November 2018
Volume 22 | No. 11

The Hospitalist

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Dr. Mel Anderson is chief of hospital medicine for the Veterans Administration of Eastern Colorado.

Read about his unique career as a VA hospitalist on p. 8.

Shawn Fury

Hospitalist groups explore use of medical scribes

Can charting specialists reduce doctors' job stress?

By Larry Beresford

Physician stress and burnout remain major concerns for the U.S. health care system, with frustrations over the electronic health record driving much of the dissatisfaction experienced in the hospital.[1] Underlying the EHR conundrum is a deeper question: Is entering clinical data on a computer the best use of a doctor's time and skills? Or could a portion of that clerical function be delegated to nonphysicians?

Trained medical scribes, charting specialists who input EHR data for physicians on rounds, have been offered as a potential solution. But while scribes have been used and tested by different hospitalist groups around the country, the concept has not taken off in hospital medicine the way it has in certain other settings, such as emergency departments.

"The demand for scribes doesn't seem to have materialized in a big way for hospital medicine," said John Nelson, MD, MHM, a hospitalist and consultant in Bellevue, Wash., and a

Continued on page 10

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Hospitalist Movers and Shakers

By Matt Pesyna

George Kasarala, MD, recently was named the hospitalist medical director at Nash UNC Health Care in Rocky Mount, N.C. Dr. Kasarala will guide Nash UNC's team of hospitalists, a program that has partnered with Sound Physicians.

Dr. Kasarala has a wealth of hospitalist experience, serving in a variety of positions since 2012. He comes to Nash UNC from Vidant Medical Center in Greenville, N.C. Prior to that, he was the associate hospitalist program director at the Apogee Hospitalist program in Elkhart, Ind.

In addition to his medical degree from Saint Louis University, Dr. Kasarala holds an MBA from the University of Findlay (Ohio).

Donald W. Woodburn, MD, has been selected as the new medical director at Carolinas Primary Care in Wadesboro, S.C. The longtime internist and hospitalist will stay in his role directing primary care for the facility, which is operated by Atrium Health.

Dr. Woodburn

Dr. Woodburn most recently was medical director for AnMed Hospitalist Services in Anderson, S.C.

Rita Goyal, MD, has been hired as chief medical officer of ConcertCare, a health care technology company based in Birmingham, Ala. Dr. Goyal has expertise in both medicine and business was cited as the key to her appointment. She founded a Web-based medical consultation business in 2017, virtualMDvisit.net.

Dr. Goyal is an academic hospitalist at the University of Alabama, Birmingham, and will continue to serve as a hospitalist and in the University's urgent care system.

Nirupma Sharma, MD, has been named chief of the newly minted division of pediatric hospital medicine at Augusta (Ga.) University Health. Dr. Sharma will oversee the pediatric hospitalist staff, including education, research, and clinical assistance.

Dr. Sharma has been the medical director of the 4C unit at Children's Hospital of Georgia in Augusta. She also has served as associate director of the Medical College of Georgia's department of pediatrics clerkship program.

Vineet Arora, MD, MHM, was recently named one of the top 10 doctors to follow on Twitter by Becker's Hospital Review. Dr. Arora is an academic hospitalist at University of Chicago Medicine.

Using the hashtag #meded, Dr. Arora provides a wealth of medical knowledge on Twitter, currently boasting more than 29,000 followers on that social media platform. She also serves as the Journal of Hospital Medicine's deputy social media editor, and blogs about topics trending in resident education.

Dr. Arora

Business Moves

Aspirus Iron River (Mich.) Hospital has partnered with **iNDIGO Health Partners** to create a telehealth hospitalist program at night. iNDIGO, a private hospitalist group, will utilize two-way video to treat Aspirus patients during overnight hours.

The telehealth providers with iNDIGO are part of the staff at Aspirus Iron River and are familiar with the facility's procedures. The remote physicians will be in contact with staff at the hospital, providing direction after meeting with patients via the video system.

The Hospitals of Providence Memorial Campus in El Paso, Tex., intends to have specialists on site at all times for expectant mothers after recently adopting an obstetric hospitalist program.

The OB hospitalists will be available to address patient concerns and medical emergencies that occur outside of normal hours for patients' primary obstetricians.

All OB hospitalists will be board-certified OB physicians. The goal is to decrease wait times for expectant mothers.

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THE HOSPITALIST is the official newspaper of the Society of Hospital Medicine, reporting on issues and trends in hospital medicine. THE HOSPITALIST reaches more than 35,000 hospitalists, physician assistants, nurse practitioners, medical residents, and health care administrators interested in the practice and business of hospital medicine. Content for THE HOSPITALIST is provided by Frontline Medical Communications. Content for the Society Pages is provided by the Society of Hospital Medicine.

Letters to the Editor: rpizzi@mdedge.com

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

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

THE HOSPITALIST (ISSN 1553-085X) is published monthly for the Society of Hospital Medicine by Frontline Medical Communications Inc., 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609. Print subscriptions are free for Society of Hospital Medicine members. Annual paid subscriptions are available to all others for the following rates:

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Dealing with HM staffing shortages

Persistent demand for hospitalists nationally

By Andrew White, MD, SFHM

During the last two decades, the United States health care labor market had an almost insatiable appetite for hospitalists, driving the specialty from nothing to more than 50,000 members.

Evidence of persistent demand for hospitalists abounds in the freshly released 2018 State of Hospital Medicine (SoHM) report: rising salaries, growing responsibility for the overall hospital census, and a diversifying scope of services.

The SoHM offers fascinating and detailed insights into these trends, as well as hundreds of other aspects of the field's growth. Unfortunately, this expanding and dynamic labor market has a challenging side for hospitals, management companies, and hospitalist group leaders – we are constantly recruiting and dealing with open positions!

As a multisite leader at an academic health system, I'm looking toward the next season of recruitment with excitement.

In the fall and winter we're fortunate to receive applications from the best and brightest graduating residents and hospitalists. I realize that this is a blessing, particularly compared with programs in rural areas that may not hear from many applicants.

However, even when we succeed at filling the openings, there is an inevitable trickle of talent out of our clinical labor pool during the spring and summer. One person is invited to spend 20% of his or her time leading a teaching program, another secures a highly coveted grant, and yet another has to move because of the relocation of a spouse. By then, we don't have a packed roster of applicants and we have to solve the challenge in other ways. What does the typical hospital medicine program do when faced with this circumstance?

The 2018 SoHM survey first asked program leaders whether they had open and unfilled physician positions during the last year because of turnover, growth, or other factors.

On average, 66% of groups serving adults and 48% of groups serving children said "yes."

For the job seekers out there, take note of some important regional differences: The regions with the highest percentage of programs dealing with unfilled positions were the East and West coasts at 79% and 73%, respectively.

Next, the survey asked respondents to describe the percentage of total approved physician staffing that was open or unfilled during the year.

On average, 12% of positions went unfilled, with important variation between different types of employers. For a typical HM group with 15 full-time equivalents, that means constantly working short two physicians!

Not only is it difficult for group leaders to manage chronic understaffing, it definitely takes a toll on the group.

We asked leaders to describe all of the ways in which their groups address coverage of the open positions. The most common tactics were for existing hospitalists to perform voluntary extra shifts (70%) and the use of moonlighters (57%).

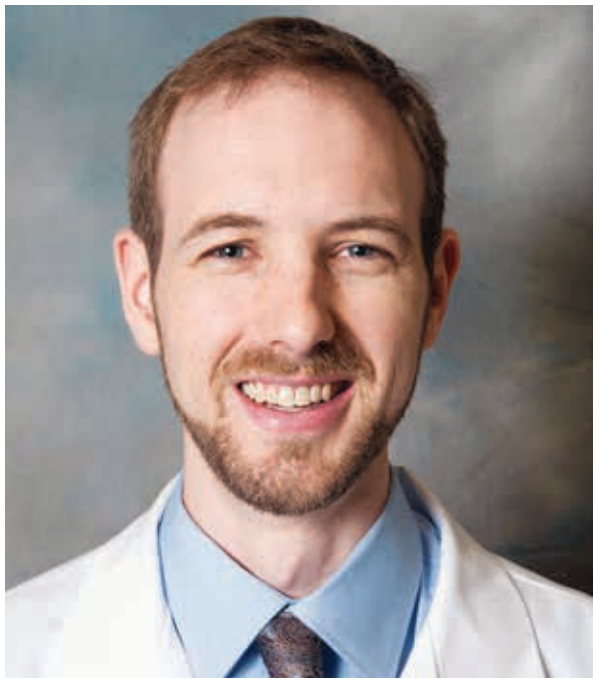
Also important were the use of locum tenens physicians (44%) and just leaving some shifts uncovered (31%).

The last option might work in a large group, where everyone can pick up an extra couple of patients, but it nonetheless degrades continuity and care progression. In a small group, leaving shifts uncovered sounds like a recipe for burnout and unsafe care – hopefully subsequent surveys will find that we can avoid that approach!

Obviously, the solutions must be tailored to the group, their resources, and the alternative sources of labor available in that locality.

The SoHM report provides insight into how this is commonly handled by different employers and in different regions – we encourage anyone who is interested to purchase the report (www.hospitalmedicine.org/sohm) to dig deeper.

For better or worse, the issue of unfilled positions looks likely to persist for the intermediate future. The exciting rise of hospital medicine against the backdrop of an aging population means job security, rising income, and opportunities for many to live where they choose. Until the job market saturates, though, we'll all find ourselves looking at email inboxes with a request or two to pick up an extra shift!

