

THE Hospitalist

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Hospitalist NPs and PAs note progress

But remain underutilized

By Thomas R. Collins

Nurse practitioners (NPs) and physician assistants (PAs) have become a more prominent part of the hospitalist workforce, and at many institutions, they account for a large proportion of patient care and have a powerful effect on a patient's experience. But NP and PA roles in hospital medicine continue to evolve – and understanding what they do is still, at times, a work in progress.

One myth that persists regarding NPs and PAs is that, if you've seen one, you've seen them all.

At the 2018 Annual Conference of the Society of Hospital Medicine, Noam Shabani, MS, PA-C, lead physician assistant at Massachusetts General Hospital's Hospital Medicine Unit, Boston, offered an example to help shatter this misperception.

Mr. Shabani described a 28-year-old woman who had a Bachelor's degree in biology with a premed track and spent 4 years as a paramedic before attending the physician assistant program at Duke University, Durham, N.C. As a new PA graduate, she was hired as a hospitalist at a community hospital in Kentucky.

Given this new PA's clinical experience and formal education, there are certain skills she should bring to the table: the ability to develop a differential diagnosis and a good understanding of disease patho-

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SPOTLIGHT

Atashi Mandal, MD

p7

A Med-Peds voice on the
Public Policy Committee.

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Hospitalist Movers and Shakers

By Matt Pesyna

Modern Healthcare recently announced its list of the 50 Most Influential Physician Executives and Leaders, and hospital medicine was well represented among the honorees. The honored physicians were selected by a panel of experts and peers for their leadership and impact on the profession.

Topping the list was **Scott Gottlieb, MD**, the commissioner of the Food and Drug Administration. Dr. Gottlieb was confirmed to his position in May 2017 and, in his first year, has focused on price transparency and the approval of generic medications.



Dr. Gottlieb

Dr. Gottlieb was deputy commissioner of the FDA from 2005 to 2007, and he has worked as an adviser and analyst for GlaxoSmithKline, the American Enterprise Institute, Vertex Pharmaceuticals, and Avilene Health.

Dr. Gottlieb earned his medical degree from the Icahn School of Medicine at Mount Sinai, New York, and completed his residency at Mount Sinai Hospital. He has worked as a hospitalist at New York University's Tisch Hospital, the Hospital for Joint Diseases, and Stamford (Conn.) Hospital.

Patrick Conway, MD, was listed at number 23 on Modern Healthcare's

50 Most Influential Physician Executives and Leaders. Formerly the deputy administrator for innovation and quality at the Centers for Medicare & Medicaid Services, Dr. Conway recently became president and chief executive officer of Blue Cross and Blue Shield of North Carolina.



Dr. Conway

Dr. Conway is known for his ability to develop and promote alternative payment models. He was elected to the National Academy of Medicine's Institute of Medicine in 2014 and was selected as a Master of Hospital Medicine by the Society of Hospital Medicine.

Lynn Massingale, MD, the cofounder and chairman of TeamHealth, was named 1 of the 50 Most Influential Physician Executives and Leaders for a third year running, coming in at number 27 on the list. Dr. Massingale, who also recently was named to the Tennessee Healthcare Hall of Fame, founded TeamHealth in 1979 and was its chief executive officer for 30 years before assuming the role of chairman in 2008.

TeamHealth provides outsourced emergency medicine, hospitalist, critical care, anesthesiology, and acute care surgery services, among other specialties, at more than 3,200 facilities and physician groups across the United States.

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Business Moves

U.S. Acute Care Solutions (Canton, Ohio), a physician-owned, national provider of emergency medicine and hospitalist services, has extended its relationship with Central Health of Colorado and western Kansas. USACS has acquired the physicians of Front Range Emergency Specialists (Colorado Springs), Southwest Emergency Physicians (Durango, Colo.), and Southern Colorado Emergency Specialists (Pueblo).

USACS's acquisition of these three physician groups adds care to more than 175,000 patients each year in central and southwest Colorado. USACS cares for more than

6 million patients per year at more than 200 locations across the United States.

VEP Healthcare (Concord, Calif.), an emergency medicine and hospitalist staffing company, has signed on to manage hospitalist and ED services at City Hospital at White Rock in Dallas. Its goals are to increase patient satisfaction, decrease wait times in seeing providers, raise recommendation rates, and lower malpractice claims.

White Rock is a 218-bed, community hospital providing care to East Texas since 1959.

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AWARDS FOR
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Q&A

New perspectives keep SHM relevant

Atashi Mandal, MD, finds committee work illuminating and gratifying

By Felicia Steele

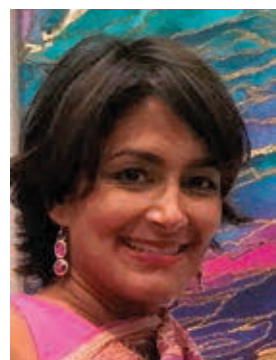
Editor's note: SHM occasionally puts the spotlight on some of our most active members who are making substantial contributions to hospital medicine. Visit www.hospitalmedicine.org for more information on how you can lend your expertise to help improve the care of hospitalized patients.

This month, *The Hospitalist* spotlights Atashi Mandal, MD, a Med-Peds hospitalist in Huntington Beach, Calif. Dr. Mandal has been a member of SHM for more than a decade, has served on the Public Policy Committee, and is currently serving on the Patient Experience Committee.

How did you initially hear about SHM, and why did you become a member?

I was a newly minted hospitalist and eagerly searching for a way to use my CME allowance, when I discovered SHM's annual conference, which happened to be nearby in San Diego that year. I also was intrigued by, and excited to learn more about, an organization that dedicated itself only to hospital medicine. After attending the conference, I was hooked!

As a member of more than a decade, what aspects of your membership have you found to be most valuable?



Dr. Mandal

I've always been very impressed by the quality and variety of the educational offerings. As a Med-Peds hospitalist, I can happily attest to greater inclusion of pediatric-specific content and a more robust presence of pediatric

hospitalists over the years. Moreover, I am very appreciative of SHM's progressive attitude as demonstrated by incorporating topics such as gender disparities, LGBTQ health, and the opioid

crisis into our curriculum. I also have greatly enjoyed the networking opportunities with fellow hospitalists, some of whom I am happy to say have also become good friends over the years. More recently over the past few years, I've participated on committees, which has been an illuminating and gratifying way to help shape SHM's current and future directives.

Describe your role on the Public Policy Committee. What did the committee accomplish during your term?

I was very honored to serve as a member of this committee for three terms. The staff is truly superhuman and amazing, considering how well they stay abreast of the swiftly changing administrative and legislative currents in health care. Just during my tenure as an SHM member, we've witnessed paramount shifts in our practice and culture, from the passage of MACRA [the Medicare Access and CHIP Reauthorization Act] to the opioid epidemic. The Public Policy Committee identifies issues that affect our practice as hospitalists and advocates on our behalf through various means, from submitting comments and letters as well as personally meeting with our regulatory agencies such as CMS [Centers for Medicare & Medicaid Services], and our federal legislators. Some major victories were the acquisition of our specialty billing code and approval of an advanced care billing code. Additionally, the committee has been tirelessly advocating for reform with observation status. We have submitted comments to legislative committees regarding the opioid crisis and continue to work with MACRA as it affects our membership. While I served, I took a special interest in mental health and pediatric issues, including CHIP [Children's Health Insurance Program] reauthorization and the 21st Century Cures Act.

What is Hill Day, and what can Hospital Medicine 2019 attendees expect to gain from participating?

Hill Day is a truly educational, exciting – and most important – fun opportunity to hone our

advocacy skills and gain some real-world experience interacting with legislators and their staffs. On the last day of the annual conference attendees can travel to D.C., where we will spend about a half-day meeting with our respective state's legislators or their staff. We typically discuss two or three preselected bills that can directly impact our practice as hospitalists. The legislators and their staffers generally are not aware of how certain legislative items can greatly benefit or adversely affect our patients, and they therefore

“During my tenure as an SHM member, we've witnessed paramount shifts in our practice and culture, from the passage of MACRA [the Medicare Access and CHIP Reauthorization Act] to the opioid epidemic.”

rely on frontline clinicians like us to provide this narrative, much to their gratitude. I learn a lot and have even more fun each time I go to Capitol Hill, so I strongly encourage everyone to participate in this unique opportunity.

Do you have any advice for early-career hospitalists looking to gain experience and get involved with SHM?

I would encourage you to find your voice and participate! Whether by joining a committee or a Special Interest Group or just chatting on one of the many stimulating forums, we each have something to bring to the table, irrespective of our tenure as hospitalists. The new perspectives mingling with those that are well established is what keeps our organization relevant, so I look forward to new ideas and fresh faces!

Ms. Steele is a marketing communications specialist at the Society of Hospital Medicine.

