic in Virginia.

Robyn Chase, DO, a staff hospitalist at Yavapai Regional Medical Center (Prescott, Ariz.), recently was selected as the hospital's Physician of the Year for 2018.

Dr. Chase has practiced at YRMC since 2010. She also serves as an associate professor at the University of Arizona, Phoenix.

Kevin Dishman, MD, has been elevated to senior vice president and chief medical officer at Stormont Vail Health (Topeka, Kan.). Dr. Dishman also will be president of Stormont medical services division's medical staff.

Dr. Dishman came to Stormont in 2000 to work as a hospitalist. Most recently, he has served as the center's vice president of acute care services.

Business Moves

The Hazel Hawkins Memorial Hospital Women's Center (Hollister, Calif.) recently established a relationship with Pediatrix Medical Group (Sunrise, Fla.) to provide pediatric hospitalists to help with high-risk delivery of newborns.

Hazel Hawkins has been in operation for the past 5 years. Pediatrix hospitalists will be used as consultants for attending staff and emergency physicians and will help treat

patients in emergency situations.

American Physician Partners (Brentwood, Tenn.), a national hospital medicine management services company, has acquired private physician group Progressive Medical Associates (Mesa, Ariz.). Progressive's 37 physicians and 21 private clinicians – working at Banner Health's 28 nonprofit hospitals covering six states – join the APP team.

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Hospitalist scheduling: A search for balance

Survey says ...

By Amanda T. Trask, MBA,
MHA, SFHM

Scheduling. Has there ever been such a simple word that is so complex? A simple Internet search of hospitalist scheduling returns thousands of possible discussions, leaving readers to conclude that the possibilities are endless and the challenges great. The answer certainly is not a one-size-fits-all approach.

Hospitalist scheduling is one of the key sections in the 2018 *State of Hospital Medicine (SoHM)* report; the 2018 report delves deeper into hospitalist scheduling than ever before.



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

For those of you who have been regular users of prior *SoHM* reports, you should be pleasantly surprised to find new comparative values: There are nearly 50% more pages dedicated just to scheduling!

For those readers who have never subscribed to the *SoHM* Report, this is your chance to study how other groups approach schedules.

Why is hospitalist scheduling such a hot topic? For one, flexible and sustainable scheduling is an important contributor to job satisfaction. It is important for hospitalists to have a high degree of input into managing and effecting change for personal work-life balance.

As John Nelson, MD, MHM, a co-founder of the Society of Hospital Medicine, wrote recently in *The Hospitalist*, "an optimal schedule alone isn't the key to preventing it [burnout], but maybe a good schedule can reduce your risk you'll suffer from it."

Secondly, ensuring that the hospitalist team is right sized – that is, scheduling hospitalists in the right place at the right time – is an art. Using resources, such as the 2018



SoHM report, to identify quantifiable comparisons enables hospitalist groups to continuously ensure the hospitalist schedule meets the clinical demands while optimizing the hospitalist group's schedule.

Unfilled positions

The 2018 *SoHM* report features a new section on unfilled positions that may provide insight and better understanding about how your group compares to others, as it relates to properly evaluating your recruitment pipeline.

For hospital medicine groups (HMGs) serving adults only, two out of three groups have unfilled positions, and about half of pediatric-only hospitalist groups have unfilled positions. Andrew White, MD, SFHM, associate professor of medicine at the University of Washington, Seattle, provided us with a deep-

diverse discussion of this topic in a recent article in *The Hospitalist*.

If your group has historically had more unfilled positions than the respondents, it might mean your group should consider different strategies to close the gap. It may also lead to conversations about how to rethink the schedule to better meet the demands of clinical care with limited resources.

So, with all these unfilled positions, how are hospitalist groups filling the gap? Not all groups are using locum tenens to fill those unfilled positions. About a third of hospitalist groups reported leaving those gaps uncovered.

The most commonly reported tactic to fill in the gaps was voluntary extra shifts by existing hospitalists (physicians and/or nurse practitioners/physician assistants). This approach is used by 70% of hospitalist groups. The second most-used tactic was "moonlighters" or p.r.n. phy-

sicians (57.4%). Thirdly, was use of locum tenens physicians.

With these baselines, we will be able to better track and trend the industry going forward.

Scheduling methodologies

For HMGs serving adults only, 7 on/7 off remains the preferred scheduling method (56% of groups). This is higher than in the 2016 survey (38%), but it is probably related to year-over-year differences in the mix of survey respondents as opposed to a significant change in how groups are scheduling.

For pediatric practices, the fixed rotating block scheduling has decreased over the two survey periods (16.7% versus 6.7%).

Even though the 7-on/7-off schedule remains quite popular among adult-only HMGs, many seasoned hospitalists wonder whether this is sustainable through all seasons of life. Some hospitalists have said a 7-on/7-off schedule is like turning on and off your personal life and that it takes a day or 2 to recover from 7 consecutive 12-hour days.

On the other hand, a fixed schedule is the easiest to explain, and many new hospitalists are requesting a fixed schedule. Even so, a fixed schedule may not allow for enough flexibility to adapt the schedule to the demands of patient care.

Nonetheless, a fixed schedule remains a very popular scheduling pattern. Does this scheduling model lead to burnout? Does this scheduling model increase or decrease elasticity? The debate of flexible versus fixed schedules continues!

Results by shift type

Very simply, the length of individual shifts has not changed much in prior years. For adult-only practices, most all day and night shifts are 12 hours in length. For pediatric-only HMGs, most day shifts are about 10 hours, and most night shifts are about 13 hours.

Most evening or swing shifts for adult-only practices are about 10 hours, which is a slight decrease from 2016. Pediatric-only practices' evening shifts are about 8 hours in length.

A new question this year is about daytime admitters. For adult hospitalist groups, over half of groups have daytime admitters. For pediatric groups, nearly three out of four groups have daytime dedicated admitters. Also, the larger the group size, the more likely it is to have a



Ms. Trask is national vice president of the Hospital Medicine Service Line at Catholic Health Initiatives in Englewood, Colo. She is also a member of SHM's Practice Analysis Committee.

dedicated daytime admitter.

Nocturnists remain in demand! Over 80% of adult hospitalist groups have on-site hospitalists at night. About a quarter of pediatric-only practices have nocturnists.

Scheduled workload distribution

One way of scheduling patient assignments is the phenomenon of unit-based assignments, or geographic rounding. As this has become more prevalent, the SHM Practice Analysis Committee recommended adding a question about unit-based assignments to the 2018 *SoHM* report.

The adoption of unit-based assignments is higher in academic groups (54.3%), as well as among hospitalists employed at a "hospital, health system or integrated delivery system" (47.4%), than in other group practice models.

Just as with the presence of daytime admitters, the larger the group the more likely it has some form of unit-based assignments. Further study would be needed to determine whether there is a link between the presence of daytime admitters and successful unit-based assignments for daytime rounders.

What's the verdict?

Hospitalist scheduling is a never-ending balance of what's best for patients and what's best for hospitalists and other key stakeholders.

Scheduling is personal. Scheduling is an art form. Has anyone figured out the "secret sauce" to hospitalist scheduling? Go online to SHM's HMX to start the discussion!

Is a telehospitalist service right for you and your group?

Telemedicine “ripe for adoption” by hospitalists

By Peter J. Kaboli, MD, MS,
and Jeydith Gutierrez, MD

For medical inpatients, the advent of virtual care began decades ago with telephones and the ability of physicians to give “verbal orders” while outside the hospital. It evolved into widespread adoption of pagers and is now ubiquitous through smart phones, texting, and HIPPA-compliant applications. In the past few years, inpatient telemedicine programs have been developed and studied including tele-ICU, telestroke, and now the telehospitalist.

Telemedicine is not new and has seen rapid adoption in the outpatient setting over the past decade,¹ especially since the passing of telemedicine parity laws in 35 states to support equal reimbursement with face-to-face visits.² In addition, 24 states have joined the Interstate Medical Licensure Compact (IMLC).³ This voluntary program provides an expedited pathway to licensure for qualified physicians who practice in multiple states. The goal is to increase access to care for patients in underserved and rural areas and to allow easier consultation through telemedicine. Combined, these two federal initiatives have lowered two major barriers to entry for telemedicine: reimbursement and credentialing.

Only a handful of papers have been published on the telehospitalist model with one of the first in 2007 in *The Hospitalist* reporting on the intersection between tele-ICU and telehospitalist care.⁴ More recent work describes the implementation of a telehospitalist program between a large university hospitalist program and a rural, critical access hospital.⁵ A key goal of this program, developed by Ethan Kuperman, MD, and colleagues at the University of Iowa, was to keep patients at the critical access hospital that previously would have been transferred. This has obvious benefits for patients, the critical access hospital, and the local community. It also benefited the tertiary care referral center, which was dealing with high occupancy rates. Keeping lower acuity patients at the critical access hospital helps maintain access for more complex patients at the referral center. This same principle has applied to the use of the tele-ICU

where lower acuity ICU patients could remain in the small, rural ICU, and only those patients who the intensivist believes would benefit from a higher level of care in a tertiary center would be transferred.

As this study and others have shown, telemedicine is ripe for adoption by hospitalists. The bigger question is how should it fit into the current model of hospital medicine? There are several different applications we are familiar with and each has unique considerations. The first model, as applied in the Kuperman paper, is for a larger hospitalist program to provide a telehospitalist service to a smaller, unaffiliated hospital (for example, critical access hospitals) that employs nurse practitioners or physician assistants on site but can't recruit or retain full-time hospitalist coverage. In this collaborative model of care, the local provider performs the physical exam but provides care under the guidance and supervision of a hospital medicine specialist. This is expected to improve outcomes and bring the benefits of hospital medicine, including improved outcomes and decreased hospital spending, to smaller communities.⁶ In this model, the critical access hospital pays a fee for the service and retains the billing to third-party payers.

A variation on that model would provide telehospitalist services to other hospitals within an existing health care network (such as Kaiser Permanente, Intermountain Healthcare, government hospitals) that have different financial models with incentives to collaborate. The Veterans Health Administration is embarking on a pilot through the VA Office of Rural Health to provide a telehospitalist service to small rural VA hospitals using the consultative model during the day with a nurse practitioner at the local site and physician backup from the emergency department. Although existing night cross-coverage will be maintained by a physician on call, this telehospitalist service may also evolve into providing cross-coverage on nights and weekends.

A third would be like a locum tenens model in which telehospitalist services are contracted for short periods of time when coverage is needed for vacations or staff shortages. A fourth model of telehospitalist care

would be to international areas in need of hospitalist expertise, like a medical mission model but without the expense or time required to travel. Other models will likely evolve based on the demand for services, supply of hospitalists, changes in regulations, and reimbursement.

Another important consideration is how this will evolve for the practicing hospitalist. Will we have dedicated virtual hospitalists, akin to the “nocturnist” who covers nights and weekends? Or will working on the telehospitalist service be in the rotation of duties like many programs have with teaching and “nonteaching” services, medical consultation, and even transition clinics and emergency department triage responsibilities?

For any of these models to work, technical aspects must be ironed out. It is indispensable for the provider to have remote access to the electronic health record for data review, documentation, and placing orders if needed. Adequate broadband for effective video connection, accompanied by the appropriate HIPPA-compliant software and hardware must be in place. Based upon prior experience with telemedicine programs, establishment of trusting relationships with the receiving hospital staff, physicians, and nurse practitioners is also critical. Optimally, the telehospitalist would have an opportunity to travel to the remote site to meet with the local care team and learn about the local resources and community. Many other operational and logistical issues need to be considered and will be supported by the Society of Hospital Medicine through publications, online resources, and national and regional meeting educational content on telehospitalist programs.