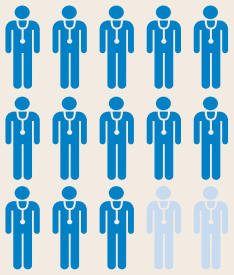


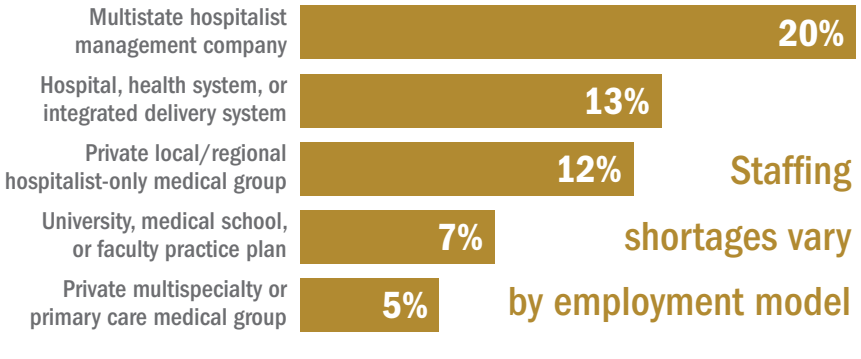
Dr. White is associate professor of medicine at the University of Washington, Seattle. He is the chair of SHM's Practice Analysis Committee.

> *"The exciting rise of hospital medicine against the backdrop of an aging population means job security, rising income, and opportunities for many to live where they choose."*

2018 SoHM: Unfilled and open positions lead to extra work

Two-thirds of HMGs reported open positions during the year, with a median of 12% of their hospitalist jobs unfilled.





Staffing shortages vary by employment model

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70% of groups address the coverage of open positions with **voluntary extra shifts.**

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

MDEDGE NEWS

Reference

Society of Hospital Medicine. 2018 State of Hospital Medicine Report. pp. 89, 90, 152, 181.

A deep commitment to veterans' medical needs

VA hospitalist Mel Anderson loves his work

By Larry Beresford

Mel C. Anderson, MD, FACP, section chief of hospital medicine for the Veterans Administration of Eastern Colorado, and his hospitalist colleagues share a mission to care for the men and women who served their country in the armed forces and are now being served by the VA.

"That mission binds us together in a deep and impactful way," he said. "One of the greatest joys of my life has been to dedicate, with the teams I lead, our hearts and minds to serving this population of veterans."

Approximately 400 hospitalists work nationwide in the VA, the country's largest integrated health system, typically in groups of about a dozen. Not every VA medical center employs hospitalists; this depends on local tradition and size of the facility. Dr. Anderson was for several years the lone hospitalist at the VA Medical Center in Denver, starting in 2005, and now he heads a group of 17. The Denver facility employs five inpatient teams plus nocturnists, supported by residents, interns, and medical students in training from the University of Colorado at Denver, Aurora, to deliver all of its inpatient medical care.

"We also have an open ICU here. Hospitalists are able to follow their patients across the hospital, and we can make the decision to move them to the ICU," Dr. Anderson said. The Denver group also established a hospitalist-staffed postdischarge clinic, where patients can reconnect with their hospital team. "It's not to supplant primary care but to help promote safe transit as the patient moves back to the community," he said. "We've also developed a surgery consult service for orthopedics and other surgical subspecialties."

The VA's integrated electronic medical record facilitates communication between hospitalists and primary care physicians, with instant messaging for updating the PCPs on the patient's hospital stay.

The Denver VA hospitalists value their collegial culture, Dr. Anderson said. "We are invested in our group and in one another and in lifelong learning. I often ask my group for their feedback. It's one of the singular joys of my career to lead such a wonderful group, which has been built up person by person. I hired every single member. As much as their clinical skills and the achievements on their curriculum vitae were important, I also paid attention to their interpersonal communication skills."

Members of the Denver hospitalist group also share an academic focus and commitment to scholarship and research. Dr. Anderson's academic emphasis is on how to promote teaching and faculty development through organized bedside rounding and how to orient students to teaching as a potential career path. He is associate program director for medicine residencies at the University of Colorado and leads its Clinician/Educator Pathway.

The VA hospital's interdisciplinary bedside rounding initiative involves the medicine team – students, residents, attending – and pharmacist, plus the patient's bedside nurse and nurse care coordinator. "We have worked on fostering an interdisciplinary culture, and we're very proud of the rounding model we developed here. We all round together at the bedside, and typically that might include seven or eight people," Dr. Anderson explained.

"In planning this program, we used a Rapid Performance Improvement Project team with a nurse, pharmacist, and physical therapist helping us envision how to redesign rounds to overcome the time constraints," he said. "We altered nurses' work flow to permit them to join the rounding for their patients, and we moved morning medication administration to 7 a.m., so it wouldn't get in the way of the rounding. We now audit rates of physician-to-nurse communication on rounds and how often we successfully achieve the nurse's participation."[1] This approach has also cut rates of phone pages from nurses to house staff, and substantially increased job satisfaction.

What's different in the VA?

The work of hospitalists in the VA is mostly similar to other hospital settings, but perhaps with more intensity, Dr. Anderson said. There are comorbidities such as higher rates of PTSD, alcohol use disorder, substance abuse, and mental health issues – all of which have an effect over time on patients. But veterans also have different attitudes about, for example, pain.

"When patients are asked to rate their pain on a scale of 0-10, for a veteran of a foreign war, 2 out of 10 is not the same as someone else's 2 out of 10. How do we compensate for that difference?" he said. "And while awareness of PTSD and efforts to mitigate its impact have made incredible gains over the past 15 years, we still see a lot of these issues and their manifestations in social challenges such as homelessness. We are fortunate to have VA outpatient services and homeless veteran programs to help with these issues."

There is a different paradigm for care at the VA, Dr. Anderson said. "We are a not-for-profit institution with the welfare of veterans as our primary aim. Beyond their health and wellness, that means supporting them in other ways and reaching out into the community. As doctors and nurses we feel a kinship around that mission, although we also have to be stewards of taxpayer dollars. We recognize that the VA is a large and complicated, somewhat inertia-laden organization in which making changes can be very challenging. But there are also opportunities as a national organization to effect changes on a national scale."

Dr. Anderson chairs the VA's Hospitalist Field Advisory Committee (HFAC), a group of about eight hospitalists empaneled to advise the system's Office of Specialty Care Services on clinical policy and program development. They serve 3-year terms and meet monthly by phone and annually in Washington. The HFAC's last annual meeting occurred in mid-September 2018 in Washington with a focus on developing a hospital medicine annual survey and needs assessment, revisiting strategic goals, and convening multilateral meetings with the chiefs of medicine and emergency medicine FACs.

"Our biggest emphasis is clinical – this includes clinical pathways, best practices for managing PTSD or acute coronary syndrome, and the like. We also share management issues, such as how to configure medical records or arrange night coverage. This is a national conversation to share what some sites have already experienced and learned," Dr. Anderson said.

"We also have a VA Academic Hospitalist Subcommittee, working together on multisite research studies and on resident education protocols. Because we're a large system, we're able to connect with one another and leverage what we've learned. I get emails almost every day about research topics from colleagues across the country," he said. A collaborative website and email distribution list allows doctors to post questions to their peers nationwide.

A calling for hospital medicine

Before moving to Denver, Dr. Anderson served as a major in the Air Force Medical Corps and was based at the David Grant U.S. Air Force Medical Center on Travis Air Force Base in California – which is where he did his residency. In the course of a "traditionalist" internal medical training, including 4-month stints on hospital wards in addition to outpatient services, he realized he had a calling for hospital medicine.

In a job at the Providence (R.I.) VA Medical Center, he exclusively practiced outpatient care, but he found that he missed key aspects of inpatient work, such as the intensity of the clinical issues and teaching encounters. "I cold-called the hospital's chief of medicine and volunteered to start mentoring inpatient residents," Dr. Anderson said. "That was 17 years ago."

Another abiding interest derived from Dr. Anderson's military service is travel medicine. While a physician in the Air Force, he was deployed to Haiti in 1995 and to Nicaragua in 2000, where he treated thousands of patients – both U.S. service personnel and local populations.

"In Haiti, our primary mission was for U.S. troops who were still based there following the 1994 Operation Uphold Democracy intervention, but there were a lot fewer of them, so we mostly kept busy providing care to Haitian nationals," he said. "That work was eye opening, to say the least," and led to a professional interest in tropical illnesses. "Since then, I've been a visiting professor for the University of Colorado posted to the University of Zimbabwe in Harare in 2012 and 2016."

What gives Dr. Anderson such joy and enthu-

siasm for his VA work? "I am a curious lifelong learner. Every day, there are 10 new things I need to learn, whether clinically or operationally in a big hospital system or just the day-to-day realities of leading a group of physicians. I never feel like I'm treading water," he said. He is also energized by teaching – seeing "the light bulb go on" for the students he is instructing – and by serving as a role model for doctors in training.

"As I contemplate all the simultaneous balls I have in the air, including our recent move into a new hospital building, sometimes I think it is kind of crazy to be doing as much as I do," he said. "But I also take time away, balancing work versus nonwork." He spends quality time with his wife of 21 years, 17-year-old daughter, other relatives, and friends, as well as on physical activity, reading books about philosophy, and his hobby of rebuilding motorcycles, which he says offers a kind of meditative calm.

"I also feel a deep sense of service – to patients, colleagues, students, and to the mission of the VA," Dr. Anderson said. "There is truly something special about caring for the veteran. It's hard to articulate, but it really keeps us coming back for more. I've had vets sing to me, tell jokes, do magic tricks, share their war stories. I've had patients open up to me in ways that were both profound and humbling."

Reference

1. Young E et al. Impact of altered medication administration time on interdisciplinary bedside rounds on academic medical ward. J Nurs Care Qual. 2017 Jul/Sep;32(3):218-25.

Giving hospitalists a larger clinical footprint

Something you did not know about warm handoffs

By Bradley Flansbaum, DO, MPH, MHM

I am going to teach you something you do not know. I am almost sure of it.

Warm handoffs – a term you often hear within the confines of hospital walls when transferring a patient service to service or ward to ward. You do it in-house, but it's unlikely you make the same connection when you discharge the same patient or transfer them to an outside entity.