Continued from previous page

Veeravat Taecharvongphairoj, MD, a veteran internist and hospitalist at Hemet Valley Medical Center in Hemet, Calif., has been honored by the International Association of Healthcare Professionals in its Leading Physicians of the World publication.

Dr. Taecharvongphairoj completed his residency at the University of Hawaii, Honolulu, before accepting a fellowship in hospital and palliative care at Cedars-Sinai Medical Center, Los Angeles. He is a member of the

American Academy of Hospice and Palliative Medicine.

Sean Bain, MD, has been selected to the Glen Falls (N.Y.) Hospital Foundation Board of Trustees for 2018. Dr. Bain works as a hospitalist/internist at Glen Falls Hospital, where he is the president of medical staff. He manages the credentialing, continuing education, and policies and practices for the staff's providers.

Dr. Bain received his medical degree at Albany (N.Y.) Medical College and served his residency at Wake

Forest Baptist Medical Center, Winston-Salem, N.C.

George Harrison, MD, has been tabbed the new chief medical officer at Fairview Park Hospital in Dublin, Ga. Dr. Harrison will be charged with managing clinical quality and patient safety, staff relations, and clinical integration strategies at the hospital.

Prior to his appointment, Dr. Harrison was the codirector of the hospitalist program at Fairview Park. The Georgia native previously

worked in management roles at urgent care centers, family practice centers, and hospitalist programs in North Carolina, South Carolina, and Georgia. He is a member of the American Academy of Family Physicians, the Society of Hospital Medicine, and the American Academy of Physician Leaders.

Dr. Harrison taught high school geometry and chemistry before earning his medical degree at the Morehouse School of Medicine, Atlanta. He did his residency at Duke University Medical Center, Durham, N.C.

Sneak Peek: *The Hospital Leader*

White coats and provider attire:

How much does it really matter to patients?

By Brad Flansbaum, MD, MPH, MHM

The question of appropriate ward garb is a problem for the ages. Compared with photo stills and films from the 1960s, the doctors of today appear like vagabonds. No ties, no lab coats, and scrub tops have become the norm for a number (a majority?) of hospital-based docs – and even more so on the surgical wards and in the ER.

Past studies have addressed patient preferences for provider dress, but none like the results of a recent survey.

From the University of Michigan, Ann Arbor, comes a physician attire survey of a convenience sample of 4,000 patients at 10 U.S. academic medical centers. It included both inpatients and outpatients, and used the design of many previous studies, showing patients the same doctor dressed seven different ways. After viewing the photographs, the patients



Dr. Flansbaum

received surveys as to their preference of physician based on attire, as well as being asked to rate the physician in the areas of knowledge, trust, care, approachability, and comfort.

You can see the domains: casual, scrubs, and formal, each with and without a lab coat. The seventh category is business attire (future C-suite wannabes – you know who you are).

Over half of the participants indicated that how a physician dresses was important to them, with more than one in three stating that this influenced how happy they were with care received. Overall, respondents indicated that formal attire with white coats was the most preferred form of physician dress.

I found the discussion in the study worthwhile, along with the strengths and weaknesses of the author's outline. They went to great lengths to design a nonbiased questionnaire and used a consistent approach to shooting their photos. They also discussed lab coats, long sleeves, and hygiene.

But what to draw from the findings? Does patient satisfaction matter or just clinical outcomes? Is patient happiness a means to an end or an end unto itself? Can I even get you exercised about a score of 6 versus 8 (a 25% difference)? For instance, imagine the worst-dressed doc – say shorts and flip-flops. Is that a 5.8 or a

2.3? The anchor matters, and it helps to put the ratings in context.

Read the full post at hospitalleader.org.

Dr. Flansbaum works for Geisinger Health System in Danville, Pa., in both the divisions of hospital medicine and population health. He is a founding member of the Society of Hospital Medicine and served as a board member and officer.

Also in
The Hospital Leader

- Hospitalists Can Improve Patient Trust ... in Their Colleagues
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- Treatment of Type II MIs
By Brad Flansbaum, MD, MPH, MHM
- The \$64,000 Question: How Can Hospitalists Improve Their HCAHPS Scores?
By Leslie Flores, MHA, SFHM

Mistakes to avoid when starting a locum tenens job

Beware inefficient placement systems and unorganized companies

By Geeta Arora, MD

For the last 8 years I have worked as a locum tenens hospitalist. I began on this path when it was the least popular option upon graduation from residency.

I did countless hours of research trying to find accurate information about locum tenens companies, but never found anything written by physicians, only by the companies themselves. So, I stepped into this field blindfolded and learned the hard way. Since then, I have worked with over 16 locum tenens companies, 14 hospitals, and eight electronic medical record systems.

Through these experiences I've realized that, unfortunately, some locum tenens companies do not act with the professionalism and efficiency that both physicians and hospital systems would expect. This can lead to more stress than an actual employed position for physicians, and poor coverage with enormous costs for hospitals.

I decided to take matters into my own hands because I wanted to make the locum tenens system easier to navigate. I believe that the system can play a role in decreasing physician burnout, and I deeply understand the need that hospitals have to serve their patients with a shortage of doctors. As locum tenens physicians, we serve a

need and shouldn't have to deal with inefficient placement systems.

Here are five mistakes to avoid for physicians that are first entering into the locum tenens world:

1. Beware choosing a "factory mill" locum tenens company. Bigger companies have higher overhead, which usually means that they take more of a margin from physicians. Generally speaking, larger locum tenens companies pay their recruiters a lower percentage commission, so each recruiter has more physicians. This can lead to mistakes, which can cause stress for both physicians and hospitals.

2. Beware long travel. Hourly rates that are \$5-\$10 dollars more per hour in remote locations are attractive. However, the amount of travel needed to get to these locations may not be worth it. When negotiating a rate, make sure not to lose sight of the amount of time it will take to travel to the hospital or outpatient location.

3. Beware short-term placements. There are a lot of hospitals that just need 1 or 2 weeks covered. Even if it's at a much higher rate, the amount of paper work and credentialing hassle may not be

worth the amount of time you work there. The greater number of cumulative hospitals worked, the longer credentialing will take in future locum tenens placements.

4. Beware using multiple travel services. Stick to one airline, one rental car company, and one hotel chain. This way when you are not working, you may be able to use the points earned during your work days for future vacations.

5. Beware companies that are not organized. If you find that a locum tenens company is asking you to do all of the paperwork to get credentialed, move on. This can be a red flag and may mean they lack credentialing staff. You should never have to fill out your own paperwork; rather you should be the one that simply reviews and corrects it.

Dr. Arora works as a liaison between hospitals, physicians, and locum tenens companies and is a member of The Hospitalist's editorial advisory board. She negotiates rates and expectations with multiple locum tenens companies on behalf of physicians in all fields of practice and does not own or endorse a locum tenens company. You can contact her at www.doctorsliaison.com.



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Trump, not health care, likely focus of midterms

Provider community must be “creative and participative” in improving care delivery

By Kelly April Tyrrell

Come November 2018, Americans will return to the polls to vote for their representatives in Congress, for governors, and for state legislative seats.

Health care has been a topic of debate since the 2016 elections brought a Republican sweep to the executive and legislative branches, but other issues have since moved to the forefront. Will the midterm elections this year prove health care to be a significant issue at the polls?

Unlikely, said Robert Berenson, MD, FACP, Institute Fellow of the Health Policy Center at the Urban Institute. More likely, the election will be a referendum on President Trump, he said. “Things are so partisan right now and it’s all about Trump. I don’t see serious discussion about health policy.”



Dr. Berenson

Ron Greeno, MD, MHM, FCCP, immediate past president of SHM and former chair of the Public Policy Committee, also doesn’t see health care rising to the top of election year issues. But that doesn’t mean health care doesn’t matter to American voters.

“Whether Democrats control the House or Republicans control the House won’t likely make a big difference in terms of impact on the things we care about,” said Dr. Greeno. “The issues they debate in Washington are not going to save the health care system. They are just debating about who is going to pay for what and for whom. To save our health care system, we have to lower the cost of care and only providers can do that.”

What the government can do, he said, is create the right incentives for providers to move away from fee for service and participate in new models that may lower the cost of care. At the same time, “the economy also has to grow at a robust pace, which will make a huge difference. So, recent increases in economic growth rate are welcomed,” said Dr. Greeno.

In 2015, Republicans and Democrats came together to pass bipartisan legislation aimed at moving the health care system away from fee for service: the Medicare and CHIP Reauthorization Act, or MACRA.

However, the law has not been without frustrations, and these concerns will likely not be part of any candidate campaigns in 2018, Dr. Greeno predicted: “There’s not a lot of appetite to reopen the statute (more than) 2 years after it passed.”

MACRA provides clinicians two pathways to reimbursement. The first track, called MIPS (Merit-Based Incentive Payment System), bases a portion of physician reimbursement on scores measured across several categories, including cost and quality. It still operates largely under a fee-for-service framework but is meant to be budget neutral; for every winner there is a loser.