As hospital medicine adopts the telehospitalist model, it brings with it important considerations. First is how we embrace the concept of the medical virtualist, a term used to describe physicians who spend the majority or all of their time caring for patients using a virtual medium.⁷ We find it difficult to imagine spending all or the majority of our time as a virtual hospitalist, but years ago many could not imagine someone being a full-time hospitalist or nocturnist. Some individuals will see this as a career opportunity that allows them to



Dr. Kaboli

Dr. Gutierrez

Dr. Kaboli and Dr. Gutierrez are based at the Center for Access and Delivery Research and Evaluation (CADRE) at the Iowa City VA Healthcare System, the Veterans Rural Health Resource Center-Iowa City, VA Office of Rural Health, and the department of internal medicine, University of Iowa, both in Iowa City.

work as a hospitalist regardless of where they live or where the hospital is located.

Second, the telehospitalist model will require professional standards, training, reimbursement and coding adjustments, hardware and software development, and managing patient expectations for care.

Lastly, hospitals, health care systems, hospitalist groups, and even individual hospitalists will have to determine how best to take advantage of this innovative model of care to provide the highest possible quality, in a cost-efficient manner, that supports professional satisfaction and development.

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HM2019 PREVIEW

Developing clinical mastery at HM19

Boosting your bedside diagnostic skills

By Larry Beresford

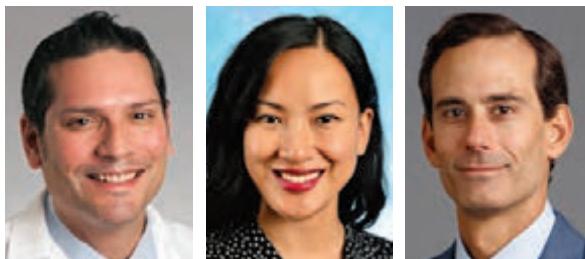
A new three-session minitrack devoted to the clinical mastery of diagnostic and treatment skills at the hospitalized patient's bedside should be a highlight of the Society of Hospital Medicine's 2019 annual conference.

The "Clinical Mastery" track is designed to help hospitalists enhance their skills in making expert diagnoses at the bedside, said Dustin T. Smith, MD, SFHM, course director for HM19, and associate professor of medicine at Emory University, Atlanta. "We feel that all of the didactic sessions offered at HM19 are highly useful for hospitalists, but there is growing interest in having sessions devoted to learning clinical pearls that can aid in practicing medicine and acquiring the skill set of a master clinician."

The three clinical mastery sessions at HM19 will address neurologic symptoms, ECG interpretation, and the role of point-of-care ultrasound (POCUS), currently a hot topic in hospital medicine. Recent advances in ultrasound technology have resulted in probes that can cost as little as \$2,000, fit inside a lab coat pocket, and be read from a smartphone – making ultrasound far easier to bring to the bedside of hospitalized patients, said Ria Dancel, MD, FHM, associate professor of internal medicine and pediatrics at the University of North Carolina at Chapel Hill.

Dr. Dancel will copresent the POCUS clinical mastery track at HM19. "Our focus will be on how POCUS and the physical exam relate to each other. These are not competing technologies but complementary, reflecting the evolution in bedside medicine. Because these new devices will soon be in the pockets of your colleagues, residents, physician assistants, and others, you should at least have the knowledge and vocabulary to communicate with them," she said.

POCUS is a new technology that is not yet in wide use at the hospital bedside, but clearly a wave is building, said Dr. Dancel's copresenter, Michael Janjigian, MD, associate professor in the department of medicine at NYU Langone Health in New York City.



Dr. Smith

Dr. Dancel

Dr. Janjigian

"We're at the inflection point where the cost of the machine and the availability of training means that hospitals need to decide if it's time to embrace it," he said. Hospitalists may also consider petitioning their hospital's leadership to offer the machines and training.

"Hospitalists' competencies and strengths lie primarily in making diagnoses," Dr. Janjigian said. "We like to think of ourselves as master diagnosticians. Our session at HM19 will explore the strengths and weaknesses of both the physical exam and POCUS, presenting clinical scenarios common to hospital medicine. This course is designed for those who have never picked up an ultrasound probe and want to better understand why they should, and for those who want a better sense of how they might integrate it into their practice."

While radiology and cardiology have been using ultrasound for decades, internists are finding uses at the bedside to speed diagnosis or focus their next diagnostic steps, Dr. Dancel noted. For certain diagnoses, the physical exam is still the

tool of choice. But when looking for fluid around the heart or ascites buildup in the abdomen or when looking at the heart itself, she said, there is no better tool at the bedside than ultrasound.

In January 2019, the SHM issued a position statement on POCUS,¹ which is intended to inform hospitalists about the technology and its uses, encourage them to be more integrally involved in decision making processes surrounding POCUS program management for their hospitals, and promote development of standards for hospitalists in POCUS training and assessment. The SHM has also developed a pathway to teach the use of ultrasound, the Point-of-Care Ultrasound Certificate of Completion.

In order to qualify, clinicians complete online training modules, attend two live learning courses, compile a portfolio of ultrasound video clips on the job that are reviewed by a panel of experts, and then pass a final exam. The exam will be offered at HM19 for clinicians who have completed preliminary work for this new certificate – as well as precourses devoted to ultrasound and other procedures – and another workshop on POCUS.

Earning the POCUS certificate of completion requires a lot of effort, Dr. Dancel acknowledged. "It is a big commitment, and we don't want hospitalists thinking that just because they have completed the certificate that they have fully mastered ultrasound. We encourage hospitalists to find a proctor in their own hospitals and to work with them to continue to refine their skills."

Dr. Dancel and Dr. Janjigian reported no relevant disclosures.

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1. Soni NJ et al. Point-of-care ultrasound for hospitalists: A position statement of the Society of Hospital Medicine. *J Hosp Med.* 2019 Jan 2. doi: 10.12788/jhm.3079.

The power of policy at HM19

By Suzanne Bopp

As a result of the steadily growing interest of SHM members in health care policy and advocacy issues, the 2019 Annual Conference will include a mini-track dedicated to policy issues.

To be held on Monday, March 25th at HM19 in National Harbor, Md., the health care policy mini-track will update conference attendees on some of the Washington developments that

affect hospitalists, said Josh Boswell, director of government relations at SHM.

"Many of the policy developments in D.C. are directly impacting our members' practices," he said. "A couple of years ago, it was decided to add a specific track at the annual conference to cover some of these policy issues, and we've generally had positive feedback on the sessions."

This year, the mini-track will consist of two separate sessions, held

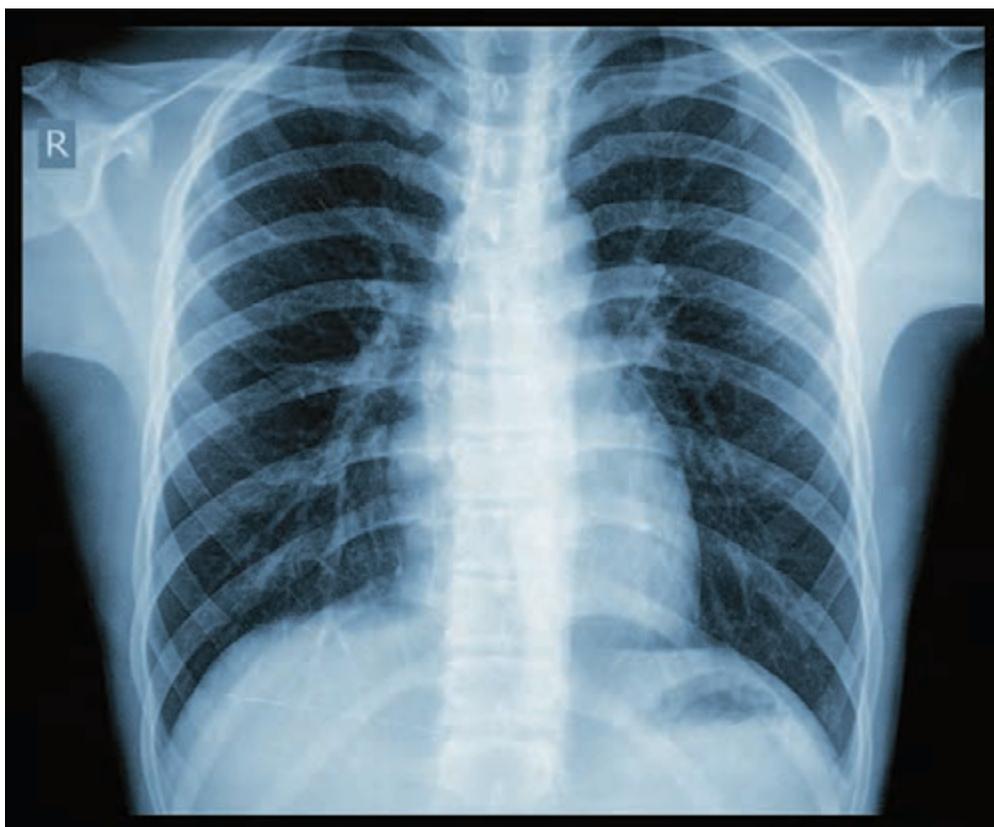
back to back. "Both sessions are designed to give attendees an entrée into health policy and explain developments that are happening right now in Washington that impact their practice," said Joshua Lapps, government relations manager at SHM.

The first session – "CMS Policy Update: An Overview of Meaningful Measures and the Quality Payment Program" – will take place from 2:00 to 3:30 p.m., and will feature Reena Duseja, MD, MS, the acting director

for Quality Measurement and Value-Based Incentives Group in the Centers for Clinical Standards and Quality at the Centers for Medicare & Medicaid Services. Dr. Duseja oversees the development of measures and analyses for a variety of CMS quality reporting and value-based purchasing programs. She is also an emergency medicine physician and was an associate professor at the University of California,

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How to address gender bias in research funding

By Sara Freeman

LONDON – Female investigators are less likely to secure research funding than male investigators, not because their proposed project is of lesser scientific merit, but simply because they are women, according to research published in *The Lancet*.

Women had a 30% lower chance of success in getting funding for a project than did their male counterparts when the caliber of the principal investigator was considered as an explicit part of the grant application process, with an 8.8% probability of getting funded versus 12.7%, respectively. If the application was considered solely on a project basis, however, the gender bias was less (12.1% vs. 12.9%).

The overall success of grant applications was 15.8% in the analysis, which considered almost 24,000 grant applications from more than 7,000 principal investigators submitted to the Canadian Institutes of Health Research (CIHR) between 2011 and 2016.

“I see our study as basically one good thwack in a long game of whack-a-mole,” lead study author Holly O. Witteman, PhD, said.

Dr. Witteman’s research was included in a thematic issue of *The Lancet* that brings together female authors and commentators to look at gender equity and what needs to be done to address imbalances.

That there are discrepancies in research funding awarded to female and male investigators has been known for years, Dr. Witteman, associate professor of family and emergency medicine at Laval University, Quebec City, said. To learn how and why, the researchers used a “quasi-experimental” approach to find out what factors

might be influencing the gender gap.

“Women are scored lower for competence compared to men with the same publication record,” she said. It’s not that they publish less or do easier research, or that the quality is lower; they are just viewed less favorably overall throughout their careers. Even when you control for confounding factors, “they still don’t advance as quickly,” she said.

“It had been documented for a while that, overall, women tend to get less grant funding and there hasn’t been any evidence to show either way if maybe women’s grant applications weren’t as good,” Dr.