But you have to be asleep under a rock not to have heard or read the changes afoot in the skilled nursing facility (SNF) realm, including the rise of the "SNFist." Too much variation in use and spending; plus, we are learning patients do not need 25 days cooped up in a rehabilitation facility when 15 might do with a segue into home health for another 10 or 14. Patients like being home, and it costs a lot less.

Unfortunately, we do not do SNF handoffs in the same manner as ICUs. Our bad, and inpatient providers better adapt.

As hospitals decant and quality measures get an intimate look in the rehab space, SNFs will notice sicker patients, and the staff there will

be more mindful of the sign outs and the data they receive.

Know a Centers for Medicare & Medicaid Services value-based program started on Oct. 1 (just like hospitals – penalties and all) and SNFists, whoever they might be – NP/PA/DO/MD – will also require of hospitals a step-up in information transfer, both in quality and timeliness.

Read the full post at hospitalleader.org.

Also on The Hospital Leader

- "Immigration & the Future of Healthcare: Looking to a Greater Good," by Jordan Messler, MD, SFHM
- "We Must Become Comfortable Talking about Physician Suicide," by Tracy Cardin, ACNP-BC, SFHM
- "A New Light in the Darkness: Using Hospital-Based Medication-Assisted Treatment to Tackle the Opioid Crisis," by Richard Bottner, PA-C

Medical scribes

Continued from page 1

cofounder of the Society of Hospital Medicine. "I'm not convinced that scribes have had a big impact on hospitalist burnout." It's difficult to share scribes between doctors on a shift, and it's a problem if the scribe and doctor get physically separated in the hospital. There's also the question of who should pay the scribe's salary, he said.

Frustrations with the EHR can be a major factor in the experience of burnout, but Dr. Nelson said hospitalists can get proficient more quickly because they're using the same computer system all day. "The bigger problem is that other doctors like surgeons don't learn how to use the EHR and dump their routine tasks involving the EHR on the hospitalist, which means more work that is less satisfying."

Could pairing a scribe with a hospitalist improve efficiency and decrease costs relative to the expense of employing the scribe? Are there specific settings, applications, and caseloads in hospital medicine where it makes more sense to use a scribe while doctors are meeting with patients, with the doctor reviewing and editing the scribe's work for accuracy? Could the scribe help with physician staffing shortages by making doctors more productive?

TeamHealth, a national physician services company based in Knoxville, Tenn., has used scribes in EDs for years but had concluded that they made less sense for its hospitalist groups after a failure to document significant net increases in productivity, according to a 2015 report in *The Hospitalist*.[2] Michael Corvini, MD, FACP, FACEP, TeamHealth's new regional medical director for acute care services, said he brought extensive positive experience with scribes to his new job and is quite excited about their potential for hospital medicine. "When I came to TeamHealth in July, I began to suggest that there was unrealized potential for scribes," he said.

Dr. Corvini noted that a potential benefit of scribes for patients is that their presence may allow for more face time with the doctor. Providers, relieved of worrying about completing the chart in its entirety, would be able to focus on the patient and critical thinking. There are even benefits for scribes themselves. Often scribes are medical students, and those who are interested in pursuing a future in the health professions gain invaluable experience in the workings of medicine. "They are making a real contribution to patient care. They are a member of the health care team," he said.

Dr. Corvini sees two primary areas in which scribes can contribute to hospital medicine. The first is shadowing the physician who is admitting patients during a high-volume admissions shift. Regular tasks like capturing the patient's medication list and populating the History and Physical document lend themselves well to data entry by scribes, in contrast to completing more routine daily progress notes, which does not.

Dr. Friedson

Dr. Edwards

Dr. Sinsky

"They can also be helpful when there is a major transition from paper charting to the EHR or from one EHR system to another, when there is a lot of stress on the physician and risk for lost billing revenue," Dr. Corvini said. "If scribes are trained in a particular EHR, they could help teach the physician how to use it." TeamHealth is now running a trial of scribes at one of its sites, and the organization plans to measure productivity, provider satisfaction, and HCAHPS patient satisfaction scores.

Scribes: "Workarounds" or "problem solvers"?

In a 2015 Viewpoint article in JAMA,[3] George Gellert, MD, MPH, MPA, former chief medical information officer for the CHRISTUS Santa Rosa health system in San Antonio and his coauthors labeled the use of scribes as a "workaround" that could curtail efforts to make EHRs more functionally operational because their use allows physicians to be satisfied with inferior EHR products.

In an interview, Dr. Gellert stated that he hasn't changed his views about the negative consequences of scribes on EHR improvement. "The work of clinicians in using and advancing EHR technology is presently the only method we have for massively distributing and ensuring the use of evidence-based medicine," he said. "That in turn is a critical strategy for reducing high rates of medical errors through a variety of decision-support applications."

For better or worse, EHRs are an essential part of the solution to the epidemic of preventable, medical error–caused patient deaths, Dr. Gellert said. Substantial progress has already been made in advancing EHR usability, as reflected in the most recent product releases by leading EHR companies, he added. However, considerable evolution is needed in both usability and optimization of clinical decision support.

"My recommendation is to not use medical scribes, or else delimit their use to only where absolutely required. Instead, develop systematic processes to regularly capture specific physician concerns with the EHR being used, and transmit that critical information to their EHR vendor with a clear expectation that the manufacturer will address the issue in the near term, or at least in the next major product iteration or generation," Dr. Gellert said.

By contrast, at the Management of the Hospitalized Patient conference in San Francisco in October 2015, Christine Sinsky, MD, FACP, vice president for professional satisfaction at the American Medical Association, identified documentation assistance as a helpful intervention for physician stress and burnout.[4] In a recent email, Dr. Sinsky called documentation assistance "the most powerful intervention to give patients the time, attention, and care they need from their physicians. The data entry and data retrieval work of health care has grown over the last decade. Sharing this work with nonphysicians allows society to get the most value for its investment in physicians' training."

Dr. Sinsky calls documentation assistance – such as that provided by medical scribes – "a logical and strategic delegation of work according to ability for greater value," not a workaround. She said it makes patient care safer by allowing physicians to focus on medical decision making and relationship building – rather than record keeping.

Experience from the front lines

Eric Edwards, MD, FAAP, FHM, of the division of hospital medicine at the University of North Carolina's Hillsborough Hospital campus, recently presented a poster on his group's experience with medical scribes at a meeting of the North Carolina Triangle Chapter of SHM. Their research showed that scribes can be successfully incorporated into an inpatient hospital medicine practice and thus increase provider satisfaction and decrease the time clinicians spend charting.

"We were able to get the support of the hospital administration to pilot the use of scribes 3 days per week, which we've now done for almost a year," Dr. Edwards said. Scribes are employed through a local company, MedScribes, and they work alongside admitting hospitalists during their 10-hour shifts. The hospitalists have been overwhelmingly positive about their experience, he said. "We established that it saves the physician 15 minutes per patient encounter by helping with documentation."

It's important that the scribe gets to know an individual provider's personal preferences, Dr. Edwards said. Some hospitalists create their own charting templates. There's also a need to train the clinician in how to use the medical scribe. For example, physicians are instructed to call out physical findings during exams, which simultaneously informs the patient while allowing the scribe to document the exam.

"We are working on getting more formal data about the scribe experience," he added. "But we have found that our providers love it, and it improves their efficiency and productivity. The danger is if the physician becomes too reliant on the scribe and fails to exercise due diligence in reviewing the scribe's notes to ensure that all relevant information is in the chart and irrelevant information is not."

Dr. Edwards said the industry is "years away" from improving the EHR to the point that it could be called doctor friendly. "For now, the scribe is a great way to alleviate some of the physician's burden. But for hospitalist groups to use scribes successfully, it can't be done haphazardly. We are lucky to have an experienced local scribe company to provide systematic training and orientation. It's also important that scribes are trained in the specific EHR that they will be using."

Christine Lum Lung, MD, SFHM, CEO and medical director of Northern Colorado Hospitalists, a hospital medicine group at the University of Colorado's North Campus hospitals in Fort Collins, has been studying

the use of scribes since 2014. "We had a problem bringing on new doctors fast enough, so I looked into the return on investment from scribes," she said. "It's difficult to say what has been the actual impact on caseload, but we all think it has reduced physician workdays by an hour or greater."

The 32-member hospitalist group, which covers two facilities, has a designated director of scribes who periodically surveys the hospitalists' satisfaction with the service. "We all embrace the use of scribes. Satisfaction is high, and quality of life has improved," Dr. Lum Lung said. "It's hard to quantify, but we feel like scribes help reduce physician burnout."

She said scribes are important to the medical team not just with managing the EHR but also with other burdens such as documenting compliance with code status, VTEs, and other quality requirements, and to help with other regulatory issues. Scribes can look up lab values and radiology reports. When there are downtimes, they can prepare discharge plans.

Typically, there are five scribes on duty for 18 hours a day at each hospital, Dr. Lum Lung said. But only those doctors primarily doing admissions are assured of having a scribe to round with them. "Most doctors in the group would say the greatest efficiency of scribes is with admitting," she said. The company that provides scribes to the UC hospitals, ScribeAmerica, handles administration, training, and human resource issues, and the scribe team has a designated Lead Scribe and Quality Scribe at their facility.

Studying the benefits

Andrew Friedson, PhD, a health care economist at the University of Colorado in Denver, recently conducted a 9-month randomized experiment in three hospital EDs in the Denver area to determine the effects of scribes on measures of emergency physician productivity.[5] He found that scribes reduced patient wait times in the ED by about 13 minutes per patient, while greatly decreasing the amount of time physicians spent after a shift completing their charting, which thus lowered overtime costs for ED physicians.

"This is one of the first times medical scribes have been studied with a randomized, controlled trial," Dr. Friedson said. "I tracked the amount of overtime, patient waiting, and charge capture for each encounter. These were hospitals where the emergency doctors weren't allowed to go home until their charting was done." He discovered that there was a large drop in the time between when patients arrived at the ED and when a decision was made regarding whether to admit them. In addition, charge capture increased significantly, and physicians had more time to perform medical procedures.