The second track, called the APMs (Alternative Payment Models), requires physicians to take on

substantial risk (with potential for reward), if they can achieve specific patient volumes under approved models. However, few providers qualify, especially among hospitalists, though the structure of the program makes it clear that the Centers for Medicare & Medicaid Services intends to have most providers ultimately transition to APMs.

“There’s growing recognition that MACRA, at least the MIPS portion, was a big mistake but Congress can’t go back and say we blew it,” Dr. Berenson said. “CMS has now exempted some-



Dr. Greeno

where between 550,000 and 900,000 clinicians from MACRA,” because they cannot meet the requirements of either pathway without significant hardship.¹

CMS wasn’t considering hospitalists specifically when implementing the law, though hospitalists admit half of the Medicare patients in the Unit-

ed States, Dr. Greeno said. There are very few hospitalists currently participating in Advanced APMs and those that are do not see the volume of patients the pathway requires.

“What hospitalists do is very conducive to alternative payment models, and we can help those alternative payment models drive improved quality and lowered costs,” said Dr. Greeno. “Hospitals use hospitalists to help them manage risk, so it’s frustrating that most hospitalists will not meet the thresholds for the APM track and benefit from the incentives created.”

However, the Society of Hospital Medicine continues to work on behalf of hospitalists. Thanks to its efforts, Dr. Greeno explained, CMS is planning in 2019 to allow hospitalists to choose to be scored under MIPS based on their hospital’s performance across reporting categories. Or, they can choose to report on their own and opt out of this new “facility-based” option.

“We are working with [CMS] to figure out how to make this new option work,” said Dr. Greeno.

At the state level, 36 governorships are up for grabs and those outcomes could influence the direction of Medicaid. In Kentucky, the Trump administration approved a waiver allowing the state to enforce work requirements for Medicaid recipients. However, on June 29, 2018, the D.C. federal district court invalidated the Kentucky HEALTH waiver approval (with the exception of Kentucky’s IMD SUD [institutions for mental disease for substance use disorders] payment waiver authority) and sent it back to the Department of Health & Human Services to reconsider. Ten other states as of August 2018 had applied for similar waivers.² However, Dr. Berenson believes that most of what could happen to Medicaid will be a topic after the midterm elections and not before.

He also believes drug prices could become an issue in national elections, though there will not be an easy solution from either side. “Democrats will be reluctant to say they’re going to negotiate drug

prices; they’re going to want the government to negotiate for Medicare-like pricing.” Republicans, on the other hand, will be reluctant to consider government regulation.

As a general principle leading into the midterms: “Democrats want to avoid an internal war about whether they are for Medicare for all or single payer or not,” Dr. Berenson said. “What I’m hoping doesn’t happen is that it becomes a litmus test for purity where you have to be for single payer. I think would be huge mistake because it’s not realistic that it would ever get there.”

However, he cites an idea from left-leaning Princeton University’s Paul Starr, a professor of sociology and public affairs, that Democrats could consider: so-called Midlife Medicare, an option that could be made available to Americans beginning at age 50 years.³ It would represent a new Medicare option, funded by general revenues and premiums, available to people age 50 years and older and those younger than 65 years who are without employer-sponsored health insurance.

Regardless, as the United States catapults toward another election that could disrupt the political system or maintain the relative status quo, Dr. Greeno said hospitalists continue to play key roles in improving American health care.

“There are programs in place where we can get the job done if we in the provider community are creative and participative,” he said. “Some of the most important work being done is coming out of the CMS Innovation Center. Hospitalists continue to be a big part of that, but we knew it would take

“Some of the most important work being done is coming out of the CMS Innovation Center. Hospitalists continue to be a big part of that, but we knew it would take decades of really hard work and I don’t see anything happening in the midterms to derail this.”

decades of really hard work and I don’t see anything happening in the midterms to derail this or bring about a massive increase in the pace of change.”

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NP and PA roles

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MARTINPRESCOTT/GETTY IMAGES

physiology and the mechanisms of action of drugs. And because of her paramedic experience, she should be comfortable with making urgent clinical care decisions and should be proficient with electrocardiograms, as well as chest and abdominal x-rays.

But compared with a newly graduated NP with registered nurse (RN) floor experience, the PA is likely to be less familiar with hospital mechanics and systems, with leading goal of care discussions with patients and families, and with understanding nuances involved with transitions of care.

The subtle differences between NPs and PAs don't end there. Because of the progressive policies and recently updated bylaws at the Kentucky hospital where the PA was hired, this health care professional can see patients and write notes independently without a physician signature. But because she practices in Kentucky, she is not allowed to prescribe Schedule II medications, per state law.

"This example demonstrates how nuanced and multi-layered the process of integrating NPs and PAs into hospitalist groups can be," Mr. Shabani said.

Managing goals, roles, and expectations

Physician assistants and nurse practitioners have reported that their job descriptions, and the variety of roles they can play within hospital medicine teams, are becoming better understood by hospitalist physicians and administrators. However, they also have acknowledged that both PAs and NPs are still underutilized.

Tricia Marriott, Mr. Shabani, PA-C, MPAS, an orthopedic service line administrator at Saint Mary's Hospital in Waterbury, Conn., and an expert in NP and PA policy, has noticed growing enlightenment about PAs and NPs in her travels to conferences in recent years.

"I'm no longer explaining what a PA is and what an NP is, and the questions have become very sophisticated," she said at HM18. "However, I spent a few days in the exhibit hall, and some of the conversations I

had with physicians are interesting in that the practice and utilization styles have not become sophisticated. So I think there is a lot of opportunity out there."

Mr. Shabani said the hospitalist care provided by PAs and NPs sits "at the intersection" of state regulations, hospital bylaws, department utilization, and – of course – clinical experience and formal medical education.

"What this boils down to is first understanding these factors, followed by strategizing recruitment and training as a response," he said.

Tracy Cardin, ACNP-BC, SFHM, associate director of clinical integration at Adfinitas Health in Hanover, Md., and a Society of Hospital Medicine board member, said that, even though she usually sees and hears about a 10%-15% productivity gap between physicians and PAs or NPs, there is no good reason that an experienced

PA or NP should not be able to handle the same patient load as a physician hospitalist – if that's the goal.

"Part of it is about communication of expectation," she said, noting that organizations must provide the training to allow NPs and PAs to reach prescribed goals along with an adequate level of administrative support. "I think we shouldn't accept those gaps in productivity."

Nicolas Houghton, DNP, MBA, ACNP-BC, CFRN, nurse practitioner/physician assistant manager at the Cleveland Clinic, thinks that it is completely reasonable for health care organizations to have an expectation that, at the 3- to 5-year mark, NPs and PAs "are really going to be functioning at very high levels that may be nearly indistinguishable."

Dr. Houghton and Mr. Shabani agreed that, while they had considerably different duties at the start of their careers, they now have clinical roles which mirror one another.

For example, they agreed on these basics: NPs must be a certified RN, while a PA can have any undergraduate degree with certain

Continued on following page



Mr. Shabani



Ms. Cardin

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Continued from previous page

prerequisite courses such as biology and chemistry. All PAs are trained in general medicine, while NPs specialize in areas such as acute care, family medicine, geriatrics, and women's health. NPs need 500 didactic hours and 500-700 clinical hours in their area of expertise, while physician assistants need 1,000 didactic and 2,000 clinical hours spread over many disciplines.

For NP's, required clinical rotations depend on the specialty, while all PAs need to complete rotations in inpatient medicine, emergency medicine, primary care, surgery, psychiatry, pediatrics, and ob.gyn. Also, NPs can practice independently in 23 states and the District of Columbia, while PAs must have a supervising physician. About 10% of NPs work in hospital settings, and about 39% of PAs work in hospital settings, they said.

Dr. Houghton and Mr. Shabani emphasized that Medicare does recognize NP and PA services as physician services. The official language, in place since 1998, is that their services "are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy."

Mr. Shabani said this remained a very relevant issue. "I can't overstate how important this is," he said.

Debunking myths

Several myths continue to persist about PAs and NPs, Ms. Marriott said. Some administrators and physicians believe that they can't see new patients, that a physician must see every patient, that a physician cosignature means that a claim can be submitted under the physician's name, that reimbursement for services provided by PAs and NPs "leaves 15% on the table," and that patients won't be happy being seen by a PA or an NP. All of those things are false, she said.

"We really need to improve people's understanding in a lot of different places – it's not just at the clinician level," she said. "It goes all the way through the operations team, and the operations team has some very old-fashioned thinking about what PAs and NPs really are, which is – they believe – clinical support staff."

But she suggested that the phrase "working at the top of one's license" can be used too freely – individual experience and ability will encompass a range of practices, she said.