Witteman explained.

In 2014, the CIHR changed the way it funded research projects, creating a “natural experiment.” Two new grant application programs were put in place which largely differed by whether or not an explicit review of the principal investigator and their ability to conduct the research was included.

Adjusting for age and type of research, Dr. Witteman and her coauthors found that there was little difference in the success of women in securing research funding when their grant applications were judged solely on a scientific basis; however, when the focus was placed on the principal investigator, women were disadvantaged.

Dr. Witteman said that “this provides robust evidence in support of the idea that women write equally good grant applications but aren’t evaluated as being equally good scientists.”

So how to redress the balance? Dr. Witteman suggested that one way was for funders to col-

lect robust evidence on the success of grant applications and be transparent who is getting funded and how much funding is being awarded. Institutions should invest in and support young investigators, distributing power and flattening traditionally male-led hierarchies. Salaries should be aligned and research support evened out, she said.

Investigators themselves also have a role to play to do the best possible work and try to change the system. “Advocate for others,” she said. That included advocating for others in groups that you may not be part of – which can be easier in some respects than advocating for a group that you are in.

“Funders should evaluate projects, not people,” Jennifer L. Raymond, PhD, and Miriam B. Goodman, PhD, both professors at Stanford (Calif.) University wrote in a comment in *The Lancet* special issue. They suggested that people-based funding had been gaining popularity but that funders would be better off funding by project to achieve scientific and clinical goals. “Assess the investigator only after double-blind review of the proposed research is complete,” they suggested. “Reduce the assessment of the investigator to a binary judgment of whether or not the investigator has the expertise and resources needed to do the proposed research.”

Cassidy R. Sugimoto, PhD, associate professor of informatics at Indiana University in Bloomington and a program director for the Science and Innovation Policy Program at the National Science Foundation (NSF) observed that data on gender equality in research funding were already being collected and will be used to determine how best to adjust funding policies.



Dr. Witteman

Continued from page 10

San Francisco, in the department of emergency medicine, where she led quality improvement activities.

“The session with Dr. Duseja will be an inside look into the approach that CMS is taking for quality measurement and pay-for-performance programs, specifically looking at the quality payment program which came out of the Medicare Access and Chip Reauthorization Act,” Mr. Lapps said. “It will be a high-level discussion about how the programs affect hospitalists, and how hospitalists participate in the programs. It’s also a chance for attendees to hear some of the thinking inside CMS.”

Dr. Duseja is also hoping to get feedback from HM19 attendees. “She wants the session to be educational for our members, as well as an opportunity for her to learn from hospitalists,” Mr. Lapps said.

According to Dr. Duseja, her presentation will provide attendees

with an overview of the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), specifically highlighting policy changes from 2018 to 2019 to the Merit-Based Incentive Payment System (MIPS) and Meaningful Measures Initiative. Attendees will learn more about CMS’s approach to quality and quality measurement, as well as the future of quality reporting programs.

Following Dr. Duseja’s presentation, the second mini-track session will take place from 3:40 to 4:25 p.m. It will focus more intently on the processes around health care policy making.

“We heard from our members who attended this mini-track at the past two annual conferences that they would like us to explain how policy making works: the play-by-play in D.C. on how we get to where we are,” Mr. Boswell said.

The second session will feature

a presentation by Jennifer Bell, founding partner at Chamber Hill Strategies, who represents SHM in Washington. “Jennifer will be discussing how Washington works, the policy process and the pressure points at which SHM and its members can exert influence,” Mr. Lapps said.

Attendees can expect to learn a lot from either session, Mr. Lapps said. “Attendees will learn about the basic contours of the Quality Payment Program that Medicare oversees, and some of the specific new elements of that program this year that were designed with hospitalists in mind. For example, Dr. Duseja will be talking about a facility-based reporting option under the Merit-Based Incentive Payment System. I think our members should gain a concrete understanding of some of the new directions that CMS is heading this year. Overall, they’ll have a better sense of the

vision behind quality measures and quality measurement. This is a really exciting opportunity to hear from someone who is both a clinician and works on policy at CMS.”

The policy mini-track offers hospitalists a chance to get a look “behind the curtain” at policy making from someone who is helping to write the rules.

“Attendees will gain insight on where they fit in these programs – and also have the opportunity to tell Dr. Duseja if they don’t feel these programs are a good fit for them,” Mr. Boswell said. “Oftentimes these programs are not structured ideally for hospitalists. So, hearing directly from hospitalists who are experiencing problems would be extraordinarily helpful to a CMS official. I think attendees should view the policy track not only as an opportunity to learn from CMS, but as an opportunity to educate CMS about our issues.”

Learning from the history of hospitals

Storytelling can inform medical practice

By Larry Beresford

Each year the Society of Hospital Medicine's Annual Conference Committee examines prior attendee surveys, reviews the content presented the preceding year, and asks itself what new areas of



Dr. Messler

learning are needed, said Dustin Smith, MD, SFHM, hospitalist and associate professor of medicine at Emory University, Atlanta, and HM19 course director.

"The conference's schedule-at-a-glance of content can be overwhelming, so we have tried to use distinct educational tracks to provide focus and clarity for conference attendees," he said. "Every year there are a few areas where questions often come up about complex clinical situations where established medical guidelines aren't much help."

For HM19 an educational mini-track, "Between the Guidelines," was developed to gather several of these areas of clinical complexity where what's available in established clinical practice guidelines doesn't offer clear answers, he said. These include controversies around antithrombotic therapy in patients with major bleeds, and a debate on controversial aspects of guidelines to direct inpatient care.

Another planned session, "The History of Hospitals via Arts and Stories," fits nicely into this mini-track, Dr. Smith noted.

"It's a history lesson you can't glean from medical guidelines, which maybe points us toward what to incorporate and what not to repeat from across the history of hospitals," he said. "That could help us better appreciate the work hospitalists are doing today and into the future."

Jordan Messler, MD, a hospitalist with the Morton Plant Hospitalist group in Clearwater, Fla., will lead the session. He says that modern physicians can learn a lot from both the history of medicine and the evolution of hospitals, starting with the

ancient Greek physician, Galen (129-200 AD), who directed the celebrated Asclepeion or hospital in Pergamon (present-day Bergama, Turkey). This ancient hospital's treatment of disease also addressed the senses, the emotions, and the spirit – an early prototype for whole-person care – with an emphasis on self-therapy through rest, relaxation, exercise, and the promotion of healthy lifestyles.

A different perspective on hospitals

"People used to travel to Pergamon for healing at the Asclepeion, next to the amphitheater, where plays and music were presented, and to be outdoors in the natural elements. Now we're seeing hospitals being built with healing gardens, and a new emphasis on how artwork and music and environmental design can assist in healing," Dr. Messler said.

His presentation will survey the advent of more recent hospitals in France in the 18th century, pioneering work done at Johns Hopkins Hospital in Baltimore and Bellevue Hospital in New York, and the influence on the modern hospital of nursing pioneer Florence Nightingale (1820-1910). Her influence fundamentally changed the role of nursing in hospitals, introducing professional training standards, he said.

The portico of the beautiful 15th century Hospital of the Innocents in Florence, Italy, the first organic creation of Filippo Brunelleschi (1377-1446), marks the birth of Renaissance architecture in Florence, he added. The Hospital of Santa Maria Nuova, founded in 1288, is the oldest hospital still active in Florence.

Part of the goal for this session is to take a break from clinically focused presentations, and to think about the hospital from a different perspective, Dr. Messler said. His session will emphasize the power of stories and storytelling to inform and inspire medical practice.

"We need to ask ourselves, 'How can we analyze hospital history to inform what we do today?'"

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Well-rounded program

Continued from page 1

at the conference to kick off planning for the following year's conference, then holds weekly conference calls for the next 4-5 months, Dr. Smith said. "These are all highly creative leaders in hospital medicine, with voices to be heard and taken under consideration."

Committee members wear badges at the annual meeting to encourage attendees to offer them feedback and suggestions. "We have our ears to the ground. We look at the session ratings from prior years, speaker ratings, and all of the feedback we have received, and we take all of that into account to come up with new ideas for educational tracks," Dr. Smith said. New for 2019 are "Between the Guidelines" and "Clinical Mastery." "We went around the table at our meeting and asked everybody for their ideas for new tracks, and then we voted in the most popular ones."

One change for 2019 was to "completely open" the call for submission of proposals – and for nominations of content to be covered and who should present it – for all sessions



at HM19, not just for the workshop tracks. Dr. Smith said all submissions were peer reviewed by committee members and scored with objective ratings.

"For example, there was a lot of interest in emergency and disaster preparedness for hospitalists in a number of the submissions. Wheth-

er we're talking about wildfires or mass shootings, it affects hospitals, and we are among the frontline practitioners for whatever happens in those hospitals. So we may need to be able to respond to large-scale emergencies," he said. "But most of us haven't been trained for that."

A love of teaching

Dr. Smith's preparation for being the HM19 course director includes his work teaching medical students, residents, and physicians at Emory University where he also attended medical school. He chairs the Emory division of hospital medicine's education council, directs hospital medicine grand rounds at Emory, and serves as associate program director for the J. Willis Hurst Internal Medicine Residency Program at Emory as well as a section chief for education in medical specialty at the Atlanta Veterans Affairs Medical Center. Dr. Smith has also codirected, since 2012, the annual Southern Hospital Medicine regional conference.

"I have long had an interest in medical education for medical students, trainees, and faculty and I wanted to do more of it – with a number of mentors encouraging me along the way," he said. "I have planned and coordinated teaching sessions needed for maintenance of board certification, which is similar to what we will present at HM19. Based on that experience, I applied to be on SHM's annual conference committee, starting in 2012 for the planning of Hospital Medicine 2013. I believe I have been preparing myself all along to take on this role."

A well-rounded program

The HM19 educational program will be well rounded, Dr. Smith said, offering clinical updates on topics such as sepsis, heart failure, and new clinical practice guidelines.

"You will see a big focus on wellness and how to avoid burnout, as well as other sessions on how to develop and sustain a career in hospital medicine," he said. Another important HM19 theme will be the delivery of new models of population health and accountable care and their impact on both patients and hospital operations.

The 2019 agenda emphasizes other interactive formats, such as the "Great Debates," where experts in the field are paired to debate clinical conundrums in hospital medicine. The number of Great Debates has grown from one on perioperative medicine at the 2017 annual conference, to three in 2018, and now to seven planned for 2019. "This format is very popular. We're also planning 'Medical Jeopardy,' with three brilliant master clinicians in a quiz show format, and two 'Stump the Professor' sessions with expert diagnosticians," Dr. Smith said.

It's important to make every session at the conference interactive to engage attendees in learning from, and talking to, experts in the field, he said. "But it's also important for some of them to be more entertaining in approach as a way to encourage learning. We know that this actually increases retention of information."

The annual conference course director typically is selected several years in advance, in order to plan for the time commitment that will be required, and spends the year before this term as assistant course director. "It is a big honor to serve as course director. It's fun and exciting to work with such a talented and diverse committee, but it's also a lot of work," Dr. Smith acknowledged. "I reviewed all 450 session proposals from this year's open call for course content. The volume of emails is pretty outstanding, and I was extremely busy with conference planning for a season."

Dr. Smith has continued to pursue his full-time commitments at Emory, without getting dedicated time off for planning the SHM conference. "But as a parent of three young children, I already feel busy all the time," he said. "I put in a lot of late nights, but I found a way to make it work."