Dr. Friedson believes that his findings hold implications for other settings and medical groups, including hospital medicine. To the extent that scribes free up hospitalists to perform tasks other than charting, they should provide an efficiency benefit.

So why hasn't the medical scribe caught on in a bigger way for hospitalists, compared with ED physicians? For Dr. Corvini, the ED is an obvious, high-pressure, high-volume setting where the cost of the scribe can be easily recouped. "That doesn't exist in such an obvious fashion in hospital medicine, except where high-volume admissions are concentrated in a single physician's caseload," he said. Not all hospitalist groups will fit that model. Some may divide admissions between hospitalists on a shift, and others may not be large enough to experience significant caseload pressures.

"EDs are obviously time pressured, and once scribes demonstrate the ability to produce documentation in a high-quality fashion, they are quickly accepted. In hospital medicine, the time pressures are different – not necessarily less, but different," Dr. Corvini said. There are also differences in physician responsibilities between the ED and hospital medicine, as well as in physicians' willingness to let go of documentation responsibilities. "My prediction, if the scribe test is rolled out successfully in TeamHealth, with measurable benefits, it will be adopted in other settings where it fits."

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CMS modifies the inpatient admission order requirement, or did it?

By Edward Hu, MD, and Charles Locke, MD

When the Centers for Medicare & Medicaid Services make a significant change to the inpatient hospital rules, hospitalists are among the first to feel the effects.

Starting in October 2013, when a resident, nurse practitioner, or physician assistant entered an inpatient admission order on a physician's behalf, the physician was told to cosign that order before discharge or the hospital would forfeit payment for the entire stay. This policy was put in place by the Inpatient Prospective Payment System (IPPS) Final Rule.

CMS felt that the decision to admit a Medicare beneficiary to inpatient care required the attending physician to complete a series of certification requirements to justify every inpatient stay. If not finalized prior to discharge, CMS would not pay for the stay. After 15 months of enforcing that policy, CMS backed off on most of the certification requirements for most stays. However, the requirement for an authenticated inpatient order prior to discharge was kept in place for all stays.

In the spring of 2018, CMS proposed a change to "revise the admission order documentation requirements by removing the requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment." CMS also stated that it did not intend for Medicare auditors to deny hospital inpatient claims based solely on a deficiency in the inpatient order, such as a missing order or one signed after discharge.

Many providers assumed that they, too, would be provided similar discretion if they discovered the order defect. Are inpatient orders now optional? What rate of inpatient order technical deficiencies is acceptable to still submit inpatient claims for payment? Can 2-day observation stays where medical necessity for hospital care was present, but no inpatient order given, be billed as an inpatient now?

These providers had not read the fine print. Consider that the annual IPPS Final Rule has a length of about 2,000 pages. Of those, only about 30 pages represent changes to the Code of Federal Regulations (CFR). The CFR carries the weight of law (as long as it does not contradict law). What changes were actually made to the CFR? Consider the following two sentences.

- "For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner."
- "This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A."

These are the first two sentences of 42 CFR 412.3(a), the regulation that defines the inpatient order requirement. On Oct. 1, 2018, the second sentence was removed, but the first sentence remains. That's the only change for this section. Does removal of the second sentence absolve providers of the requirement to document inpatient admission orders? Does it absolve providers of the requirement to cosign a resident's admission order prior to discharge? The Medicare Benefit Policy Manual (MBPM) Chapter 1, Section 10(B) still reads "if the order is not properly documented in the medical record prior to discharge, the hospital should not submit a claim for Part A payment."

Understanding what changed and what did not change in the CFR is key to understanding why CMS repeatedly responded to providers that an inpatient order is still a requirement for a Part A stay and that none of the MBPM guidance regarding the inpatient order, such as the excerpt above, is changing.

We can only be reasonably certain that, if a claim a hospital submits for Part A payment happens to get audited and found to have only one deficiency which is related to the inpatient order, it probably won't get denied. That is very different from saying the attending physician no longer has to provide a signed (or cosigned) inpatient admission order prior to discharge, or at all.

The American College of Physician Advisors asked CMS about the inpatient order policy change: "Can providers thus submit a claim, that the provider believes meets all other requirements for Part A payment, in the rare circumstance of an inpatient order deficiency, such as an inpatient order that was cosigned shortly after discharge?"

CMS declined to answer the question on an Open Door Forum call, asking us to submit the question to the Forum's electronic mailbox. If the inpatient order was truly no longer being required for CMS to pay for inpatient hospital stays, the answer would have been an easy "yes," but it was not. Subsequently, CMS responded in writing to the ACPA that "the responsibilities of providers regarding inpatient admission orders is unchanged."

Our recommendation is to continue your processes to ensure that the inpatient admission order is completed and signed (or cosigned) prior to discharge by the attending physician for every Medicare patient. This will not only help make sure that the decision to make a hospitalized Medicare beneficiary an inpatient remains with the attending physician, but it will also reduce the risk of nonpayment.

Dr. Hu is executive director of physician adviser services of University of North Carolina Health Care System in Chapel Hill, and president of the ACPA. Dr. Locke is senior physician adviser at Johns Hopkins Hospital in Baltimore, and president-elect of the ACPA.

Q and A

Glycemic control at Norwalk Hospital

SHM eQUIPS program yields new protocols, guidelines

The Hospitalist recently sat down with Nancy J. Rennert, MD, FACE, FACP, CPHQ, chief of endocrinology and diabetes at Norwalk (Conn.) Hospital, Western Connecticut Health Network, to discuss her institution's glycemic control initiatives.

Tell us a bit about your program:

Norwalk Hospital is a 366-bed community teaching hospital founded 125 years ago, now part of the growing Western Connecticut Health Network. Our residency and fellowship training programs are affiliated with Yale University, New Haven, Conn., and we are a branch campus of the University of Vermont, Burlington.

With leadership support, we created our Glycemic Care Team (GCT) 4 years ago to focus on improving the quality of care for persons with diabetes who were admitted to our hospital (often for another primary medical reason). Our hospitalists – 8 on the teaching service and 11 on the nonteaching service – are key players in our efforts as they care for the majority of medical inpatients.

GCT is interdisciplinary and includes stakeholders at all levels, including quality, pharmacy, nutrition, hospital medicine, diabetes education, administrative leadership, endocrinology, information technology, point-of-care testing/pathology, surgery and more. We meet monthly with an agenda that includes safety events, glucometrics, and discussion of policies and protocols.

Subgroups complete tasks in between the monthly meetings, and we bring in other clinical specialties as indicated based on the issues at hand.

What prior challenges did you encounter that led you to enroll in the Glycemic Control (GC) eQUIPS Program?

In order to know if our GCT was making a positive difference, we needed to first measure our baseline metrics and then identify our goals and develop our processes. We wanted actionable data analysis and the ability to differentiate areas of our hospital such as individual clinical units. After researching the options, we chose SHM's GC eQUIPS Program, which we found to be user friendly. The national benchmarking was an important aspect for us as well. As a kick-off event, I invited Greg Maynard, MD, MHM, a hospitalist and the chief quality officer, UC Davis Medical Center, to speak on inpatient diabetes and was thrilled when he accepted my invitation. This provided an exciting start to our journey with SHM's eQUIPS data management program.

As we began to obtain baseline measurements of glucose control, we needed a standardized, validated tool. The point-of-care glucose meters generated an enormous amount of data, but we were unable to sort this and analyze it in a meaningful and potentially actionable way. We were especially concerned about hypoglycemia.

Our first task was to develop a prescriber-ordered and nurse-driven hypoglycemia protocol. How would we measure the overall effectiveness and success of the stepwise components of the protocol? The eQUIPS hypoglycemia management report was ideal in that it detailed metrics in stepwise fashion as it related to our protocol. For example, we were able to see the time from detection of hypoglycemia to the next point-of-care glucose check and to resolution of the event.

In addition, we wanted some comparative benchmarking data. The GC eQUIPS Program has a robust database of U.S. hospitals, which helped us define our ultimate goal – to be in the upper quartile of all measures. And we did it! Because of the amazing teamwork and leadership support, we were able to achieve national distinction from SHM as a "Top Performer" hospital for glycemic care.

How did the program help you and the team design your initiatives?

Data are powerful and convincing. We post and report our eQUIPS Glucometrics to our clinical staff monthly by unit, and through this process, we obtain the necessary "buy-ins" as well as participation to design clinical protocols and order sets. For example, we noted that many patients would be placed on "sliding scale"/coverage insulin alone at the time of hospital admission. This often would not be adjusted during the hospital stay. Our data showed that this practice was associated with more glucose fluctuations and hypoglycemia.

Courtesy Norwalk Health

The Glycemic Control Team at Norwalk (Conn.) Hospital: Dr. Nancy J. Rennert is in the back row on the left.

When we reviewed this with our hospitalists, we achieved consensus and developed basal/bolus correction insulin protocols, which are embedded in the admission care sets. Following use of these order sets, we noted less hypoglycemia (decreased from 5.9% and remains less than 3.6%) and lower glucose variability. With the help of the eQUIPS metrics and benchmarking, we now have more than 20 protocols and safety rules built into our EHR system.

What were the key benefits that the GC eQUIPS Program provided that you were unable to find elsewhere?

The unique features we found most useful are the national benchmarking and "real-world" data presentation. National benchmarking allows us to compare ourselves with other hospitals (we can sort for like hospitals or all hospitals) and to periodically evaluate our processes and reexamine our goals.

As part of this program, we can communicate with leaders of other high-performing hospitals and share strategies and challenges as well as discuss successes and failures. The quarterly benchmark webinar is another opportunity to be part of this professional community and we often pick up helpful information.

We particularly like the hyperglycemia/hypoglycemia scatter plots, which demonstrate the practical and important impact of glycemic control. Often there is a see-saw effect in which, if one parameter goes up, the other goes down; finding the sweet spot between hyperglycemia and hypoglycemia is key and clinically important.