"I'm licensed to drive a car," she said. "But you do not want me in the Daytona 500. I am not capable of driving a race car."

She cautioned that nurse prac-

Onboarding NPs and PAs

According to SHM's Nurse Practitioner/Physician Assistant Committee, the integration of a new NP or PA hire, whether experienced or not, requires up-front organization and planning for the employee as he or she enters into a new practice.

To that end, the NP/PA Committee created a toolkit to aid health care organizations in their integration of NP and PA staffers into hospital medicine practice groups. The document includes resources for recruiting and interviewing NPs and PAs, information about orientation and onboarding, detailed descriptions of models of care to aid in the utilization of NPs and PAs, best practices for staff retention, insights on billing and reimbursement, and ideas for program evaluation.

Readers can download the Onboarding Toolkit in PDF format at shm.hospitalmedicine.org/acton/attachment/25526/f-040f/1/-/-/-/SHM_NPPA_OboardingToolkit.pdf.

itioner care must still involve an element of collaboration, according to the Medicaid benefit policy manual, even if they work in states that allow NPs to provide "independent" care. They must have documentation "indicating the relationships that they have with physicians to deal with issues outside their scope of practice," the manual says.

"Don't ask me how people prove it," Ms. Marriott said. "Just know that, if someone were to audit you, then you would need to show what this looks like."

Regarding the 15% myth, she showed a calculation: Data from the Medical Group Management Association reveal that median annual compensation for a physician is \$134 an hour while median compensation is approximately \$52 an hour for a PA or NP. An admission history and physical that takes an hour can be reimbursed at \$102 for a physician and at 85% of that – \$87 – for a PA or NP. That leaves a deficit of \$32 for the physician and a surplus of \$35 for the PA or NP.

"If you properly deploy your PAs and NPs, you're going to generate positive margins," Ms. Marriott said.

Physicians often scurry about seeing all the patients that have already been seen by a PA, she said, because they think they must capture the extra 15% reimbursement. But that is unnecessary, she said.

"Go do another admission. You should see patients because of their clinical condition. My point is not that you go running around because you want to capture the extra 15% – because that provides no additional medically necessary care."

Changing practice

Many institutions continue to be hamstrung by their own bylaws in the use of NPs and PAs. It's true that a physician doesn't have to see every patient, unless it's required in a hospital's rules, Ms. Marriott noted.

"Somebody step up, get on the bylaws committee, and say, 'Let's update these,'" she said.

As for patient satisfaction, access and convenience routinely rank higher on the patient priority lists than provider credentials. "The patient wants to get off the gurney in the ED and get to a room," she said.

But changing hospital bylaws and practices is also about the responsible use of health care dollars, Ms. Marriott affirmed.

"More patients seen in a timely fashion, and quality metrics improvement: Those are all things that are really, really important," she said. "As a result, [if bylaws and practice patterns are changed] the physicians are hopefully going to be happier, certainly the administration is going to be happier, and the patients are going to fare better."

Scott Faust, MS, APRN, CNP, an acute care nurse practitioner at Health Partners in St. Paul, Minn., said that teamwork without egos is crucial to success for all providers on the hospital medicine team, especially at busier moments.

"Nobody wants to be in this alone," he said. "I think the hospitalist teams that work well are the ones that check their titles at the door."

PAs and NPs generally agree that, as long as all clinical staffers are working within their areas of skill without being overly concerned about specific titles and roles, hospitals and patients will benefit.

"I've had physicians at my organization say 'We need to have an NP and PA set of educational requirements,' and I said, 'We have some already for physicians, right? Why aren't we using that?'" Dr. Houghton said. "I think we should have the same expectations clinically. At the end of the day, the patient deserves the same outcomes and the same care, whether they're being cared for by a physician, an NP, or a PA."

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Does nurse-physician rounding matter?

Advancing the Quadruple Aim

By **Andres Laufer, MD, and Venkat Prasad, MD**

Inadequate and fragmented communication between physicians and nurses can lead to unwelcome events for the hospitalized patient and clinicians. Missing orders, medication errors, patient misidentification, and lack of physician awareness of significant changes in patient status are just some examples of how deficits in formal communication can affect health outcomes during acute stays.

A 2000 Institute of Medicine report showed that bad systems, not bad people, account for the majority of errors and injuries caused by complexity, professional fragmentation, and barriers in communication. Their recommendation was to train physicians, nurses, and other professionals in teamwork. However, there are significant differences in how physicians and nurses perceive collaboration and communication.

Nurse-physician rounding was historically standard for patient care during hospitalization. When physicians split time between inpatient and outpatient care, nurses had to maximize their time to collaborate and communicate with physicians whenever the physicians left their outpatient offices to come and round on their patients. Today most inpatient care is delivered by hospitalists on a 24-hour basis. This continuous availability of physicians reduces the perceived need to have joint rounds.

However, health care teams in acute care facilities now face higher and sicker patient volumes, different productivity models and demands, new compliance standards, changes to work flows, and increased complexity of treatment and management of patients. This has led to gaps in timely communication and partnership. Erosion of the traditional nurse-physician relationships affects the quality of patient care, the patient's experience, and patient safety. Poor communication among health care team members is one of the most com-



Dr. Laufer

mon causes of patient care errors. Poor nurse-physician communication can also lead to medical errors, poor outcomes caused by lack of coordination within the treatment team, increased use of unnecessary resources with inefficiency, and increases in the complexity of communication among team members, and time wastage. All these lead to poor work flows and directly affect patient safety.

At Lee Health System in Lee County, Fla., we saw an opportunity in this changing health care environment to promote nurse-physician rounding. We created a structured, standardized process for morning rounding and engaged unit clerks, nursing leadership, and hospitalist service line leaders. We envisioned improvement of the patient experience, nurse-physician relationship, quality of care, the discharge planning process, and efficiency, as well as decreasing length of stay, improving communication, and bringing the patient and the treatment team closer.

Some data suggest that patient-centered bedside rounds on hospitalized patients have no effect on patient perceptions or their satisfaction with care. However, we felt that collaboration among a multidisciplinary team would help us achieve better outcomes. For example, our patients would perceive the care team (MD-RN) as a cohesive unit, and in turn gain trust in the members of the treatment team. Our vision was to empower nurses to be advocates for patients and their family members as they navigated their acute care admission. Nurses could also support physicians by communicating the physicians' care plans to families and patients. After rounding with the physician, the nurse would be part of the decision-making process and care planning.

Every rounding session had discharge planning and hospital stay expectations that were shared with the patient and nurse, who could then partner with case managers and social workers, which



Dr. Prasad

would streamline and reduce length of stay. We hoped rounding would also decrease the number of nurse pages to clarify or question orders. This would, in turn, improve daily work flow for the physicians and the nursing team with improvements in employee satisfaction scores. A study also has demonstrated a reduction in readmission rates from nurse-physician rounding.

A disconnect in communication and trust between physicians and the nursing staff was reflected in low patient experience scores and perceived quality of care received during in-hospital stay. Research has demonstrated how a lack of communication and poor team dynamics can translate to poor patient experience and be a major cause for sentinel events. Artificial, forced hierarchies and role perception among health care team members led to

frustration, hostility, and distrust, which compromises quality and patient safety.

One of our biggest challenges when we started this project was explaining the "Why" to the hospitalist group and nursing staff. Physicians were used to being the dominant partner in the team. Partnering with and engaging nurses in shared decision making and care planning was a seismic shift in culture and work flow within the care team. Early gains helped skeptical team members begin to understand the value in nurse-physician rounding. Near universal adoption of the rounding process at Lee Health has caused improvements in the working relationship and trust among the health care professionals. We have seen improvements in utilization management, as well as appropriateness and timeliness of resource use,

Continued on following page

Job Instruction Breakdown Sheet		
JOB INSTRUCTION BREAKDOWN SHEET		
No. 63	Operation: MD RN Rounding - Physician Responsibility	
	Parts:	
	Tools and Materials: Communication Board, Dry Erase Marker	
	Date: 15-Dec-16	
What	How	Why
Important Steps	Key Points	Reasons
A logical segment of the operation when something happens to advance the work.	Anything in a step that might: 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. "knack", "trick", special timing or information	Reasons for the key points
1. Unit Arrival	1. Notify Nurse or Charge ready to round	1. Round Together
2. Nurse meets Physician	1. At Patient's Bedside 2. Physician/Nurse Present	1. See Patient as Care Team
3. Introduction	1. Introduces him/herself	1. Patient to know who is in room
4. Check Communication Board	1. Nurse to update board with Care Teams' names if not already done	1. Visual Reminder of Care Team
5. Rounds	1. Physician leads rounds 2. Nurse listens and participates 3. Ensures Doc Talk questions are reviewed.	1. Physician/Nurse present as a professional cohesive team.
6. Nurse will summarize information with Patient and Physician using PATIENT acronym	1. Nurse summarizes PATIENT acronym: P: Plan of Care A: Anticipated discharge date/transfer T: Tests/diagnostic results I: Issues, concerns identified by patient E: Explanation of meds/diagnosis/progress N: Nurse feedback assessment/pain control T: Thank patient, encourage patient to use the "DOC Talk" tool.	1. Patient/Family are receiving up-to-date information and kept informed of Plan of Care 2. Improves Communication 3. Decreases unnecessary calls/pages to Physicians 4. Ensures all key components are addressed.
7. Physician Order Entry	1. Update EPIC with any order changes.	1. Updated orders have been placed in EPIC as soon as possible.
8. Rounds Completed	1. Leave Room 2. Doc Talk available.	1. Patient/Family have tools to capture future questions.
Med Surg 63		Date Created: 12/15/16 KD & SG

Continued from previous page

because of better communication and understanding of care plans by nursing and physicians. Collaboration with specialists and alignment in care planning are other gains. Hospitalists and nurses are both very satisfied with the decrease in the number of pages during the day, and this has lowered stressors on health care teams.