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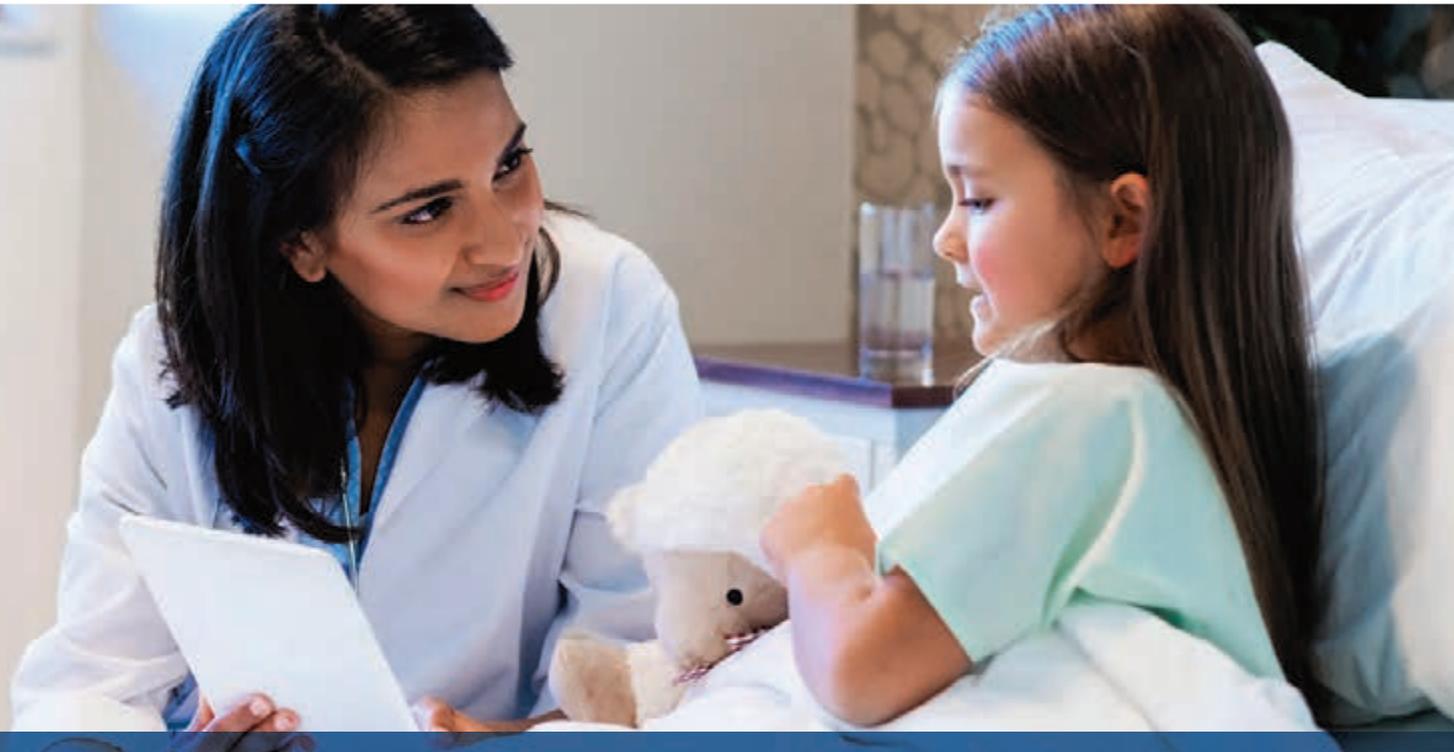
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Creating innovative discharge plans

'Long Stay Committee' may help

Hospitalists pay attention to length of stay as a measure of hospital efficiency and resource utilization; outliers on that measure – “long stay patients” – who present complex discharges are a barrier to length of stay reduction. To address this challenge, one institution formed a multidisciplinary Long Stay Committee and described the results in an abstract.

The Long Stay Committee is composed of medical directors, the chief quality officer, directors in nursing, directors of case management/social work, hospitalists, risk management, finance, ethics, psychiatry, and directors of rehabilitation. The most complex patient discharges, identified by case management and social work, are brought to the Long Stay Committee.

“Lack of guardianship is one of the most encountered barriers,” according to the authors.



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“The Long Stay Committee played an integral part in our institution partnering with the local county to form a guardian service board which facilitates guardianship appointments. Other

solutions have included working with the patient and support persons to find appropriate discharge levels of care throughout the United States and other countries as well as guiding them through the process to gain the necessary financial resources.”

The authors conclude that the foundation of the committee’s success in coming up with innovative discharge solutions is the broad range of disciplines that attend this committee and the atmosphere of teamwork it creates.

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Highlighting the value in high-value care

Consumers learn about choices

Hospitalists can have a role in helping patients choose and receive high-value care from the vast array of health care choices they face. Helping them use quality and cost reports is one way to do that, according to a recent editorial by Jeffrey T. Kullgren, MD, MS, MPH.

We know that, if consumers used public reporting of quality and costs to choose facilities that generate the best health outcomes for the resources utilized, it might improve the overall value of health care spending. But most people choose health care services based on personal recommendations or the requirements of their insurance network.

Even if they wanted to use reports of quality or cost, the information in these reports is meant for providers and would likely be unhelpful for consumers.

Research suggests that different presentation of the information could make a difference. “Simpler presentations of information in public reports may be more likely to help consumers choose higher-value providers and facilities,” Dr. Kullgren said.

He concluded that consumers may also need additional incentives, “such as financial incentives

to encourage high-value choices or programs that educate consumers about how to use cost and quality information when seeking care,” he said.

There’s an opportunity for hospitalists to help consumers learn to use that information. “This strategy would approach consumerism as a teachable health behavior and could be particularly helpful for consumers with ongoing medical needs who face high cost sharing,” he wrote.

“Some hospitalists may be involved in the implementation of programs to publicly report quality and costs for their institutions,” said Dr. Kullgren. “Others may treat patients who have chosen hospitals based on publicly reported information, or patients who might be interested in using such information to choose sites of postdischarge outpatient care. In each of these cases, it is important for hospitalists to understand the opportunities and limits of such public reports so as to best help patients receive high-value care.”

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Remembering the importance of caring

AI will change the practice of medicine

As artificial intelligence (AI) takes on more and more tasks in medical care that mimic human cognition, hospitalists and other physicians will need to adapt to a changing role.

Today AI can identify tuberculosis infections in chest radiographs with almost complete accuracy, diagnose melanoma from images of skin lesions more accurately than dermatologists can, and identify metastatic cells in images of lymph node tissue more accurately than pathologists can. The next 20 years are likely to see further acceleration in the capabilities, according to a recent article by S. Claiborne Johnston, MD, PhD.

“AI will change the practice of medicine. The art of medicine, including all the humanistic components, will only become more important over time. As dean of a medical school, I’m training students who will be practicing in 2065,” Dr. Johnston said. “If I’m not thinking about the future, I’m failing my students and the society they will serve.”

The contributions of AI will shift the emphasis for human caregivers to the caring. Studies have shown that the skills of caring are associated with improved patient outcomes, but most medical schools

allocate substantial time in the curriculum to memorization and analysis – tasks that will become less demanding as artificial intelligence improves. The art of caring – communication, empathy, shared decision making, leadership, and team building – is usually a minor part of the medical school curriculum.

Effective leadership and creativity are distant aspirations for artificial intelligence but are growing needs in a system of care that is ever more complex.

At Dr. Johnston’s school, the Dell Medical School at the University of Texas at Austin, they have reduced the duration of basic science instruction to 12 months and emphasized group problem solving, while deemphasizing memorization. This has freed up additional time for instruction in the art of caring, leadership, and creativity.

“Hospitalists should acknowledge the value of caring,” Dr. Johnston said. “They do it every day with every patient. It is important today, and will be more important tomorrow.”

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Johnston SC. Anticipating and training the physician of the future: The importance of caring in an age of artificial intelligence. *Acad Med.* 2018;93(8):1105-6. doi: 10.1097/ACM.0000000000002175.

Improving research dissemination among hospitalists

Social media a great platform

Medical journals and societies are trying to figure out ways to use social media to connect with hospitalists and others interested in their subject matter, says Charlie Wray, DO, MS, lead author of a paper proposing a way they can do that: implementing a journal-sponsored club on Twitter.

“At the *Journal of Hospital Medicine (JHM)*, we noticed that there was a large community of hospitalists on Twitter who were looking for a community to engage in hospital medicine topics,” Dr. Wray said. “We created #JHMChat to bring the hospital medicine community together on a regular basis to talk about pertinent research, medical education philosophies, and value-based care interventions. Our ultimate goal was to increase engagement, networking, and communication among this community, while highlighting the



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work that is being published in *JHM*.”

A study of #JHMChat showed that social media is a great platform for large organizations to reach out, connect, and create a community around, he added. “We were very surprised by both the Twitter metrics (i.e., number of participants and overall impressions), which showed very large dissemination numbers, in addition to the external dissemination

metrics (i.e., page views and altmetrics scores), which showed that each chat basically corresponded to a release of a new issue. This could be informative to other journals as they look for ways to increase their web traffic or disseminate their work to their respective audiences.”

Dr. Wray hopes the study alerts hospitalists to the fact that there is a large and ever-growing community available within social media.

“Second, we know that careers in hospital medicine can be tough, regardless of whether you’re at a community hospital or a large academic center. Knowing that there is a community with which you can connect to is both comforting and reassuring.”

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SOUTHERLYCOURSE/GETTY IMAGES

Quick Byte: Trauma care

Innovating quickly

The U.S. military has completely transformed trauma care over the past 17 years, and that success offers lessons for civilian medicine.

In the civilian world, it takes an average of 17 years for a new discovery to change medical practice, but the military has developed or significantly expanded more than 27 major innovations, such as redesigned tourniquets and new transport procedures, in about a decade. As a result, the death rate from battlefield wounds has decreased by half.

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Hospitalists and PTs: Building strong relationships

Optimizing discharge disposition and longitudinal recovery

By Luann Tammany, PT, MBA

Sanctimonious, self-righteous, discharge saboteurs. These are just a few descriptors I've heard hospitalists use to describe my physical therapy (PT) colleagues.

These charged comments come mostly after a hospitalist reads therapy notes and encounters a contradiction to their chosen discharge location for a patient.

I recently met with hospitalists from four different hospitals. They echoed the frustrations of their physician colleagues across the country. The PTs they work with write “the patient requires 24-hour supervision and 3 hours of therapy a day,” or “the patient is unsafe to go home and needs continued therapy at an inpatient rehabilitation center.” The hospitalists in turn want to know “If I discharge the patient home am I liable if the patient falls or has some other negative outcome?” The frustration hospitalists experience is palpable and understandable as their attempts to support a home recovery are often contradicted.

Outside the four walls

The transition from fee-for-service to value-based care now calls upon hospitalists to be innovators in man-

aging patients in alternative payment models, such as accountable care organizations, bundled payment programs, and Medicare Advantage plans. Each model looks to support a home recovery whenever possible and prevent readmissions.

“For hospitalists, working collaboratively with PTs is crucial to improving the value of care provided as patients transition beyond the four walls of the hospital.”

Case managers for Medicare Advantage programs routinely review PT notes to inform hospital discharge disposition and postacute authorization for skilled nursing facility (SNF) admissions and days in SNF. Hospitalists, working with care managers, can follow suit to succeed in alternative payment models. They have the advantage of in-person access to PT colleagues for elaboration and push-back as necessary. For hospitalists, working collaboratively with PTs is crucial to improving the value of care provided as patients transition beyond the four walls of the hospital.