Do you have any other comments to share related to your institution's participation in the program?

We are fortunate to have many successes driven by our participation with the GC eQUIPS Program.

These include the coordination of capillary blood glucose (CBG) testing, insulin administration and meal delivery; improved patient education regarding insulin use; an emphasis on clinician and leader education; an analysis and characterization of the link between hypoglycemia and hyperkalemia in certain patients; the design of a guideline for medical consultation on nonmedical services; and significant improvements in medical student and house staff education.

Perhaps our biggest success is our Glycemic Care Team itself. We now receive questions and items to review from all departments and are seen as the hospital's expert team on diabetes and hyperglycemia. It is truly a pleasure to lead this group of extremely high functioning and dedicated professionals. It is said that "team work makes the dream work." Moving forward, I hope to expand our Glycemic Care Team to all the hospitals in our network.

For a more comprehensive version of the inpatient glycemic control program at Norwalk Hospital, read the online version of this article at www.the-hospitalist.org.

What is the 'meta' in 'meta-leadership'?

The knowns and the unknowns

By Leonard J. Marcus, PhD

Over the course of a career, it is not uncommon for people to become narrower and more focused in their work purview and interests. Competence in select procedures and practices imparts confidence and reliability in performance and results. One develops a reputation for those skills and capabilities, and others call upon them.

Rewards and incentives encourage advancement and promotion along established career paths, further accelerating specialization and concentration. At the top of your game, you advocate for and ease into your comfort zone. That zone is defined by the knowns of practice and the certainties they provide.

For those who prefer to practice in the confines of a narrow clinical sphere, that strategy could be the pathway to career success.

However, for those promoted to leadership positions, the inward and insulated focus today is counterproductive and even dangerous. Many times, physicians advance to a senior position because it is the next step in a preset career ladder, the reward for acumen in clinical skills, or simply out of boredom, with hope for a new landscape and a higher wage. But just because one has a high rank or impressive title does not mean that one is fulfilling the mandates of leadership. It takes more than that. You must be attuned to what is known and unknown in building stability and progress for those you lead.

A brief historic angle: For years, medicine occupied a sweet spot within the health care system. The profession protected its perks and privileges deriving from its untouchable status. It was an inward, parochial focus of thinking, status, and reward. The problem was: This insulated mindset prompted a blind spot. The profession missed changes and transformation that were occurring just beyond the comfort zone. Those changes were unknowns in planning and perspective.

In the 1990s, medicine as a whole woke up to calls for change and a new order. The rise of the hospitalist was in part an outgrowth of that wake-up call. It reshaped power structures, status, and lucrative business arrangements within the profession. For many, the sweet spot soured.

The problem with collapsing into a sweet spot today is that so much is changing: all that is known and much that is unknown. Finances, technology, and demand are all in flux. The health care system finds itself in a quantity/quality/cost paradox. Volume accelerates, but at what cost to quality and morale? If someone or something can accomplish similar outcomes at less cost, why not go with the cheaper option? These questions can best be addressed by seeing them in the context of larger changes happening in the health system.

A new view for leaders

The "meta" in meta-leadership hopes to provide a broader, disciplined slant on this phenomenon. That prefix – used to modify many concepts and terms – refers to a wider, more expansive view or a more comprehensive and transcendent perch on a topic. A "meta-" prefix invites a critical analysis of the original topic with the addition of new perspectives and insights, as with a meta-analysis.

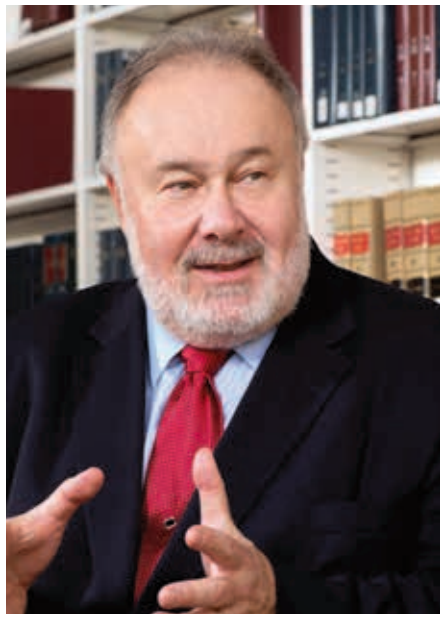
Why then the need now for a "meta" view among health care leaders? It is easy in the course of career progression to lose track of the bigger picture of what you are doing and how it fits into changes occurring in society and for the profession. Even if your focus is on a particular clinical procedure, how does what you are doing fit into larger metatrends and changes? If you are in a leadership position, how do you fit your practice or department into the bigger picture? How might this enterprise perspective speak to your career trajectory?

To inform these questions, build your platform for knowns and unknowns. There are four combinations in the "known-unknown" equation. They are each important and provocative for leaders. Your awareness of them prompts curiosity about "meta" problems and problem solving.

- There are the "known-knowns": what you know and you know you know it. The problem here is that you may assume that you know something that you don't.
- There are the "known-unknowns": Clear and curious about what you need to learn, you develop pathways to find out.
- There are the "unknown-knowns": what others know and you don't; a point of vulnerability if you are not careful to discover and figure this out.
- And finally, the "unknown-unknowns": the mysteries of what could lie ahead that no one yet fully comprehends.

The task for the "meta-leader"? Be clear on what you know, and seek always to learn and discover those unknowns. The better you factor them into your assessments, the better you are able to shape trends and the less likely you are to be overrun by them.

With this wider mindset, you fashion a fresh and innovative perspective on what is happening with health care and the options for constructively addressing new constraints and opportunities. You think big, reach far, and with this broader understanding, foment a lively set of perspectives and options that would otherwise not be available for those you lead. And when seen as a puzzle to learn and solve, the "meta" perch provides an engaging angle on the game of health care change. You too can be a player.



Dr. Marcus is coauthor of "Renegotiating Health Care: Resolving Conflict to Build Collaboration," 2nd ed. (San Francisco: Jossey-Bass Publishers, 2011) and is director of the program for health care negotiation and conflict resolution at Harvard T.H. Chan School of Public Health, Boston. Dr. Marcus teaches regularly in the SHM Leadership Academy. He can be reached at ljmarcus@hsph.harvard.edu.

In the Literature

Clinician reviews of HM-centric research

By Yelena Burklin, MD; Karen Clarke, MD, MS, MPH, FACP, FHM; Ketino Kobaidze, MD, PhD; Kyle James, MD; Ryan Marten, MD; Jessica Nave, MD; Willie H. Smith Jr., MD; and Lucy Witt, MD, MPH

Division of Hospital Medicine, Emory University, Atlanta

IN THIS ISSUE

By Yelena Burklin, MD

1 One-dose-fits-all aspirin administration strategy may not be advisable

CLINICAL QUESTION: Are the same doses of aspirin equally effective in preventing cardiovascular (CV) events and long-term colorectal risk reduction in patients of various body sizes?

BACKGROUND: Strong evidence for the one-dose-fits-all approach to use of aspirin in long-term prevention of CV events is lacking. Aspirin effect may be dependent on patient's body size. Excess dosing of aspirin in patients of small body size might negatively affect their outcomes.

Dr. Burklin

STUDY DESIGN: Meta-analysis.

SETTING: Trials from the Antithrombotic Trialists' Collaboration, other systematic reviews of trials of aspirin, and from the Cochrane Database of Systematic Reviews.

SYNOPSIS: The authors included 10 trials (117,279 participants altogether) and analyzed the association of body weight with the effectiveness of aspirin doses on CV event and colon cancer prevention. The greatest benefit of low-dose aspirin (75-100 mg) in reducing CV events was seen in patients weighing 50-69 kg (hazard ratio, 0.75; 95% confidence interval, 0.65-0.85; *P* less than .0001), with CV events increasing with increasing weights (*P* interaction = .0072). There was an increased rate of fatality with low-dose aspirin among patients at body weights greater than 70 kg (HR, 1.33; 95% CI, 1.08-1.64; *P* = .0082) or less than 50 kg (HR, 1.52; 95% CI, 1.04-2.21; *P* = .031). Higher doses of aspirin were more effective at higher body weights (*P* interaction = .017). Similar weight-dependent effects were seen in the 20-year risk of colorectal cancer.

While findings are consistent across trials looking at dose-dependent aspirin effects in patients of various body sizes, limitations included lack of generalizability of the results in secondary prevention trials, inclusion of older trials, variability of participants' characteristics, and aspirin compliance across trials.

BOTTOM LINE: Weight-based aspirin dosing may be required for prevention of CV events, sudden cardiac death, and cancer. Based on the results of this meta-analysis, one-dose-fits-all aspirin administration strategy may not be advisable.

CITATION: Rothwell PM et al. Effects of aspirin on risks of vascular events and cancer according to body weight and dose: Analysis of individual patient data from randomized trials. Lancet. 2018;392:387-99.

Dr. Burklin is an assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.

By Karen Clarke, MD, MS, MPH, FACP, FHM

2 How common are noninfectious complications of Foley catheters?

CLINICAL QUESTION: How common are noninfectious complications of Foley catheters?

BACKGROUND: Approximately 20% of hospitalized patients have a Foley catheter inserted at some time during their admission. Infectious complications associated with the use of Foley catheters are widely recognized; however, much less is known about noninfectious complications.

STUDY DESIGN: Prospective cohort study.

SETTING: Four U.S. hospitals in two states.

SYNOPSIS: The study included 2,076 hospitalized patients with a Foley catheter. They were followed for 30 days after its insertion, even if catheter removal occurred during this time period. Data about infectious and noninfectious complications were collected through patient interviews.

Dr. Clarke

At least one complication was noted in 1,184 of 2,076 patients (57%) during the 30-day period following Foley catheter insertion. While infectious complications occurred in 219 of 2,076 patients (10.5%), noninfectious complications (such as pain, urinary urgency, hematuria) were reported by 1,150 patients (55.4%; *P* less than .001). For those with catheters still in place, the most common complication was pain or discomfort (54.5%). Postremoval leaking urine (20.3%) and/or urgency and bladder spasms (24.0%) were the most common complications.