How we did it

Nurse-physician rounding is a proven method to improve collaboration, communication, and relationships among health care team members in acute care facilities. In the complex health care challenges faced today, this improved work flow for taking care of patients can help advance the Quadruple Aim of high quality, low cost, improved patient experience, physician, and staff satisfaction.

Lee Health System includes four facilities in Lee County, with a total of 1,216 licensed adult acute care beds. The pilot project began in 2014.

Initially the vice president of nursing and the hospitalist medical director met to create an education plan for nurses and physicians. We chose one adult medicine unit to pilot the project because there al-

ready existed a closely knit nursing and hospitalist team. In our facility there is no strict geographical rounding; each hospitalist carries between three and six patients in the unit. As a first step, a nurse floor assignment sheet was faxed in the morning to the hospitalist office with the direct phone numbers of the nurses. The unit clerk, using physician assignments in the EHR, teamed up the physician and nurses for rounding. Once the physician arrived at the unit, he or she checked in with the unit clerk, who alerted nurses that the hospitalist was available on the floor to commence rounding. If the primary nurse was unavailable because of other duties or breaks, the charge nurse rounded with the physician.

Once in the room with the patient, the duo introduced themselves as members of the treatment team and acknowledged the patient's needs. During the visit, care plans and treatment were reviewed, the patient's questions were answered, a physical exam was completed, and lab and imaging results were discussed; the nurse also helped raise questions he or she had received from family members so answers could be communicated to the fam-

ily later. Patients appreciated knowing that their physicians and nurses were working together as a team for their safety and recovery. During the visit, care was taken to focus specially on the course of hospitalization and discharge planning.

We tracked the rounding with a manual paper process maintained by the charge nurse. Our initial rounding rates were 30%-40%, and we continued to promote this initiative to the team, and eventually the importance and value of these rounds caught on with both nurses and physicians, and now our current average rounding rate is 90%. We then decided to scale this to all units in the hospital.

This process was repeated at other hospitals in the system once a standardized work flow was created (see Instruction Sheet page 13). This initiative was next presented to the health system board of directors, who agreed that nurse-physician rounding should be the standard of care across our health system. Through partnership and collaboration with the IT department, we developed a tool to track nurse-physician rounding through our EHR system, which gave accountability to both physicians and nurses.

In conclusion, improved communication by timely nurse-physician rounding can lead to better outcomes for patients, reduce costs, and improve patient and staff experience, advancing the Quadruple Aim. Moving forward to build and sustain this work flow, we plan to continue nurse-physician collaboration across the health system consistently and for all areas of acute care operations.

Explaining the "Why," sharing data on the benefits of the model, and reinforcing documentation of the rounding in our EHR are some steps we have put into action at leadership and staff meetings to sustain the activity. We are soliciting feedback, as well as monitoring and identifying any unaddressed barriers during rounding. Addition of this process measure to our quality improvement bonus opportunity also has helped to sustain performance from our teams.

Dr. Laufer is system medical director of hospital medicine and transitional care at Lee Health in Ft. Myers, Fla. Dr. Prasad is chief medical officer of Lee Physician Group, Ft. Myers. For a complete list of references, see the online version of this article at www.the-hospitalist.org.

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Key Clinical Question

Treating cannabinoid hyperemesis syndrome

Incidence may increase as marijuana use rises

By Manisha Gupta, MD

Clinical Case

WS is a 54-year-old African American male with a medical history of diabetes mellitus type 2, hypertension, obstructive sleep apnea, and gastroparesis. He has multiple admissions for intractable nausea, vomiting, and abdominal pain believed to be from diabetic gastroparesis despite a normal gastric-emptying study. Endoscopy done in prior admission showed duodenitis, gastritis, and esophagitis, and colonoscopy revealed diverticulosis. He had a negative gastric-emptying study of 6% retention at 4 hours. His last hemoglobin A_{1c} was 5 and his glucose has been well controlled. He is hospitalized again for intractable abdominal pain, nausea, and vomiting. His examination was unremarkable except for dry mucosa and epigastric tenderness. His labs were also insignificant except for prerenal azotemia. Upon further questioning he admitted to significant marijuana use, and his symptoms transiently improved with a hot shower in the hospital. He was diagnosed with cannabinoid hyperemesis syndrome (CHS) and admitted for further management.



Background

In the United States, 9 states and the District of Columbia have legalized recreational marijuana use, and 29 states and DC have legalized medical marijuana. Marijuana use is likely to rise, and with it may arise an increasing incidence of CHS.

The exact prevalence of CHS is not known. Diagnosis is often delayed as there is no reliable diagnostic test. A high index of suspicion is needed for prompt diagnosis.

CHS was first described in 2004

in South Australia and since then many case reports have been published. Marijuana has both proemetic and antiemetic effects. Unlike its antiemetic effect, the pathophysiology of the proemetic effect of marijuana is not well understood.

Key clinical features

CHS typically has three phases. Initially patients present with prodromal symptoms of abdominal discomfort and nausea. There is no emesis at this early phase. Patients

are still able to tolerate a liquid diet in this prodromal phase.

This is followed by a more active phase of intractable vomiting, which is relieved by hot showers or baths. Most patients take compulsively long hot showers or baths many times a day. Also, they develop diaphoresis, restlessness, agitation, and weight loss.

The active phase is followed by a recovery phase when symptoms resolve and patients return to baseline, only to have it recur if marijuana use continues.

Diagnostic approach and management

CHS should be suspected in patients coming in with recurrent symptoms of abdominal pain, nausea, and vomiting, and who have normal CBC, basic metabolic panel, lipase, and liver function tests. Patients should be directly questioned about marijuana use and whether symptoms are relieved with hot showers. A toxicology screen should be done. For patients with marijuana use and compulsive hot showers, further work-up of their symptoms (e.g., upper endoscopy, abdominal ultrasound, and/or nuclear medicine emptying study) should be avoided. Figure 1 shows the suggested work-up.

The differential diagnosis for recurrent abdominal pain, nausea, and vomiting is chronic pancreatitis, gastroparesis, severe gastritis, medica-

tion adverse effects (especially GLP1 receptor agonists), cyclic vomiting syndrome, psychogenic vomiting, and (with the rise of narcotic abuse) narcotic bowel syndrome.

Our patient had a history of diabetes with an HbA_{1c} at goal and a normal nuclear medicine gastric-emptying study (6% retention at 4 hours). He was also on liraglutide, but his symptoms predated this medicine use.

The mainstay of treatment for CHS is supportive therapy with intravenous fluids and antiemetics like 5-HT₃-receptor antagonists (ondansetron); D₂-receptor antagonists (metoclopramide); and H₁-receptor antagonists (diphenhydramine). The effectiveness of these agents is limited, which is also a clue for the diagnosis of CHS. If traditional agents fail in controlling the symptoms, haloperidol can be tried, but



Dr. Gupta

it has been used with limited success. Our patient did not respond to traditional antiemetics, but responded well to a small dose of lorazepam. Even though a benzodiazepine is not

the mainstay of treatment, it may be tried if other agents fail. Acid-suppression therapy with a proton pump inhibitor should be used as esophagogastroduodenoscopy usually reveals mild gastritis and esophagitis, as in our patient. Narcotic use should be avoided for management of abdominal pain.