The evolution of PT in acute care

Prior to diagnosis-related groups (DRGs), PTs were profit centers for hospitals – rehabilitation departments were well staffed and easily accommodated consults and requests for mobility.

With the advent of DRGs, physical therapy became a cost center, and rehabilitation staffs were reduced. PTs became overextended, were less available for consultations for mobilization, and patients suffered the deleterious effects of immobility. With reduced staffing and a rush to get patients out of the hospital, acute PT practice morphed into evaluating functional status and determining discharge destination.

Now, as members of an aligned health care team, PTs need to facilitate a safe home discharge whenever possible and determine what skilled services a patient needs post-

acute stay, not where they should receive them.

Discharge disposition and longitudinal recovery

PTs, as experts in function, have a series of “special tests” at their disposal beyond pain, range of motion, and strength assessments. These include Activity Measure for Post-Acute Care (AM-PAC) or “6-Clicks” Mobility Score, Timed Up and Go, Six-Minute Walk Test, Tinetti, Berg Balance Scale, Modified Barthel Index, Five Times Chair Rise, and Thirty-Second Chair Rise. These are all objective measures of function that can be used to inform discharge disposition and guide longitudinal recovery.

To elaborate on one tool, the 6-Clicks Mobility Score is a validated test that allows PTs to assess basic mobility.^{1,2} It rates six functional tasks (hence 6 clicks) that include turning over in bed, moving from

“PTs ... have a series of ‘special tests’ at their disposal.”

lying to sitting, moving to/from bed to chair, transitioning from sitting to standing from a chair, walking in a hospital room, and climbing three to five steps. These functional tasks are scored based on the amount of assistance needed. The scores, in turn, have been shown to support discharge destination planning.¹ In addition to informing discharge destination decisions, hospitalists and the rest of the health care team can use 6-Clicks to estimate prolonged hospital stays, readmissions, and emergency department (ED) visits.³

Of course, discharge disposition is influenced by many factors in addition to functional status. Hospitalists are the obvious choice to lead the health care team in interpreting relevant data and test results, and to communicate these results to patients and caregivers so together they can decide the most appropriate discharge destination.

I envision a conversation between a fully informed hospitalist and a patient as follows: “Based on your past history, your living



Ms. Tammany is SVP of clinical strategy & innovation for Remedy Partners, Norwalk, Conn.

situation, all of your test results including labs, x-rays and the functional tests performed by your PT, your potential for a full recovery is good. You have a moderate decline in function with a high likelihood of returning home in the next 7-10 days. I recommend you go to a SNF for high-intensity rehabilitation for 7 days and that the SNF order PT and OT twice a day and walks with nursing every evening.”

This fully informed conversation can take place only if hospitalists are provided clear, concise documentation, including results of objective functional testing, by their physical therapy colleagues.

In conclusion, PTs working in the acute setting need to use validated tests to objectively assess function and educate their hospitalist colleagues on the meaning of these tests. Hospitalists in turn can incorporate these assessments into a discussion of discharge disposition and longitudinal recovery with patients. In this way, hospitalists and physical therapists can work together to achieve patient-centered, high-value care during and following a hospitalization.

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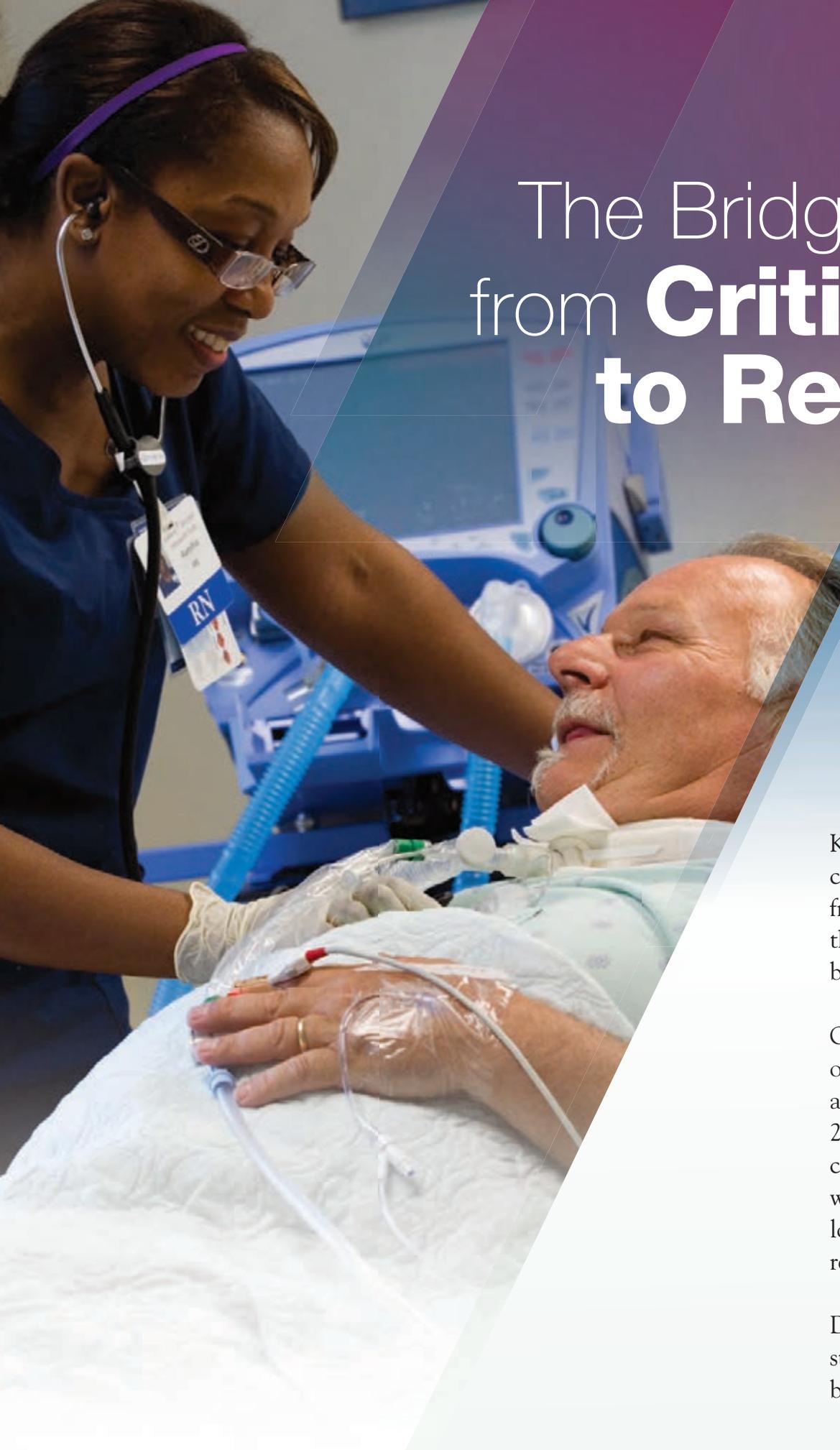
Working Together: Hospitalists and PTs

Hospitalists

- Understand physical therapy assessment of function to inform discharge disposition and longitudinal recovery.
- Interpret all test results, including PT, to inform discharge disposition.

Physical Therapists

- Identify what skilled services a patient will need after hospitalization, not where they should receive those services.
- Support recommendations for ongoing skilled services with objective functional tests.
- Participate as part of the health care team, led by the physician, in determination of discharge disposition.



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ITL: Clinician reviews of HM-centric research

By Bryan Huang, MD, FHM; Nhan Vuong, MD; Talya Bordin-Wosk, MD; Jonathan McIntyre, MD; and Constance Chace, MD, MPH

Division of Hospital Medicine at the University of California, San Diego

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By Bryan Huang, MD, FHM

1 Additional physical therapy decreases length of stay

CLINICAL QUESTION: Does additional physical therapy reduce length of stay and improve outcomes?

BACKGROUND: The optimal quantity of physical therapy provided to hospitalized patients is unknown. It has been hypothesized that the costs of additional physical therapy might be outweighed by a decrease in length of stay. A prior meta-analysis done by the same authors was inconclusive; subsequently, additional large trials were published, prompting the authors to repeat their meta-analysis.

STUDY DESIGN: Meta-analysis.

SETTING: Literature review of English-language studies conducted worldwide.

SYNOPSIS: A total of 24 randomized controlled trials with a total of 3,262 participants was included in this meta-analysis. The primary finding was that additional physical therapy was associated with a 3-day reduction in length of stay in subacute settings (95% confidence interval, -4.6 to -0.9) and a 0.6-day reduction in acute care settings (95% CI, -1.1 to 0.0). Furthermore, additional physical therapy was associated with small improvements in self-care and activities of daily living. One trial included an economic analysis that suggested additional physical therapy was cost effective.

Of note, there was no standard definition of "additional physical

therapy" across the heterogeneous group of trials analyzed in this meta-analysis. In all studies, the experimental group received more physical therapy than the control group, either by increased frequency or duration of sessions. Nonetheless, hospitals may consider increasing physical therapy services as a cost-effective means of reducing length of stay.

BOTTOM LINE: Additional physical therapy in acute and subacute care settings results in a decreased length of stay and may be cost effective.

CITATION: Peiris CL et al. Additional physical therapy services reduce length of stay and improve health outcomes in people with acute and subacute conditions: an updated systematic review and meta-analysis. *Arch Phys Med Rehabil.* 2018;99(11):2299-312.

2 Productivity-based salary structure not associated with value-based culture

CLINICAL QUESTION: What hospitalist reimbursement models are associated with value-based care culture?

BACKGROUND: Although new payment models have been implemented by the Centers for Medicare

& Medicaid Services (CMS) for hospital reimbursement, little is known about the effects of reimbursement models on the culture of providing value-based care among individual hospitalists. The concern is that productivity-based models increase pressure on hospitalists to maximize volume and billing, as opposed to focusing on value.

STUDY DESIGN: Observational, cross-sectional, survey-based study.

SETTING: A total of 12 hospitals in California, which represented university, community, and safety-net settings.

SYNOPSIS: Hospitalists were asked to complete the High-Value Care Culture Survey (HVCCS), a validated tool that assesses value-based decision making. Components of the survey assessed leadership and health system messaging, data transparency and access, comfort with cost conversations, and blame-free environments. Hospitalists were also asked to self-report their reimbursement structure: salary alone, salary plus productivity, or salary plus value-based adjustments.

A total of 255 hospitalists completed the survey. The mean HVCCS score was 50.2 on a 0-100 scale. Hospitalists who reported reimbursement with salary plus productivity adjustments had a lower mean HVCCS score (beta = -6.2; 95% confidence interval, -9.9 to -2.5) when compared with hospitalists paid with salary alone. An association was not found between HVCCS score and reimbursement with salary plus value-based adjustments when compared with salary alone, though this finding may have been limited by sample size.

BOTTOM LINE: A hospitalist reimbursement model of salary plus productivity was associated with lower measures of value-based care culture.

CITATION: Gupta R et al. Association between hospitalist productivity payments and high-value care culture. *J Hosp Med.* 2019;14(1):16-21.

Dr. Huang is a physician adviser and associate clinical professor in the division of hospital medicine at the University of California, San Diego.

By Nhan Vuong, MD

3 Standardized communication may prevent anticoagulant adverse drug events

CLINICAL QUESTION: What information is needed on discharge to reduce anticoagulant adverse drug events (ADEs)?

BACKGROUND: With increased use of anticoagulants, the amount of related ADEs has also increased. ADEs may be preventable through improved communication during transitions of care. The key communication elements are not standardized.