The study included only patients who had a Foley catheter placed during a hospitalization; the results may not apply to patients who receive catheters in other settings.

BOTTOM LINE: Noninfectious complications affect over half of patients with a Foley catheters. These types of complications should be targeted in future harm prevention efforts and should be considered when deciding to place a Foley catheter.

CITATION: Saint S et al. A multicenter study of patient-reported infectious and noninfectious complications associated with indwelling urethral catheters. JAMA Intern Med. 2018;178(8):1078-85.

Dr. Clarke is an assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.

By Ketino Kobaidze, MD, PhD

3 IVC filter placement increases mortality in some VTE patients

CLINICAL QUESTION: How does inferior vena cava (IVC) filter placement affect 30-day mortality in patients with venous thromboembolism (VTE) with increased risk of bleeding when anticoagulation is not feasible?

BACKGROUND: Standard treatment for VTE, including deep venous thrombosis (DVT) and pulmonary embolism (PE), is anticoagulation. However, for patients with active bleeding or increased risk of bleeding, anticoagulation may be contraindicated. In these circumstances, placing an IVC filter is recommended by major professional societies; however, the mortality benefit of IVC filter placement is uncertain.

Dr. Kobaidze

STUDY DESIGN: A retrospective cohort study.

SETTING: State Inpatient and Emergency Department Databases from California, Florida, and New York hospitals from 2005 to 2012.

SYNOPSIS: The authors compared the 30-day mortality rates in 45,771 hospitalized adult patients with inpatient diagnosis codes of PE and/or DVT, as well as a contraindication

Continued on following page

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to anticoagulation, who underwent IVC filter placement with 80,259 similar patients who did not undergo IVC filter placement. Baseline characteristics and coexisting conditions were similar in the two populations. The authors found that patients with IVC filter placement had an increased risk of 30-day mortality, compared with patients without an IVC filter placed (HR, 1.18; 95% CI, 1.13-1.22; *P* less than .001).

This study used observational data derived from reimbursement codes, which lacked unmeasured confounders (for example, severity of VTE and fragility score), so randomized, controlled trials are required to confirm the results. Nevertheless, this study should prompt physicians to carefully consider decisions to place an IVC filter in the setting of a contraindication to anticoagulation.

BOTTOM LINE: IVC filter placement in patients with VTE and contraindication for anticoagulation was associated with an increased 30-day mortality. Randomized, controlled trials are required to confirm the observed results.

CITATION: Turner TE et al. Association of inferior vena cava filter placement for venous thromboembolic disease and a contraindication to anticoagulation with 30-day mortality. JAMA Network Open. 2018;1(3):e180452.

Dr. Kobaidze is an assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.

By Kyle James, MD

4 Sodium bicarbonate decreases death and organ failure in patients with severe AKI

CLINICAL QUESTION: Does sodium bicarbonate treatment improve clinical outcomes in critically ill patients with severe metabolic acidosis?

BACKGROUND: Severe acidemia is associated with impaired cardiac function, decreased perfusion, and increased mortality. Many physicians use sodium bicarbonate to improve hemodynamic stability in critically ill patients with acidemia. However, the use of sodium bicarbonate in this role remains controversial because the evidence to support it is limited.

STUDY DESIGN: Multicenter, open-label, randomized, controlled trial.

SETTING: Twenty-six ICUs in France.

SYNOPSIS: Investigators randomized 389 adult patients with severe acidemia and Sequential Organ Failure Assessment (SOFA) scores of 4 or greater or serum lactate level of 2 mmol/L or greater to receive either no sodium bicarbonate or 4.2% intravenous sodium bicarbonate. The primary composite outcome was at least organ failure at day 7 or mortality by day 28.

Dr. James

When compared as a whole, the treatment group did not demonstrate improvement in the primary outcome. However, patients with Acute Kidney Injury Network scores of 2 or 3 at enrollment who received bicarbonate had lower rates of the composite primary outcome (70% vs. 82%; *P* = .462). Additionally, 35% of the treatment group utilized a renal replacement therapy (RRT) during their ICU stay versus 52% of the control group (*P* = .0009).

Limitations of the study included unblinding of the ICU physicians and the lack of a control intravenous solution. Notably, 47 of the 194 patients in the control group received sodium bicarbonate as salvage therapy.

BOTTOM LINE: Sodium bicarbonate treatment may decrease the need for RRT in patients with significant metabolic acidemia and may decrease the likelihood of death or organ failure in those with severe acute kidney injury.

CITATION: Jaber S et al. Sodium bicarbonate therapy for patients with severe metabolic acidaemia in the intensive care unit (BICAR-ICU): A multicentre, open-label, randomised controlled, phase 3 trial. Lancet. 2018;392(10141):31-40.

5 Delay RRT for severe AKI in septic shock or ARDS

CLINICAL QUESTION: Does early renal replacement therapy (RRT) initiation affect clinical outcomes in patients with severe acute kidney injury (AKI) in the setting of septic shock or acute respiratory distress syndrome (ARDS)?

BACKGROUND: Critically ill patients with AKI can benefit from RRT via improvement of electrolyte abnormalities, volume overload, and acid-base status. Potential harm from RRT includes complications of central venous access, intradialytic hypotension, and the bleeding risk of anticoagulation. The optimal timing of the elective initiation of RRT for AKI in septic shock or ARDS is unknown.

STUDY DESIGN: A post hoc subgroup study of a randomized, controlled trial.

SETTING: Thirty-one ICUs in France.

SYNOPSIS: Using data from the Artificial Kidney Initiation in Kidney Injury trial, the authors evaluated 619 patients with severe AKI and requirement for catecholamine infusion and/or invasive mechanical ventilation. Patients were randomly given RRT in an early or a delayed time frame. The early strategy involved RRT as soon as possible after randomization. In addition to the other parameters, the patients in the delayed group were given RRT for the following: anuria/oliguria 72 hours after randomization, blood urea nitrogen greater than 112 mg/dL, serum potassium greater than 6 mmol/L, metabolic acidosis with pH less than 7.15, or pulmonary edema from fluid overload causing severe hypoxia.

Early RRT did not show significant improvement in 60-day mortality, length of mechanical ventilation, or length of stay, compared with delayed RRT. The delayed RRT strategy was significantly associated with renal function recovery, with hazard ratios of 1.7 in ARDS (*P* = .009) and 1.9 in septic shock (*P* less than .001).

Short Takes

Both sleep quantity and quality is disturbed in hospitalized patients

A cross-sectional, observational, single-day study of over 2,000 hospitalized patients showed that, on average, these patients received 83 minutes less sleep time than at home. Quality of sleep – as measured by the Consensus Sleep Diary (CSD) and the Dutch-Flemish Patient-Reported-Outcomes Measurement Information System (PROMIS) Sleep Disturbance item bank – was also significantly disturbed. Sleep disruptions were most commonly caused by noise from other patients and by being awakened by hospital staff.

CITATION: Wesselius H et al. Quality and quantity of sleep and factors associated with sleep disturbance in hospitalized patients. JAMA Intern Med. 2018 Jul 16. doi: 10.1001/jamainternmed.2018.2669.

Additionally, the likelihood of adequate urinary output was greater in the delayed RRT group.

BOTTOM LINE: A delayed RRT strategy in those with severe AKI and septic shock or ARDS may safely afford time for renal recovery in some patients.

CITATION: Gaudry S et al. Timing of renal support and outcome of septic shock and acute respiratory distress syndrome. A post hoc analysis of the AKIKI randomized clinical trial. Am J Respir Crit Care Med. 2018;198(1):58-66.

Dr. James is a hospitalist at Emory University Hospital Midtown and an assistant professor at Emory University, both in Atlanta.

Short Takes

Health care costs and mortality improve in Medicare beneficiaries who receive transitional care management (TCM) services

In a retrospective cohort analysis of Medicare Fee-for-Service beneficiaries, the adjusted total Medicare costs (average, $3,358 vs. $3,033) and mortality (1.6% vs 1.0%) were higher among those beneficiaries who did not receive TCM services, compared with those who did receive TCM services, in the 31-60 days following an eligible discharge; however, use of this service by clinicians remained very low.

CITATION: Bindman AB et al. Changes in health care costs and mortality associated with transitional care management services after a discharge among Medicare beneficiaries. JAMA Intern Med. 2018 Jul 30. doi: 10.1001/jamainternmed.2018.2572.

By Ryan Marten, MD

6 Rivaroxaban versus heparin at preventing recurrent, cancer-related VTE

CLINICAL QUESTION: Is an oral direct factor Xa inhibitor an effective alternative to low-molecular-weight heparin (LMWH) in treating cancer related venous thromboembolism (VTE)?

BACKGROUND: LMWH has been the standard of care for treatment in patients with VTE and cancer. A newer class of drug, the direct factor Xa inhibitors, have been shown to be noninferior to vitamin K antagonists (VKAs) in treatment of VTE in noncancer patients, but little is known about their use in patients with cancer.


Dr. Marten

STUDY DESIGN: Randomized, open-label, multicenter pilot trial.

SETTING: United Kingdom; patients were recruited through the Clinical Trials Unit at the University of Warwick, Coventry.

SYNOPSIS: The authors randomly assigned 406 cancer patients with diagnosed VTE either to the LMWH group or to the oral direct factor Xa inhibitor group to evaluate the primary endpoint of VTE reoccurrence and secondary endpoints of major bleeding or clinically relevant but not major bleeding (CRNMB). Rivaroxaban was noninferior to dalteparin in preventing VTE reoccurrence, with a 6-month VTE reoccurrence rate for dalteparin of 11% (95% confidence interval, 7%-16%) and a reoccurrence rate of 6% for rivaroxaban (95% CI, 2%-9%). Rates of major bleeding events were similar, although patients with esophageal or gastroesophageal cancers tended to experience more major bleeds with rivaroxaban than with dalteparin (4 of 11 vs. 1 of 19). CRNMB was 4% for dalteparin and 13% for rivaroxaban (hazard ratio, 3.76; 95% CI, 1.64-8.69). Limitations include slow recruitment, high mortality rate, and the treatment length being only 6 months.