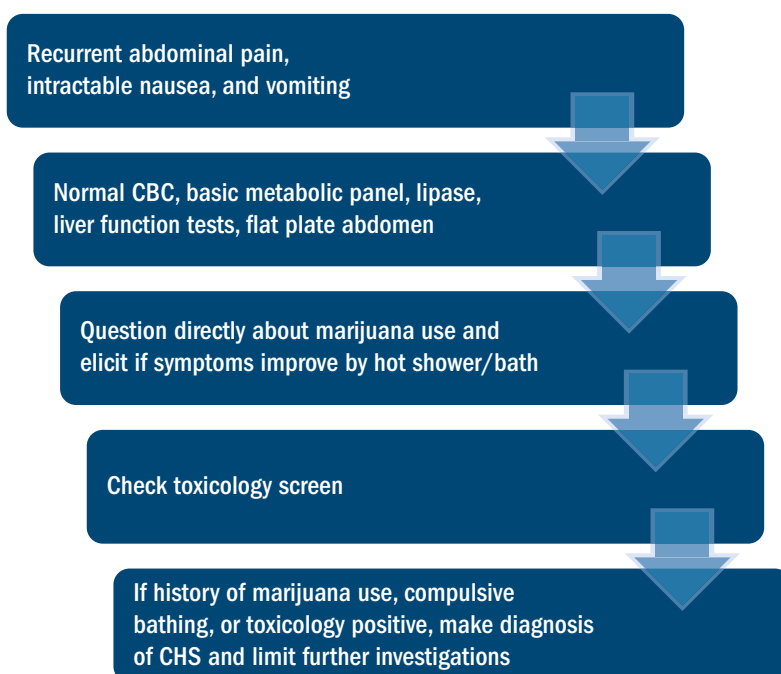
Patients should be counseled against marijuana use. This may be difficult if marijuana is being used as an appetite stimulant or for treatment of chemotherapy-induced nausea and vomiting. If willing, patients should be referred to a substance abuse rehabilitation center.

Back to the case

In this case, after a diagnosis of CHS was made, the patient was counseled against marijuana use. His abdominal pain and intractable vomiting did not improve with

Continued on page 18

Figure 1. Diagnostic work-up in patients suspected to have CHS



MDEEDE NEWS

A professional portrait of Dolly Abraham, a woman with shoulder-length brown hair, smiling. She is wearing a light pink pleated top under a cardigan with a pink, white, and beige chevron pattern. She has a silver necklace, a watch on her left wrist, and a ring on her left hand. Her right hand is on her hip. The background is a solid light blue.

Dolly Abraham

DOLLY ABRAHAM, MD, MBA, SFHM
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Asthma medication ratio identifies high-risk pediatric patients

By M. Alexander Otto

MDedge News

REPORTING FROM PHM 2018 / ATLANTA / An asthma medication ratio below 0.5 nearly doubles the risk of children ending up in the hospital with an acute asthma exacerbation, according to researchers from the Medical University of South Carolina (MUSC), Charleston.

The asthma medication ratio (AMR) – the number of prescriptions for controller medications divided by the number of prescriptions for both controller and rescue medications – has been around for a while, but it's mostly been used as a quality metric. The new study shows that it's also useful in the clinic to identify children who could benefit from extra attention.

A perfect ratio of 1 means that control is good without rescue inhalers. The ratio falls as the number of rescue inhalers goes up, signaling poorer control. Children with a ratio below 0.5 are considered high risk; they'd hit that mark if, for instance, they were prescribed one control medication such as fluticasone propionate (Flovent) and two albuterol rescue inhalers in a month.

If control is good, "you should only need a rescue inhaler very, very sporadically"; high-risk children probably need a higher dose of their controller, or help with compliance, explained lead investigator Annie L. Andrews, MD, associate professor of pediatrics at MUSC.

The university uses the EPIC records system, which incorporates prescription data from SureScripts, so the number of asthma medication fills is already available. The system just needs to be adjusted to calculate and report AMRs monthly, something Dr. Andrews and her team are working on. "The information is right there, but it's an untapped resource," she said. "We just need to crunch the numbers, and operationalize it. Why



Dr. Annie L. Andrews, associate professor of pediatrics at the Medical University of South Carolina

are we waiting until kids are in the hospital" to intervene?

Dr. Andrews presented a proof-of-concept study at the Pediatric Hospital Medicine meeting. Her team identified 214,452 asthma patients aged 2-17 years with at least one claim for an inhaled corticosteroid in the Truven MarketScan Medicaid database from 2013 to 2014.

They calculated AMRs for each child every 3 months over a 15-month period. About 9% of children at any given time had AMRs below 0.5.

The first AMR was at or above 0.5 in 93,512 children; 18.1% had a subsequent asthma-related event, meaning an ED visit or hospitalization, during the course of the study. Among the 17,635 children with an initial AMR below 0.5, 25% had asthma-related events. The initial AMR couldn't be calculated in 103,305 children, which likely

meant they had less-active disease. Those children had the lowest proportion of asthma events, at 13.9%.

An AMR below 0.5 nearly doubled the risk of an asthma-related hospitalization or ED visit in the subsequent 3 months, with an odds ratios ranging from 1.7 to 1.9, compared with other children. The findings were statistically significant.

In short, serial AMRs helped predict exacerbations among Medicaid children. The team showed the same trend among commercially insured children in a recently published study. The only difference was that Medicaid children had a higher proportion of high-risk AMRs, and a higher number of asthma events (Am J Manag Care. 2018 Jun;24[6]:294-300). Together, the studies validate "the rolling 3-month AMR as an appropriate method for identifying children at high risk for imminent exacerbation," the investigators concluded.

With automatic AMR reporting already in the works at MUSC, "we are now trying to figure out how to intervene. Do we just tell providers who their high-risk kids are and let them figure out how to contact families, or do we use this information to contact families directly? That's kind of what I favor: 'Hey, your kid just popped up as high risk, so let's figure out what you need. Do you need a new prescription or a reminder to see your doctor?'" Dr. Andrews said.

Her team is developing a mobile app to communicate with families.

The mean age in the study was 7.9 years; 59% of the children were boys, and 41% were black.

The work was funded by the National Institutes of Health, among others. Dr. Andrews had no disclosures. The meeting was sponsored by the Society of Hospital Medicine, the American Academy of Pediatrics, and the Academic Pediatric Association.

Continued from page 15

conservative management of n.p.o status, prochlorperazine, metoclopramide, and ondansetron. He was given a trial of low-dose lorazepam with significant improvement in his symptoms. He was counseled extensively against marijuana use and discharged. A follow-up phone call at 3 months showed continued abstinence and no recurrence of symptoms.

Dr. Gupta is a hospitalist at Yale New Haven (Conn.) Health and Bridgeport Hospital.

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Key Points

- Suspect CHS for patients with recurrent abdominal pain, nausea, and vomiting with negative initial work-up.
- Ask directly about marijuana use.
- Ask whether symptoms are relieved with hot shower/ bath.
- Send a toxicology screen.
- Make a diagnosis of CHS if:
 1. Positive marijuana use.
 2. Symptom improvement with hot baths or
 3. Toxicology positive for marijuana.
- Manage conservatively with hydration and antiemetics.
- Suspect CHS if traditional antiemetics are not providing relief .
- If traditional antiemetics fail, make a trial of haloperidol or low-dose benzodiazepines.
- Avoid narcotics.
- Avoid unnecessary investigations.
- Counsel patients against marijuana use and refer to substance abuse center if patient agrees.

In the Literature

Clinician reviews of HM-centric research

By Tyler Anstett, DO; Alexander Abramowicz, MD; Robert Metter, MD; Reem Hanna, MD; ASM Iftiar Chowdury, MD; Roxana Naderi, MD; Sarah Jenkins Scarpato, MD; Daniel Vela-Duarte, MD

Division of Hospital Medicine, University of Colorado School of Medicine, Denver.

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By Alexander Abramowicz, MD

1 BNP levels and mortality in patients with and without heart failure

CLINICAL QUESTION: Does B-type natriuretic peptide (BNP) have prognostic value outside of heart failure (HF) patients?

BACKGROUND: BNP levels are influenced by both cardiac and extracardiac stimuli and thus might have prognostic value outside of the traditional use to guide therapy for HF patients.

STUDY DESIGN:

Retrospective cohort study of the Vanderbilt electronic health record.

SETTING: Vanderbilt University Medical Center, Nashville, Tenn.

SYNOPSIS: The study evaluated 30,487 patients with at least two BNP values for 2002-2015. Within this cohort, 62% of patients did not have a HF diagnosis. Risk of death was elevated in all patients regardless of HF status as BNP values rose. An increase from the 25th to 75th percentile in BNP value was associated with an increased risk of death in non-HF patients (hazard ratio, 2.08; 95% confidence interval, 1.99-2.2). Additionally, in a multivariate analysis BNP was the strongest predictor of death, compared with traditional risk factors in both HF and non-HF patients. The main limitation to this study was the use of ICD codes for diagnosis of HF.



Dr. Abramowicz

BOTTOM LINE: BNP has predictive value for risk of death in non-HF patients; as BNP levels rise, regardless of HF status, so does risk of death.

CITATION: York MK et al. B-type natriuretic peptide levels and mortality in patients with and without heart failure. *J Am Coll Cardiol.* 2018; May 15;71(19):2079-88.