STUDY DESIGN: Delphi method.

SETTING: Consensus panel in New York state.

SYNOPSIS: The New York State Anticoagulation Coalition (NYSACC) tasked an expert multidisciplinary panel of physicians, pharmacists, nurse practitioners, and physician assistants to develop a list of minimum required data elements (RDEs) for transitions of care using the Delphi method.

The following items are the 15 RDEs that require documentation: (1) current anticoagulants; (2) indications; (3) new or previous user; (4) if new, start date, (5) short-term or long-term use; (6) if short term, intended duration; (7) last two doses given; (8) next dose due; (9) latest renal function; (10) provision of patient education materials; (11) assessment of patient/caregiver understanding; (12) future anticoagulation provider; and if warfarin, (13) the target range, (14) at least 2-3 consecutive international normalized ratio results, and (15) next INR level.

BOTTOM LINE: Standardized communication during transitions of care regarding anticoagulation may reduce anticoagulant ADEs. Objective evidence showing reduction of ADEs after implementation of the list is needed.

CITATION: Triller D et al. Defining minimum necessary anticoagulation-related communication at



Dr. Vuong



Dr. Huang

discharge: Consensus of the Care Transitions Task Force of the New York State Anticoagulation Coalition. *Jt Comm J Qual Patient Saf.* 2018;44(11):630-40.

4 Early extubation to noninvasive ventilation did not decrease time to liberation from ventilation

CLINICAL QUESTION: In difficult to wean patients, does a weaning protocol with noninvasive ventilation result in earlier liberation from ventilation, compared with invasive weaning (continued invasive ventilation until successful spontaneous breathing trial)?

BACKGROUND: Inclusion of noninvasive ventilation in weaning among chronic obstructive pulmonary disease (COPD) patients has been shown to reduce total duration of ventilation and invasive ventilator days with an associated reduction in morbidity and mortality. It is not well studied whether these results apply to general ICU patients.

STUDY DESIGN: Randomized, allocation-concealed, open-label, multicenter trial.

SETTING: United Kingdom National Health Service ICUs.

SYNOPSIS: Patients from 41 general adult ICUs met inclusion criteria after they had been intubated for less than 48 hours and failed a spontaneous breathing trial. Intention-to-treat analysis in 319 of 364 patients (mean age, 63.1 years; 50.5% male) showed median time to liberation of 4.3 days in the noninvasive group versus 4.5 days in the invasive group (adjusted hazard ratio, 1.1; 95% confidence interval, 0.89-1.40). However, secondary outcomes showed reduction in median time of invasive ventilation (1 day vs. 4 days) and total ventilator days (3 days vs. 4 days) in the noninvasive group without a significant difference in adverse events.

Not all secondary outcomes were powered to detect treatment differences. Hospitalists should consider noninvasive ventilation as an adjunct in weaning, especially in COPD patients, to reduce ventilator-associated complications and ICU resources when appropriate.

BOTTOM LINE: Protocolized early extubation to noninvasive ventilation was not associated with earlier liberation from all types of ventilation in the general ICU population.

CITATION: Perkins GD et al. Effect of protocolized weaning with early extubation to noninvasive ventilation vs invasive weaning on time to liberation from mechanical ventilation among patients with

respiratory failure: The breathe randomized clinical trial. *JAMA.* 2018;320(18):1881-8.

Dr. Vuong is an associate physician in the division of hospital medicine at the University of California, San Diego.

5 Predicted risk of cardiac complications varies among risk calculators

CLINICAL QUESTION: How frequently is there concordance between three recommended risk calculators in categorizing a patient as low risk for major adverse cardiac event (MACE)?

BACKGROUND: A critical juncture in the American Heart Association/American College of Cardiology 2014



Dr. Bordin-Wosk

perioperative guidelines relies on clinicians categorizing patients undergoing non-cardiac surgery as either low risk (less than 1%) or elevated risk (greater than or equal to 1%) for a MACE. The purpose of this study is to determine whether there is variability between the three risk calculators endorsed by the ACC/AHA guidelines as prediction tools to make this risk stratification.

STUDY DESIGN: Retrospective observational study.

SETTING: National Surgical Quality Improvement Program database.

SYNOPSIS: The NSQIP database was used to identify 10,000 patients who had undergone noncardiac surgery. The risk of MACE for each patient was then calculated using the Revised Cardiac Risk Index, the American College of Surgeons National Surgical Quality Improvement Program Surgical Risk Calculator, and the National Surgical Quality Improvement Program Myocardial Infarction or Cardiac Arrest calculator. Data were analyzed using the intraclass correlation coefficient and kappa analysis. Results demonstrated that 29% of the time the three calculators disagreed on which patients were classified as low risk. This suggests that, when following the ACC/AHA perioperative guidelines, a recommendation for further preoperative cardiac testing may depend on which risk prediction tool is used to calculate the risk of MACE.

BOTTOM LINE: Nearly one-third of the time, the three risk calculators recommended in the ACC/

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AHA 2014 perioperative guidelines do not agree on which patients are classified as low risk; this may affect clinical decision making for some patients.

CITATION: Glance LG et al. Impact of the choice of risk model for identifying low-risk patients using the 2014 American College of Cardiology/American Heart Association perioperative guidelines. *Anesthesiology*. 2018;129(5):889-900.

6 Use of a CDSS increases safe outpatient management of low-risk PE patients

CLINICAL QUESTION: Does the use of an electronic clinical decision support system (CDSS) increase the number of low-risk patients with acute pulmonary embolism (PE) discharged from the ED without increasing adverse events?

BACKGROUND: Despite multiple guidelines that support outpatient management of acute PE in the appropriate patient population, the rate of hospital admission for patients eligible for outpatient management remains high. One explanation is that physicians may have difficulty identifying which patients meet discharge criteria.

STUDY DESIGN: Controlled pragmatic trial.

SETTING: Kaiser Permanente Northern California (KPNC).

SYNOPSIS: A total of 21 KPNC EDs participated in this 16-month study of 1,703 patients; 11 EDs served as control sites and 10 as intervention sites. At month 9, ED physician study champions at intervention sites provided in-person training on outpatient PE management, the validated PE severity index (PESI), and the electronic CDSS. The CDSS was designed to use evidence-based guidelines to assist physicians in identifying patients eligible for outpatient care or short-term (less than 24-hour) observation in the ED. The CDSS was incorporated into the electronic medical record navigator used by ED physicians and not only calculated the PESI score, but also provided the patient's risk class and 30-day all-cause mortality estimate. Adverse outcomes were defined as 5-day return visits for PE-related symptoms, recurrent VTE, major hemorrhage, and all-cause 30-day mortality. Results demonstrated an increase in home discharge at intervention sites (17.4% pre to 28% post) without an increase in adverse outcomes.

BOTTOM LINE: Use of an electronic CDSS to identify patients appropri-

ate for home management of acute PE decreased admission rates without increasing adverse outcomes.

CITATION: Vinson DR et al. Increasing safe outpatient management of emergency department patients with pulmonary embolism: a controlled pragmatic trial. *Ann Int Med*. 2018;169(12):855-65.

Dr. Bordin-Wosk is an assistant clinical professor in the division of hospital medicine at the University of California, San Diego.

By Jonathan McIntyre, MD

7 Health care-associated infection rates going down

CLINICAL QUESTION: Have targeted quality improvement measures led to an improvement in the prevalence of health care-associated infections (HAIs)?

BACKGROUND: HAIs are key drivers of morbidity and mortality for hospitalized patients. In 2011, the Centers for Disease Control and Prevention (CDC) conducted a point-prevalence survey that revealed an HAI in 4% of hospitalized patients. The



Dr. McIntyre

most common infections included pneumonia, gastrointestinal infections, and surgical-site infections. Over time, efforts in patient safety and quality have expanded to reduce the rate of HAIs. This same survey was repeated in 2015 to assess for improvements.

STUDY DESIGN: Point-prevalence survey.

SETTING: A collection of 199 Emerging Infection Program hospitals in 10 states.

SYNOPSIS: Of 12,299 patients surveyed, 3.2% (95% confidence interval, 2.9%-3.5%) were found to have at least one HAI. This was a statistically significant reduction compared to the prevalence of 4% (95% CI, 3.7%-4.4%) found in the 2011 study. Approximately 75% of patients were on a medical ward, and 15% of patients were in the ICU. The age and sex of patients were similar to those of patients in the 2011 study.

The reduction in HAIs was primarily driven by a reduction in surgical-site infections and urinary tract infections. There was no reduction in the prevalence of health care-associated pneumonia, *Clostridium difficile* infection, or mortality. Consequently, this emphasizes the necessity of further work in

these domains.

BOTTOM LINE: The overall prevalence of HAIs has decreased, but further quality improvement work is needed in order to expand this reduction to health care-associated pneumonia, *C. difficile* infection, and mortality from HAIs.

CITATION: Magill SS et al. Changes in prevalence of health care-associated infections in U.S. hospitals. *N Engl J Med*. 2018;379(18):1732-44.

8 ARNIs effective for acute decompensated heart failure

CLINICAL QUESTION: In patients hospitalized for acute decompensated heart failure with reduced ejection fraction (HFrEF), is an angiotensin receptor-neprilysin inhibitor (ARNI) as effective as enalapril in reducing levels of N-terminal of the prohormone brain natriuretic peptide (NT-proBNP)?

BACKGROUND: The PARADIGM-HF trial demonstrated that patients with chronic HFrEF treated with an ARNI (sacubitril/valsartan) had significantly reduced cardiovascular mortality and hospitalizations when compared with enalapril. Patients with acute decompensated heart failure were excluded from this trial. The PIONEER-HF trial was designed to determine whether initiation of an ARNI in patients with acute decompensated heart failure is effective.

STUDY DESIGN: Multicenter, ran-

domized, double-blind, active-controlled trial.

SETTING: A total of 129 centers in the United States.

SYNOPSIS: Of 881 patients with acute HFrEF, 440 were randomized to receive sacubitril/valsartan and 441 were randomized to receive enalapril. The majority of patients were men; mean age was 61 years. The primary outcome was the mean reduction in NT-proBNP concentration at weeks 4 and 8 as compared with baseline. In the sacubitril/valsartan group, there was a 46.7% reduction from baseline, and in the enalapril group, there was a 25.3% reduction from baseline. With regard to drug safety, there was no difference between groups in worsening renal function, symptomatic hypotension, or hyperkalemia.

A limitation of this study is that 20% of patients in each group discontinued treatment by 8 weeks secondary to an adverse event. Additionally, a clinical measure such as cardiovascular mortality, all-cause mortality, or rehospitalization for heart failure was not included in the primary outcome.

BOTTOM LINE: In patients with acute decompensated HFrEF, ARNIs are more effective at reducing NT-proBNP levels than enalapril, while maintaining a similar safety profile. Further investigation to evaluate clinical outcomes needs to be completed.

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Short Takes

Pharmacist-led intervention reduced inappropriate medication prescriptions

An outpatient pharmacy-led intervention of notifying prescribing physicians to discontinue inappropriate Beers Criteria medications resulted in a greater discontinuation of inappropriate medications for older adults at 6 months, compared with the control group (43% vs. 12% discontinuation).

CITATION: Martin P et al. Effect of a pharmacist-led educational intervention on inappropriate medication prescriptions in older adults: The D-PRESCRIBE randomized clinical trial. *JAMA*. 2018;320(18):1889-98.

Omadacycline noninferior for community-acquired pneumonia and acute bacterial soft tissue skin infections

Randomized, double-blind, double-dummy trials showed omadacycline is a noninferior alternative to moxifloxacin for the treatment of community-acquired pneumonia and to linezolid for acute bacterial soft-tissue skin infections.