BOTTOM LINE: In this small study, rivaroxaban was equally effective at reducing the rate of reoccurrence of cancer related VTE at 6 months but had higher rates of CRNMB. Patients with GI cancers may be at higher risk for major GI bleeding with rivaroxaban.

CITATION: Young AM et al. Comparison of an oral factor Xa inhibitor with low molecular weight heparin in patients with cancer with venous thromboembolism: Results of a randomized trial (SELECT-D). J Clin Oncol. 2018 Jul 10. 36(20):2017-23.

Dr. Marten is an assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.

By Jessica Nave, MD

7 Statin exposure associated with idiopathic inflammatory myositis

CLINICAL QUESTION: What is the association between exposure to statin medications and histologically confirmed idiopathic inflammatory myositis?

BACKGROUND: More than 200 million people worldwide use statin therapy, mostly for cardiovascular risk reduction. There is mounting evidence of an infrequent side effect known as idiopathic inflammatory myositis (IIM), that requires immunosuppressive therapy rather than just discontinuation of the medication. While there is a recently described association of statin use with an immune-mediated necrotizing myositis through the formation of an autoantibody against HMG-CoA Reductase, this epidemiological study aimed to look at the incidence of statin use against all confirmed cases of IIM.

STUDY DESIGN: Retrospective, population-based, case-control study.

SETTING: Northwest Adelaide Health Study in Adelaide, Australia.

SYNOPSIS: A retrospective, population-based, case-control study was conducted that compared the incidence of histologically confirmed IIM identified from the South Australian Myositis Database in patients 40 years or older with known statin exposure (n = 221) against population-based controls obtained from the North West Adelaide Health Study. The unadjusted and adjusted odds ratios and 95% confidence intervals were calculated using the conditional logistic regression analysis for the risk of statin exposure associated with IIM. There was an almost twofold (79%) increased likelihood of statin exposure in patients with IIM by comparison with controls (adjusted OR, 1.79; 95% CI, 1.23-2.60; P = .001).

This study's results indicate that patients with histologically confirmed IIM had a significantly increased likelihood of statin exposure, compared with population-based matched controls. Results were similar even when excluding necrotizing myositis, which already has a known association with statin use, which suggests that statin use could be associated with all types of IIM.


Dr. Nave

BOTTOM LINE: There was a statistically significant association between statin use and the incidence of idiopathic inflammatory myositis, which suggests that this condition is a potential serious side effect of statin therapy.

CITATION: Caughey GE et al. Association of statin exposure with histologically confirmed idiopathic

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inflammatory myositis in an Australian population. JAMA Intern Med. 2018 Jul 30. doi: 10.1001/jamainternmed.2018.2859.

Dr. Nave is an assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.

By Willie H. Smith Jr., MD

8 More Medicare beneficiaries receiving hospice care services than in previous years

CLINICAL QUESTION: For patients with Medicare Fee-for-Service and Medicare Advantage, what are the trends regarding where they die and the type of health care received around the time of death?

BACKGROUND: Studies abound on the accelerated cost and health care activities of patients toward the end of life. Previous analyses of Medicare trends of medical care at the time of death have been compiled in 2000, 2005, 2009, and 2011; this study reexamines recent trends.


Dr. Smith

STUDY DESIGN: Retrospective cohort of a random sample of Medicare Fee-for-Service and Medicare Advantage decedents during 2000-2015.

SETTING: Medicare patients in acute care hospitals, home/community, hospice inpatient care units, or nursing homes.

SYNOPSIS: Approximately 1.4 million Medicare Fee-for-Service decedents and 870,000 Medicare Advantage decedents were studied in a random sample that included 20% of Medicare Fee-for-Service recipients in the years 2000, 2005, 2009, 2011, and 2015 and 100% of Medicare Advantage patients in the years 2011 and 2015. Deaths of Medicare Fee-for-Service recipients occurring in acute care hospitals and nursing homes decreased from 32.6% (95% confidence interval, 32.4%-32.8%) in 2000 to 19.8% (95% CI, 19.6%-20.0%) in 2015. Patients who died while receiving hospice services increased from 21.6% (95% CI, 21.5%-21.8%) in 2000 to 50.4% (95% CI, 50.2%-50.6%) in 2015. Review of Medicare Advantage data demonstrated similar shifts.

Although there are concerns about the accuracy of reported location of community deaths and these results may not be generalizable to other, non-Medicare populations, the study overall adds statistical data on death trends and suggests an improvement in the use of palliative and hospice care services.

BOTTOM LINE: Compared with previous years, fewer Medicare beneficiaries are dying in acute care settings, and more beneficiaries are receiving hospice care in other settings.

CITATION: Teno J et al. Site of death, place of care, and health care transitions among U. S. Medicare beneficiaries between 2000-2015. JAMA. 2018;320(3):264-71.

Dr. Smith is an assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.

By Lucy Witt MD, MPH

9 Prevalence and outcomes of incidental imaging findings

CLINICAL QUESTION: How frequently are incidental findings on imaging identified and how often do these findings represent true pathology?

BACKGROUND: As frequency of imaging studies increases, and those studies become more advanced, incidental findings on imaging are a growing concern. Incidentalomas can lead to anxiety for patients, increased testing, and possible interventions such as biopsies. Current literature does not provide adequate guidance for providers to discuss the risks of incidentalomas with patients, nor are there clear methods described to manage incidentalomas when discovered.

STUDY DESIGN: This study was an umbrella review of systematic reviews and meta-analyses. Authors conduced their own meta-analyses using data from pooled sources.

SETTING: MEDLINE and EMBASE were searched, which resulted in 20

Continued on following page

Short Takes

Unsafe zolpidem use is common

In a review of the 2015 US Medical Expenditure Panel Survey, investigators found that up to 77% of patients prescribed zolpidem reported being prescribed longer durations and higher doses, as well as the drug being prescribed alongside other CNS depressants, despite known risks and recommended prescription and Food and Drug Administration guidelines.

CITATION: Moore T et al. Assessment of patterns of potentially unsafe use of zolpidem. JAMA Intern Med. 2018 Jul 16. doi: 10.1001/jamainternmed.2018.3031.

Pediatric ITL

Rapid recovery pathway for pediatric PSF/AIS

An important alternative amidst the opioid crisis

By Mirna Giordano, MD

Clinical question

In pediatric postoperative spinal fusion (PSF)/adolescent idiopathic scoliosis patients, do alternatives to traditional opioid-based analgesic pain regimens lead to improved clinical outcomes?

Background

Traditional care for PSF patients has included late mobilization most often because of significant pain that requires significant opioid administration. This has led to side effects of heavy opioid use, primarily nausea/vomiting and sleepiness.

Prescribers in the U.S. have become more aware of the pitfalls of opioid use given that more people now die of opioid misuse than breast cancer. An approach of multimodal analgesia with early mobilization has been shown to decrease length of stay (LOS) and improve patient satisfaction, but data on clinical outcomes have been lacking.

Study design & Setting

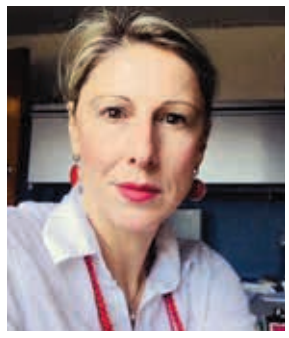
Single-center quality improvement (QI) project in an urban, 527-bed, quaternary care, free-standing children's hospital.

Synopsis

Based on the recognition that multiple "standards" of care were utilized in the postoperative management of PSF patients, a QI project was undertaken. The primary outcome measured was functional recovery, as measured by average LOS and pain scores at the first 6:00 am after surgery then on postoperative days 1, 2, and 3.

Process measures were use of multimodal agents (gabapentin and ketorolac) and discontinuation of patient-controlled analgesia (PCA) before postoperative day 3. Balancing measures were 30-day readmissions or ED revisit. Patients were divided into three groups by analyzing outcomes in three consecutive time periods: conventional management (n = 134), transition period (n = 104), and rapid recovery pathway (n = 84). In the conventional management time period, patients received intraoperative methadone and postoperative morphine/hydromorphone PCA. During the transition period, plan-do-study-act cycles with ketorolac and gabapentin pilots were instituted and assessed. Finally, a rapid recovery pathway (RRP) was designed and published as a web-based algorithm. Standardized entry order sets were developed to maintain compliance and consistency, and a transition period was allowed to reach the highest possible percentage of patients adhering to multimodal analgesia regimen.

Adherence to the multimodal regimen led to 90% of patients receiving ketorolac on postop day 1, 100% receiving gabapentin on night of surgery, 86% off of IV PCA by postop day 3, and 100% order set adherence after full implementation of the RRP. LOS decreased from 5.7 to 4 days after RRP implementation. Pain scores also improved significantly on postop day 0 (average pain score, 3.8 vs. 4.9) and postop day 1 (3.8 vs. 5). Balancing measures of 30-day readmissions or ED visits after discharge was 2.9% and 3.6% after full implementation.



Dr. Giordano

Dr. Giordano is a pediatric neurosurgery hospitalist and assistant professor in pediatrics at Columbia University Irving Medical Center in New York.

Bottom line

Multimodal analgesia – including preoperative gabapentin and acetaminophen, intraoperative methadone and acetaminophen, and postoperative PCA diazepam, gabapentin, acetaminophen, and ketorolac – results in decreased length of stay and improved self-reported daily pain scores.

Citation

Muhly WT et al. Rapid recovery pathway after spinal fusion for idiopathic scoliosis. Pediatrics. 2016 Apr;137(4):e20151568.

Continued from previous page

unique systematic reviews analyzed, 15 of which provided incidence data and 18 included outcome data.