2 Surgical repair of hip fractures in nursing home patients

CLINICAL QUESTION: Does surgical repair of hip fractures in nursing home residents with advanced dementia reduce adverse outcomes?

BACKGROUND: Hip fractures are common in the advanced dementia nursing home population. The benefit of surgical repair is unclear in this population given significant baseline functional disability and limited life expectancy.

STUDY DESIGN: Retrospective cohort study.

SETTING: Medicare claims data set.

SYNOPSIS: Among 3,083 nursing home residents with advanced dementia and hip fracture, nearly 85% underwent surgical repair. The 30-day mortality rate in the nonsurgical group was 30.6%, compared with 11.5% in the surgical group. In an adjusted model, the surgical group had decreased risk of death, compared with the nonsurgical group (hazard ratio, 0.88; 95% confidence interval, 0.79-0.98). In additional adjusted models, surgical patients also had decreased risk of pressure ulcers (HR 0.64; 95% CI, 0.47-0.86) and less pain (HR, 0.78; 95% CI, 0.61-0.99). Limitations included the observational

nature of the study. Although the models were adjusted, unmeasured confounding may have contributed to the findings.

BOTTOM LINE: Surgical repair of hip fractures in nursing home patients with advanced dementia reduces post-fracture mortality, pain, and pressure ulcer risk.

CITATION: Berry SD et al. Association of clinical outcomes with surgical repair of hip fracture vs. nonsurgical management in nursing home residents with advanced dementia. *JAMA Intern Med.* 2018;178(6):774-80.

Dr. Abramowicz is an assistant professor in the division of hospital medicine, University of Colorado, Denver.

By Robert Metter, MD

3 Liberal oxygen therapy associated with increased mortality

CLINICAL QUESTION: What is the efficacy and safety of liberal versus conservative oxygen therapy in acutely ill adults?

BACKGROUND: An increasing body of literature suggests that hyperoxia may be harmful, yet liberal use of supplemental oxygen remains widespread.

STUDY DESIGN: Systematic review and meta-analysis.

SETTING: Acutely ill hospitalized adults.

SYNOPSIS: The authors performed a meta-analysis of 25 randomized controlled trials of oxygen therapy in acutely ill adults, encompassing 16,037 patients comparing liberal oxygen strategy (median fraction of inspired oxygen, 0.52; interquartile range, 0.39-0.85) to conservative oxygen strategy (median FiO₂, 0.21; IQR, 0.21-0.25). Results showed the liberal oxygen strategy was associated with higher in-hospital (risk ratio, 1.21; 95% confidence interval, 1.03-1.43) and 30-day (RR, 1.14, 95% CI, 1.01-1.28) mortality, without a difference in length of stay or disability.

Much like transfusion thresholds, more may not always be better when it comes to supplemental ox-

ygen. Hospitalists should consider the harmful effects of hyperoxia when caring for patients on supplemental oxygen. Unfortunately, median blood oxygen saturation during therapy was not available for each group in this trial, so more research is needed to clearly define the upper limit of oxygen saturation at which harm outweighs benefit.

BOTTOM LINE: When compared to conservative oxygen administration, liberal oxygen therapy increases mortality in acutely ill adults.

CITATION: Chu DK et al. Mortality and morbidity in acutely ill adults treated with liberal versus conservative oxygen therapy (IOTA): a systematic review and meta-analysis. *Lancet.* 2018;391:1693-705.

Dr. Metter is an assistant professor in the division of hospital medicine, University of Colorado, Denver.

By Reem Hanna, MD

4 Burden of atrial fibrillation associated with stroke risk

CLINICAL QUESTION: In patients with paroxysmal atrial fibrillation (PAF), is the burden of atrial fibrillation associated with increased risk of ischemic stroke?

BACKGROUND: Atrial fibrillation (AF) is a well-known risk factor for ischemic stroke; however, it is unclear if atrial fibrillation burden in patients with PAF is correlated with increased stroke risk.

STUDY DESIGN: Retrospective cohort chart review study during October 2011–October 2016.

SETTING: Outpatients in two Kaiser Permanente California health systems.

SYNOPSIS: Among 1,965 adult patients with PAF not on anticoagulation therapy, PAF burden was defined as the percentage time spent in AF during 14-day ECG monitoring. Outcomes included hospitalization for ischemic stroke or arterial thromboembolism while not taking anticoagulants.

Continued on following page



Dr. Metter



Dr. Hanna

Continued from previous page

Patients in the highest tertile of PAF burden (less than 11%) had 215% higher risk of thromboembolic events, compared with those with lower PAF burden (less than 11%), yielding a hazard ratio of 3.15 (95% confidence interval, 1.51-6.61), even after adjustment.

This study was limited by short ECG monitoring period (14 days), low total number of events (29 total events, 17 in the highest tertile), and no minimum follow-up time. Further, with all patients insured in a single health care system, and excluded on disenrollment from the health plan, selection bias could have affected the results.

BOTTOM LINE: In patients with PAF, a larger AF burden (greater than 11%) is associated with increased risk of ischemic stroke. Assessment of AF burden may help determine the need for anticoagulation for stroke prevention.

CITATION: Go AS et al. Association of burden of atrial fibrillation with risk of ischemic stroke in adults with paroxysmal atrial fibrillation: the KP-RHYTHM study. *JAMA Cardiol.* 2018 Jul 1;3(7):601-8.

Dr. Hanna is an assistant professor in the division of hospital medicine, University of Colorado, Denver.

By ASM Ifthar Chowdury, MD

5 Opiate-prescribing standard decreases opiate use in hospitalized patients

CLINICAL QUESTION: Can an opiate-prescribing standard that favors oral and subcutaneous over intravenous administration reduce exposure to intravenous opiates for hospitalized adults?

BACKGROUND: IV opiates, while effective for analgesia, may have a higher addictive potential because of the rapid and intermittent rises of peak concentrations. Subcutaneous and/or oral administration is a proven method of opioid delivery with similar bioavailability and efficacy of intravenous administration with more favorable pharmacokinetics.

STUDY DESIGN: Intervention-based quality improvement project.

SETTING: Adult general medicine inpatient unit in an urban academic center.

SYNOPSIS: Clinical leadership of the study unit collaborated to create an opiate-prescribing standard recommending oral over parenteral opioids and subcutaneous over IV if parental administration was required. The standard was promoted

and reinforced with prescriber and nurse education, and prescribers were able to order intravenous opiates per usual protocol.

After a 6-month preintervention control period of 4,500 patient-days, the 3-month intervention period included 2,459 patient-days and led to a 84% decrease in IV opiate doses (0.06 vs. 0.39; P less than .001) and a 55% decrease in parenteral doses (0.18 vs. 0.39; P less than .001). Surprisingly there was a 23% decrease in overall doses of opiates (0.73 vs. 0.95; $P = .02$). Pain scores were similar between the two groups during hospital days 1-3 and improved in the intervention group between days 4 and 5.

This study was limited by a narrow focus, unblinded participants, and nursing-reported pain scores. While promising, more information is needed before establishing conclusions on a broader scale.

BOTTOM LINE: Establishing and promoting an opioid prescribing standard on a single unit led to a decrease in intravenous, parenteral, and overall opiates prescribed with similar or improved pain scores.

CITATION: Ackerman AL et al. Association of an opioid standard of practice intervention with intravenous opioid exposure in hospitalized patients. *JAMA Intern Med.* 2018 Jun 1;178(6):759-63.



Dr. Chowdury

6 Patient-centered primed communication and goals-of-care discussions

CLINICAL QUESTION: Can primed communication increase the frequency of goals-of-care conversations in the outpatient setting?

BACKGROUND: Effective outpatient communication helps patients and families with serious illnesses with increased quality of life, improved quality of the dying process, and decreased resource utilization at the end of life.

STUDY DESIGN: Cluster-randomized trial.

SETTING: Multicenter, primary care, and subspecialty clinics for adults in the Pacific Northwest.

SYNOPSIS: Patients with advanced age and/or severe chronic medical conditions were selected to participate. The median survival

Short Takes

Surviving Sepsis Campaign bundles shortened to 1 hour

In response to the 2016 Surviving Sepsis Campaign guidelines, the 3-hour and 6-hour bundles have now been combined and shortened into a 1-hour bundle to emphasize the emergent nature of sepsis. Elements of the bundle remain the same: measuring lactate, obtaining blood cultures, administering broad-spectrum antibiotics, administering 30 mL/kg crystalloid, and using vasopressors when necessary.

CITATION: Levy MM et al. The Surviving Sepsis Campaign bundle: 2018 update. *Crit Care Med.* 2018;46(6):997-1000.

for these patients was 2 years. Clinicians were eligible to participate if they had five or more of the selected patients in their panel.