CITATION: Nuzyra (omadacycline) [package insert]. Boston, MA: Paratek Pharmaceuticals. 2018.

Lack of evidence to support low-salt diet in adult heart failure patients

Systematic review of multiple databases demonstrated there is limited high-quality evidence to support current guidelines that recommend a low-salt diet to heart failure patients.

CITATION: Mahtani KR et al. Reduced salt intake for heart failure: A systematic review. *JAMA Int Med*. 2018;178(12):1693-700.

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CITATION: Velazquez EJ et al. Angiotensin–neprilysin inhibition in acute decompensated heart failure. *N Engl J Med.* 2018 Nov 11. doi: 10.1056/NEJMoa1812851.

Dr. McIntyre is an associate physician in the division of hospital medicine at the University of California, San Diego.

By Constance Chace, MD, MPH 9 Exercise intervention reverses functional decline in elderly patients during acute hospitalization

CLINICAL QUESTION: Can an individualized, multicomponent exercise program help reverse functional and cognitive decline in acutely hospitalized, elderly patients?

BACKGROUND: Acute hospitalization has been associated with functional and cognitive decline, particularly in elderly adults. This decline is associated with increased morbidity and mortality.

STUDY DESIGN: Single-center, single-blind, randomized clinical trial.

SETTING: Acute care unit in a tertiary public hospital in Navarra, Spain.

SYNOPSIS: 370 patients aged 75 years or older who were hospitalized in an acute care unit received either individualized moderate intensity

exercise regimens (focusing on resistance, balance, and walking) or standard hospital care (with physical rehabilitation as appropriate). Patients who received standard care had a decrease in functional capacity at discharge when compared with their baseline function (mean change of –5.0 points on the Barthel Index of Independence; 95% confidence interval, –6.8 to –3.2 points), while those who received the exercise intervention had no functional decline from baseline on discharge (mean change of 1.9 points; 95% CI, 0.2-3.7 points).

Patients who received the exercise intervention had significantly higher scores on functional and cognitive assessments at discharge, compared with patients who received standard hospital care alone. Specifically, the study demonstrated a mean increase of 2.2 points (95% CI, 1.7-2.6 points) on the Short Physical Performance Battery, 6.9 points (95% CI, 4.4-9.5 points) on the Barthel Index, and 1.8 points (95% CI, 1.3-2.3 points) on a cognitive assessment, compared with those who received standard hospital care.

BOTTOM LINE: An individualized, multicomponent exercise intervention can help reverse functional and cognitive decline associated with

acute hospitalization in elderly patients.

CITATION: Martinez-Velilla N et al. Effect of exercise intervention on functional decline in very elderly adults during acute hospitalization. *JAMA Intern Med.* 2019;179(1):28-36.

10 Consider triple therapy for the management of COPD

CLINICAL QUESTION: Does triple therapy for chronic obstructive pulmonary disease (COPD) result in lower rates of COPD exacerbations when compared with dual therapy or monotherapy?

BACKGROUND: The Global Initiative for Obstructive Lung Disease (GOLD) recommends triple therapy with inhaled corticosteroids, long-acting beta₂-adrenoceptor agonists (LABA), and long-acting muscarinic receptor antagonists (LAMA) for patients with severe COPD who have frequent exacerbations despite treatment with a LABA and LAMA. Triple therapy has been shown to improve forced expiratory volume in 1 second (FEV₁), but its effect on preventing exacerbations has not been well documented in previous meta-analyses.

STUDY DESIGN: Meta-analysis.

SETTING: Studies published on PubMed, Embase, Cochrane Library website, Cochrane Central Register of Controlled Trials (CENTRAL), and ClinicalTrials.gov databases.

SYNOPSIS: 21 randomized, controlled trials of triple therapy in stable cases of moderate to very severe COPD were included in this meta-analysis. Triple therapy was

associated with a significantly greater reduction in the rate of COPD exacerbations, compared with dual therapy of LAMA and LABA (rate ratio, 0.78; 95% confidence interval, 0.70-0.88), inhaled corticosteroid and LABA (rate ratio, 0.77; 95% CI, 0.66-0.91), or LAMA monotherapy (rate ratio, 0.71; 95% CI, 0.60-0.85). Triple therapy was also associated with greater improvement in FEV₁.

There was a significantly higher incidence of pneumonia in patients using triple therapy, compared with those using dual therapy (LAMA and LABA), and there also was a trend toward increased pneumonia incidence with triple therapy, compared with LAMA monotherapy. Triple therapy was not shown to improve survival; however, most trials lasted less than 6 months, which limits their analysis of survival outcomes.

BOTTOM LINE: In patients with advanced COPD, triple therapy is associated with lower rates of COPD exacerbations and improved lung function, compared with dual therapy or monotherapy.

CITATION: Zheng Y et al. Triple therapy in the management of chronic obstructive pulmonary disease: Systemic review and meta-analysis. *BMJ.* 2018;363:k4388.

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Dr. Chace

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Short Takes

Magnesium for rate control in rapid atrial fibrillation

Randomized, controlled trial demonstrated that intravenous magnesium sulfate in combination with atrioventricular (AV) nodal blocking agents resulted in better rate control for atrial fibrillation with rapid ventricular response than did placebo given in combination with AV nodal blocking agents.

CITATION: Bouida W et al. Low-dose magnesium sulfate versus high-dose in the early management of rapid atrial fibrillation: Randomized controlled double-blind study (LOMAGHI Study). *Acad Emerg Med.* 2019 Feb;26(2):183-91.

Low versus intermediate tidal volume strategy on ventilator-free days in ICU patients without ARDS

Randomized, clinical trial of low tidal volume versus intermediate tidal volume strategies in invasively ventilated patients without acute respiratory distress syndrome (ARDS) demonstrated no difference in number of ventilator-free days, ICU length of stay, hospital length of stay, incidence of ventilator-associated adverse events (ARDS, pneumonia, severe atelectasis, pneumothorax), or 28-day mortality.

CITATION: Writing Group for the PREVENT Investigators, Simonis FD, Serpa Neto A. Effect of a low vs intermediate tidal volume strategy on ventilator-free days in intensive care unit patients without ARDS: A randomized clinical trial. *JAMA.* 2018;320(18):1872-80.

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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:
 - o Level 1b nursery
 - o 7 bed pediatrics unit
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- Comprehensive adult medicine service including:
 - o 302-bed community teaching hospital with residency programs
 - o Geographic rounding model
 - o A closed ICU/CCU
 - o A full spectrum of Specialties to support the team
 - o 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



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.

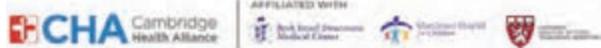
We offer:

- 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.slhn.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



ICU Hospitalist/Nocturnist CHA Everett Hospital

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

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

- Position requires PM shifts (7p-7a) plus weekend day shifts
- Work collaboratively with CHA's intensivists MDs to round on inpatients within the CHA Everett Hospital ICU
- Cross coverage of med/surg inpatient unit included as part of clinical responsibility (10% of total FTE)
- Applicants should be comfortable with procedures including central lines, vent management, intubation, etc.
- Internal training and maintenance program exists to assist in certification of these skills competencies
- Academic appointment is available commensurate with medical school criteria

Applicants should be trained and Board Certified in Internal Medicine or Family Medicine and possess excellent clinical and communication skills plus a demonstrated commitment to CHA's multicultural, underserved patient population.

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

Please visit www.CHAproviders.org to learn more and apply through our secure candidate portal. CVs may be sent directly to Lauren Anastasia, Manager, CHA Provider Recruitment via email at LAnastasia@challiance.org. CHA's Department of Provider Recruitment may be reached by phone at (617) 665-3555 or by fax at (617) 665-3553.

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

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973.290.8243
lwilson@mdedge.com



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.
- Five or more years of successfully leading a Hospitalist program.
- Strong commitment to the patient care and future academic missions of Guthrie Clinic.
- Possession of, or eligibility for, a medical license in Pennsylvania.

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).

Guthrie's (main) Sayre campus is situated in a beautiful valley in north-central PA, located just a few miles from the NY border. Guthrie's service area stretches from Corning and Ithaca, NY to Wellsboro, PA (home of PA Grand Canyon) down to Tunkhannock, PA and is less than 30 minutes from the Finger Lakes region.

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



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
- EPIC medical record system with remote access capabilities
- Dedicated RN and Social Work Clinical Care Coordinators
- Community based academic appointment
- The only Louisiana Hospital recognized by US News and World Report Distinguished Hospital for Clinical Excellence award in 4 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

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

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

Reference # SHM2017.



Sorry, no opportunities for J1 applications.

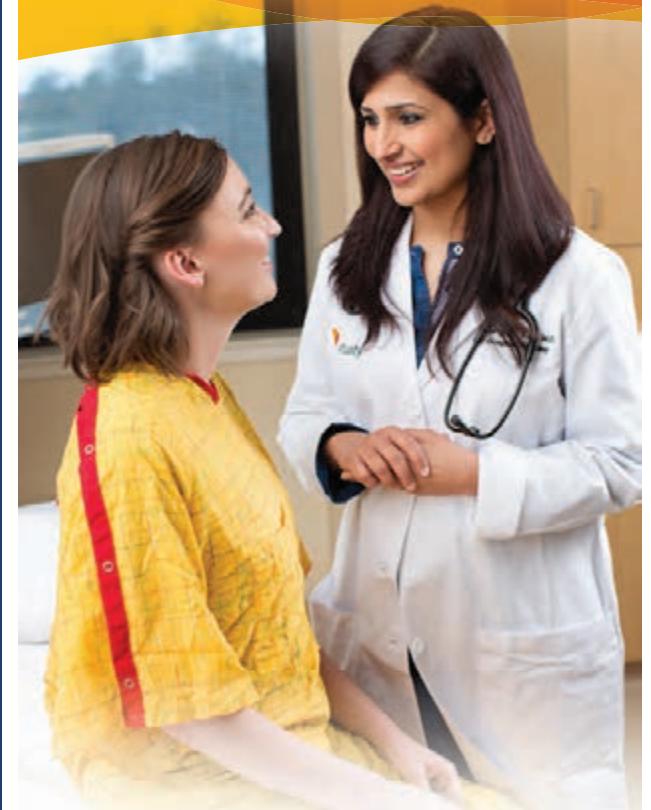
Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law

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HOSPITALIST OPPORTUNITIES IN ARIZONA & COLORADO

At the end of the day, this is where you want to be.