SYNOPSIS: To assess prevalence of incidentalomas, the authors conducted nine meta-analyses, with a median number of 14,409 patients. Each analysis was created based on the imaging modality used and the area of the body where the incidental finding occurred. They examined the outcomes specific to incidentalomas within those organs. Their analysis showed that CT of the chest had the highest prevalence of incidentalomas (45%; 95% confidence interval, 36%-55%). Incidental findings in the breast had the highest rates of malignancy (42%; 95% CI, 31%-54%). Noncancerous outcomes described included disc degeneration on MRIs of the spine, aneurysms in brain imaging, and subclinical Cushing's syndrome. There was significant heterogeneity in all the meta-analyses conducted.

Limitations included variations in how primary study authors defined a positive result and in imaging protocols. Although the authors of this study used primary data extracted from the individual studies in the systematic reviews, they did not analyze the primary studies for inclusion based on methods.

BOTTOM LINE: This study provides guidance to clinicians regarding counseling patients on the risks of incidentalomas and how to manage those incidental findings.

CITATION: O'Sullivan JW et al. Prevalence and outcomes of incidental imaging findings: umbrella review. BMJ. 2018 Jun 18. doi: 10.1136/bmj.k2387.

10 Epinephrine linked with more refractory cardiogenic shock after acute MI

CLINICAL QUESTION: Is there a difference in safety and efficacy when using epinephrine versus norepinephrine for cardiogenic shock after successful reperfusion in acute myocardial infarction (AMI)?

BACKGROUND: Norepinephrine and epinephrine are the most commonly used vasopressors in clinical practice and in septic shock have been found to be equivalent in effectiveness. Their different physiological effects may influence their effectiveness in cardiogenic shock, and previous retrospective studies have suggested that epinephrine may have worse clinical outcomes in this setting.

STUDY DESIGN: A multicenter, prospective, randomized, double-blind study.

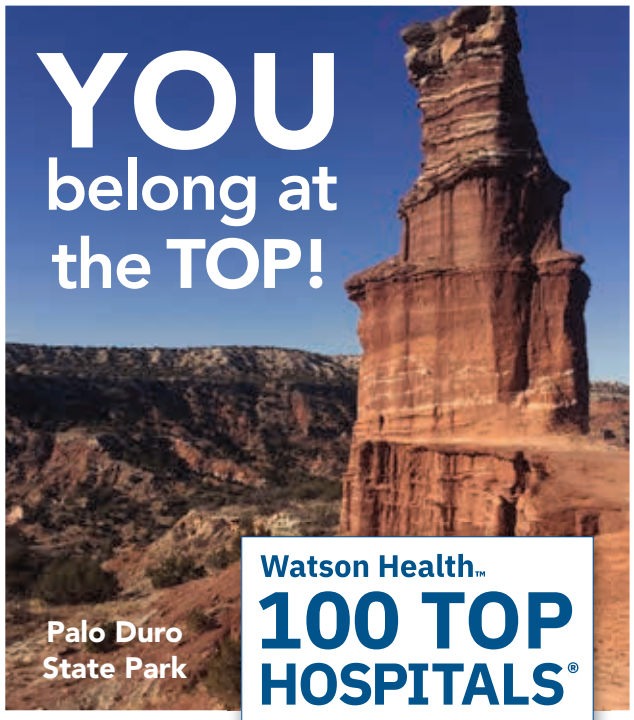
SETTING: ICUs in nine French hospitals.

SYNOPSIS: Adults (older than 18 years old) who suffered cardiogenic shock following successful revascularization after AMI were enrolled. Fifty-seven patients were randomly assigned to receive either norepinephrine or epinephrine with patients, nurses, and physicians unaware of which study drug was being used. The primary outcome variable was change in cardiac index within the first 72 hours, and refractory cardiogenic shock served as the main safety endpoint. This study was stopped early because of the higher risk of refractory cardiogenic shock noted in the epinephrine group, compared with that seen in the norepinephrine group (10 of 27 vs. 2 of 30; $P = .011$). There was no difference in evolution of cardiac index ($P = .43$) between the two groups. Potentially harmful metabolic and physiologic changes were noted in the epinephrine group including greater lactic acidosis and increased heart rate. This study was underpowered for clinical endpoints because of the study's early termination. It also did not include patients in cardiogenic shock from other causes, such as myositis or postcardiopulmonary bypass.

BOTTOM LINE: For patients in cardiogenic shock after AMI with successful reperfusion, epinephrine use was associated with increased refractory cardiogenic shock, compared with norepinephrine use.

CITATION: Levy B et al. Epinephrine versus norepinephrine for cardiogenic shock after acute myocardial infarction. J Am Coll Cardiol. 2018 Jul 10;72(2):173-82.

Dr. Witt is an assistant professor of medicine in the division of hospital medicine at Emory University, Atlanta.



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Reference # SHM2017.

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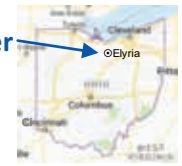

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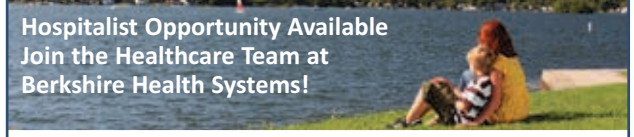

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Hospitalists as physician executives

HM provides "foundational leadership skills"

By Brian Harte, MD, SFHM

Hospitals and health systems are increasingly looking to physicians to provide leadership at the most senior executive level. While the chief medical officer (CMO) or similar role has given physicians a seat at the executive table at many organizations, physicians are also being sought for the chief executive officer (CEO) role at the head of that table.

A commonly referenced study from 2011 by Amanda Goodall, MD, in *Social Science & Medicine*, concluded that, among a cohort of highly ranked hospitals, overall quality metrics were approximately 25% higher in hospitals where a physician was CEO, in comparison to hospitals with nonphysician CEOs (2011 Aug;73[4]:535-9).

ILYAF/THINKSTOCK

In addition, new positions at the hospital and health system level are coming into existence: Examples include chief of population health, chief innovation officer, chief quality officer, and chief patient experience officer, among others.

There is every reason to think that these senior executive physician roles can – and in many cases perhaps should – be filled by hospitalists. Hospital medicine is an ideal "proving ground" for future physician leaders. I believe that the best practitioners of hospital medicine are also the best candidates for hospital, health care, and health system physician executive leadership, because many of the characteristics essential for success as an executive are the same characteristics that are essential for success as a hospitalist. Strong candidates should have the following characteristics:

- ***A patient-centered perspective:*** Perhaps the most important characteristic of a leader is empathy. To appreciate the complex, and often challenging, emotional states of our patients keeps us connected at the most fundamental, human level to the work we do and to our patients and families. Empathy can – and should – extend to fellow caregivers as well, and allows us to practice and lead teams in the most human of professions. No leader – in health care, anyway – can last long without being able to demonstrate empathy, through words and behavior.
- ***A systems-based practice:*** A hospitalist must be able to have a foot in each of two canoes – to be able to see each patient and their family individually and develop preference-based plans of care, and also to be able to focus on process, structure, and outcomes for the hospital system as a whole. The former trait is imbued in us during training and is the critical foundation for the patient-physician relationship. The latter, however, is something different entirely and reflects an ability to have perspective on the entire ecosystem of care – and apply principles of process and quality improvement to achieve forward looking results. That's leadership.
- ***Team leadership:*** Another fundamental attribute of leaders is to assemble a talented and diverse team around an objective, and then to delegate both tasks and their ownership, deferring to expertise. Hospitalists – the best ones, anyway – similarly recognize that, for the vast majority of a patient's hospital stay, the most important caregiver in a patient's care is someone other than themselves. At any given time, it might be the nurse, aide, pharmacist, care manager, transporter, radiology tech, urologist, housekeeper, surgical resident, or anyone involved in that patient's care. The hospitalist's greatest value is in developing the plan of care with the patient and their family, and then communicating – and therefore delegating – that plan to individuals with the expertise to execute that plan. I believe the biggest difficulty hospitalists have in assuming leadership roles is getting out of the comfortable weeds of daily clinical operations and instead focusing on goals, strategies, and teams to accomplish them. The best hospitalists are doing this already as part of their daily care.
- ***The ability to manage relationships:*** Hospitalists manage and work among a team of diverse talents. They also have accountability relationships to clinical and administrative leaders in the hospital, each of whom may be in a position of authority to place demands on the hospitalists: A partial list might include the CEO, the chief medical officer, chief nurse, chief of staff, other medical staff departments, academic leaders, and of course, patients and their families. Functioning in a "matrixed" organization – in which lines of authority can go in many directions – is standard fare, even at the executive level, and the key competency is open and frequent communication.
- ***Experience:*** Already, hospitalists assume leadership roles in their hospitals – leaders in quality, medical informatics, patient experience, and continuous improvement. In these roles, physicians work with senior executives and other hospital leaders to both set goals and implement strategies, providing visibility and working relationships that can be helpful to aspiring leaders.

Dr. Harte is a past president of SHM and president of Cleveland Clinic Akron General and Southern Region.

Perhaps more so than most other specialties, then, hospitalists demonstrate foundational leadership skills in their day-to-day practice – an ideal start to a leadership path. This is not to say or suggest that a career devoted purely to clinical practice is somehow inferior – far from it. However, as health care organizations turn to the medical community to provider leadership, hospitalists are well positioned to develop and be developed as executive leaders.

How can SHM help? While management degrees become a common pathway for many, some health systems and professional organizations support their membership with a leadership development curriculum which may be a better place to start. In my opinion, SHM provides one of the most thorough and relevant experiences available. The SHM Leadership Academy focuses on developing a broad set of additional leadership competencies across a spectrum of experience. The format varies depending on the course, but all rely heavily upon experienced hospitalist leaders – in fact, many current and former Board members and officers volunteer their time to facilitate and teach at the Academy, including at the entry level. It's a powerful way to learn from others who have started walking the leadership path.

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