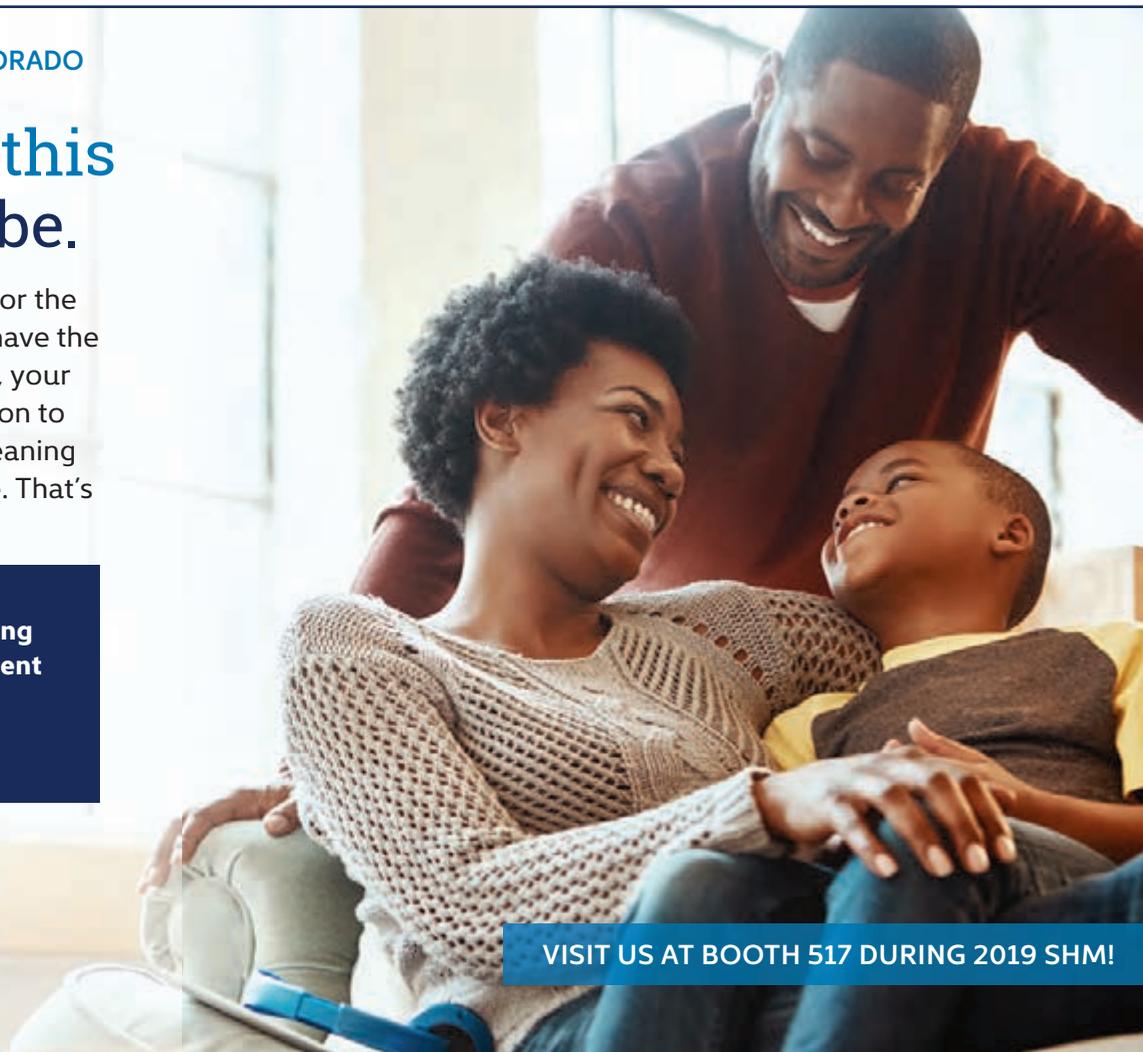
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- Physician-led
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- Robust compensation & total rewards

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St Luke's UNIVERSITY HEALTH NETWORK
Hospitalist Regional Medical Director Opportunities in Eastern PA
– Starting Bonus and Loan Repayment –

St. Luke's University Health Network (SLUHN) is interviewing for Hospitalist Regional Medical Director Candidates for our growing 10-hospital network. This is an opportunity to lead a dynamic group of physicians at several campuses, engage them as a team and work to assure consistent high quality. All campuses have a closed ICU, strong advanced practitioner assistance and all specialty back up, in addition to an opportunity for upward mobility 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

- 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

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

Where Quality of Life and Quality of Care Come Together

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

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- 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

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



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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.



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Submit CV & cover letter to Rebecca.bork@advocatehealth.com

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HOSPITALIST AND NOCTURNIST POSITION AVAILABLE

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Concord

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.

- Manageable daily census
- Flexible scheduling to ensure work life balance
- Dedicated nocturnist program
- Intensivists coverage of critical care unit
- Competitive compensation and bonus structure
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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 hospital's 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 of H1B opportunity



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.

- 100% Hospitalist work
- Wide variety of critical care
- \$275,000 base salary + productivity and quality bonus
- Excellent Benefits



Interested candidates should contact Terri Smith | tsmith@sjrmc.net
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The past and future of hospital medicine

Challenges faced, and overcome

By John Nelson, MD, MHM

While I hope I'll still be doing much the same work for many more years, I'm clearly at a stage of life that most of my career is behind me. So I guess it's natural that I think about the past a little more than I used to. And one of the things that makes me smile is how I'm like George Costanza in The Comeback episode of "Seinfeld."

In 1997 I had just delivered a presentation about what the future might hold for hospitalists to the roughly 110 attendees at the first in-person meeting of SHM (then known as the National Association of Inpatient Physicians). During the Q&A that followed, someone asked me what clinical content I would in-

clude in the hospitalist-specific test or board exam that I had speculated might be in our future. I took his tone and body language to suggest his main intent was to convey that I was crazy to think that such a test might ever be worthwhile.

A pregnant silence followed his question, after which I gave a tentative response that I worried made me sound dumb. So like George in "Seinfeld," I continued to think about this, and days later came up with what I'm sure would have been a terrific comeback that would have gotten a robust laugh from the audience without being demeaning to the questioner. For the last 22 years I've been waiting for someone to ask me the same question so I can finally deliver my winner of a response.

There have been other missed op-

portunities, but when I think about the past and future of our field and our Society, I'm reminded of many past accomplishments and a promising future.

When Win Whitcomb, MD, MHM, and I founded SHM, I had the idea that among its most important roles would be serving as a forum for exchange of ideas among hospitalists and providing robust practice management resources for hospitalist groups. Through the efforts of so many people, including Angela Musial, the first SHM staff person, and so many other staff and members, we now have dozens of active special interest groups, informative publications, an active online discussion forum, and blogs. And our annual conference has grown a lot from that first meeting of 110 people; HM19 will bring together nearly 5,000 of us to educate, inspire, and support one another. Collectively, there are a lot of ideas being exchanged through SHM.

When SHM was brand new I had hope that it would grow. But I never guessed that hospital medicine would become the fastest-growing field in the history of U.S. health care.

I also never guessed that the term "nocturnist" would become a standard part of our field's lexicon. I used it solely as a reliable way to get a laugh and find it really funny and delightful that it caught on.

And OB hospitalists? Neurohospitalists? I never saw these and the many other variations coming at all. But I see it as validating an idea first adopted by medicine and pediatrics. But dermatology hospitalists? Yep, that's a thing too. The hospitalist model has been adopted, in at least a few places, by nearly every specialty in medicine.

And it is terrific that March 7, 2019, is the first National Hospitalist Day. SHM made this happen too.

I also think about the future of our field and see some pretty big challenges, though our past success as a field makes me confident we'll navigate them effectively.

The burden of administrative, regulatory, and EHR-related tasks just keeps growing for hospitalists. This often means it is difficult or impossible to see as many patients in a day as might have been reasonable in the past. In the near term, the

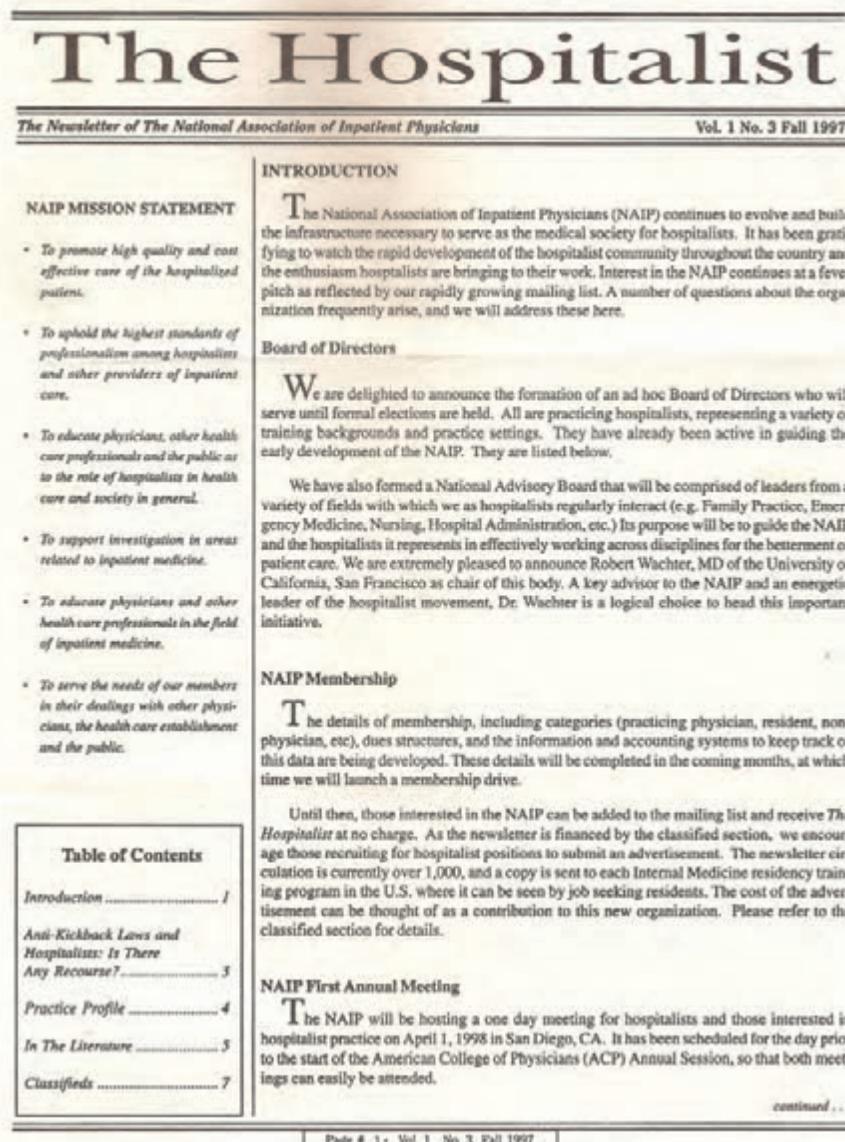


Dr. Nelson is cofounder and past president of SHM, and principal in Nelson Flores Hospital Medicine Consultants in La Quinta, Calif. He is codirector for SHM's practice management courses.

"When SHM was brand new I had hope that it would grow. But I never guessed that hospital medicine would become the fastest-growing field in the history of U.S. health care."

only solution might be to reduce patient loads, but that isn't a sustainable solution in the long term. I'm convinced we need to offload much of the work we do today that isn't purely clinical, so that a typical hospitalist in the future can see more patients each day without working harder or longer.

I imagine a future in which the typical hospitalist goes home after seeing 20 or more patients in a day and isn't completely exhausted and stressed, but sees it as a good day at work. I'm not sure exactly how we'll get there, but it will probably include things like no longer having to devote any time or attention to whether the patient is inpatient or observation status, or whether they have had a qualifying 3-midnight stay so Medicare will cover a skilled nursing facility. I'm excited to see how this will evolve.



An image of the earliest incarnation of The Hospitalist: The National Association of Inpatient Physicians (NAIP), mentioned by Dr. Nelson in his column, was the precursor to SHM.



Me, at my best.

Vituity's programs for career growth are here to illuminate and support your path forward. Our Fellowships are immersive programs that have launched the careers of industry leaders. And, our Innovation Grants nurture fresh ideas and implement them across Vituity sites nationally.



These and other Vituity programs can help you follow your passion—and achieve a personally meaningful career. Learn more at go.vituity.com/HMgrowth

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Acute Care Practice & Management.