In the intervention group (57 clinicians and 184 patients), all patients were surveyed to identify preferences, barriers, and facilitators for goals-of-care discussions. These data were compiled into "Jumpstart Tips" and distributed to providers before a visit with a study patient. The control group (57 clinicians and 211 patients) had patients complete these surveys but no information was provided to clinicians.

The "Jumpstart Tips" led to an increase in patient-reported (74% vs. 31%; P less than .001) and EHR-documented (62% vs. 17%; P less than .001) occurrences of goals-of-care discussions. Patients also reported increased quality of these conversations (4.6 vs. 2.1; $P = .01$).

However, no significant improvements were noted in goal-concordant care, depression, or anxiety scores, which may have been because of selection bias and overall difficulty in defining goal-concordant care.

BOTTOM LINE: Patient-centered primed communication can increase the frequency and quality of goals-of-care discussions in the outpatient setting.

CITATION: Curtis JR et al. Effect of a patient and clinician communication-priming intervention on patient-reported goals-of-care discussions between patients with serious illness and clinicians: A randomized clinical trial. *JAMA Intern Med.* 2018 Jul 1;178(7):930-40.

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By Roxana Naderi, MD

7 Resuming DOAC therapy in AF patients after gastrointestinal bleed

CLINICAL QUESTION: For patients who develop a gastrointestinal bleed (GIB) while using direct oral anticoagulant (DOAC) therapy for atrial fibrillation (AF), does the risk of venous thromboembolism (VTE) or recurrent GIB increase after DOAC resumption?

BACKGROUND: DOACs are increasingly used for stroke prophylaxis in nonvalvular AF and can increase the risk of GIB by 30% compared to warfarin. Although warfarin can be safely resumed within 14 days of GIB cessation, outcomes related to resuming DOAC therapy after hospitalization for GIB are lacking.

STUDY DESIGN: Retrospective analysis of claims data.

SETTING: Patients with AF on DOAC therapy admitted for acute GIB in Michigan.

SYNOPSIS: 1,338 adults, median age



Dr. Naderi

79 years, on a DOAC for AF were hospitalized for GIB. After the index hospitalization, patients were followed for resumption of DOAC (defined by new prescription fill), recurrent bleeding, and VTE. 62% of patients resumed DOAC therapy.

Resuming a DOAC within 30 days did not lead to a statistically significant difference in VTE or recurrence of GIB at 90 days or 6 months. However, at 90 days recurrent GIB risk increased with concomitant use of antiplatelet agents (hazard ratio, 3.12; 95% confidence interval, 1.55-5.81; $P = .002$). Rivaroxaban had higher rates of rebleeding events, compared with the other DOACs ($P = .04$). History of VTE increased the risk for postdischarge VTE. Key limitations included lack of cerebrovascular accident rates, exclusion of patients who switched from DOAC to warfarin, and uncertainty surrounding the timing of actual DOAC resumption.

BOTTOM LINE: DOAC resumption within 30 days of GIB did not increase VTE or recurrent GIB, but concurrent antiplatelet agent use increased recurrent GIB rates.

CITATION: Sengupta N et al. Rebleeding vs. thromboembolism after hospitalization for gastrointestinal

bleeding in patients on direct oral anticoagulants. Clin Gastroenterol Hepatol. 2018. doi: 10.1016/j.cgh.2018.05.005.

8 Procalcitonin testing does not decrease antibiotic use for LRTIs

CLINICAL QUESTION: Does testing procalcitonin for lower respiratory tract infections (LRTIs) decrease total antibiotic days without a resultant increase in adverse events?

BACKGROUND: LRTIs are frequently overtreated with antibiotics. Procalcitonin may indicate bacterial infection and promote antibacterial stewardship. Studies to evaluate how testing procalcitonin affects antibiotic use for suspected lower respiratory tract infections are limited.

STUDY DESIGN: Randomized 1:1 intention-to-treat, multicenter trial.

SETTING: 14 U.S. urban academic hospitals.

SYNOPSIS: 1,656 patients across 14 U.S. hospitals were randomized to initial procalcitonin results available prior to clinical decision making versus usual care. All providers were given Food and Drug Administration–approved guidelines to in-

Short Takes

Early ED discharge for PE

This randomized trial showed that low-risk emergency department patients diagnosed with pulmonary embolism who were discharged from the ED with rivaroxaban within 24 hours of presentation had decreased length of stay and nearly \$2,500 in cost savings, compared with patients treated according to standard of care (often including hospitalization) without increased risk of bleeding, recurrent venous thromboembolism, or death.

CITATION: Peacock WF et al. Emergency department discharge of pulmonary embolus patients. Acad Emerg Med. 2018. doi: 10.1111/acem.13451.

terpret procalcitonin results. In the procalcitonin group, procalcitonin levels were followed serially. Within 30 days of the initial encounter, total antibiotic days did not differ significantly between the two groups. Procalcitonin use did not significantly affect adverse outcomes including organ system failure, death,

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Continued from previous page

ICU admission, hospital readmission, or ED visits. A total of 20% of antibiotic prescriptions were written prior to the procalcitonin result. Providers who did not adhere to guidelines either cited a diagnosis of chronic obstructive pulmonary disease or discounted the value of procalcitonin and presumptively diagnosed bacterial infection (40% of cases).

BOTTOM LINE: Procalcitonin testing did not change provider practice patterns for antibiotic prescriptions for LRTIs.

CITATION: Huang DT et al. Procalcitonin-guided use of antibiotics for lower respiratory tract infection. *N Engl J Med.* 2018 Jul 19;379(3):236-49.

Dr. Naderi is assistant professor in the division of hospital medicine, University of Colorado, Denver.

By Sarah Jenkins Scarpato, MD

9 Beware bacteremia suspicious of colon cancer

CLINICAL QUESTION: Is bacteremia from certain microbes associated with colorectal cancer?

BACKGROUND: *Streptococcus bovis* bacteremia is classically associated with colorectal cancer. A number of other bacterial species have been found in colorectal cancer microbiota and may even exert oncogenic effects.

However, it is not known whether bacteremia from these microbes is associated with colorectal cancer.

STUDY DESIGN: Retrospective cohort study.

SETTING: Public hospitals in Hong Kong.

SYNOPSIS: Using the Clinical Data Analysis and Reporting System (representing greater than 90% of inpatient services provided in Hong Kong), researchers identified 15,215 patients with bacteremia from 11 genera of bacteria known to be present in the colorectal cancer microbiota, including *Bacteroides*, *Clostridium*, *Filifactor*, *Fusobacterium*, *Gemella*, *Granulicatella*, *Parvimonas*, *Peptostreptococcus*, *Prevotella*, *Solobacterium*, and *Streptococcus*. Compared with matched controls without bacteremia, a higher proportion of exposed patients had a subsequent diagnosis of colorectal cancer (1.69% vs. 1.16%; hazard ratio, 1.72; 95% confidence interval, 1.40-2.12). Bacteremia with other organisms was not associated with colorectal cancer,



Dr. Scarpato

and bacteremia with the preidentified organisms was not associated with other types of non-colorectal cancer or nonmalignant gastrointestinal diseases, with the exception of a few genera commonly associated with diverticulitis.

Given the observational nature of this study, no causal relationship can be established. It is not clear if these species are involved in the oncogenesis of colorectal cancer or if colorectal tumors merely serve as a site of entry for bacteria into the bloodstream.

BOTTOM LINE: Bacteremia with certain bacterial genera is associated with colon cancer and should prompt consideration of colonoscopy to evaluate for malignancy.

CITATION: Kwong TNY et al. Association between bacteremia from specific microbes and subsequent diagnosis of colorectal cancer. *Gastroenterology* 2018 Aug;155(2):383-90.

Dr. Scarpato is clinical instructor in the division of hospital medicine, University of Colorado, Denver.

By Daniel Vela-Duarte, MD

10 Rivaroxaban for stroke prevention after embolic stroke

CLINICAL QUESTION: Does rivaroxaban prevent recurrent ischemic stroke in patients with embolic stroke from undetermined source?

BACKGROUND: Embolic stroke of undetermined source (ESUS) represents approximately 20% of ischemic strokes. Rivaroxaban inhibits factor Xa and is shown to be effective for secondary stroke prevention in patients with nonvalvular atrial fibrillation. Strategies to prevent cryptogenic stroke caused by mechanisms other than cardioembolic sources are lacking.

STUDY DESIGN: International, double-blind, event-driven, randomized, phase III trial.

SETTING: 459 hospitals in 31 countries, during 2014-2017.

SYNOPSIS: 7,213 patients with ESUS were randomized to receive either 15 mg of rivaroxaban once daily or aspirin 100 mg once daily. The primary outcome was established as the first recurrent stroke of any type or systemic embolism. The primary safety endpoint was major bleeding.

Recurrent stroke was observed in 158 in the rivaroxaban group and



Dr. Vela-Duarte

156 in the aspirin group, mostly ischemic. The trial was terminated early because of a higher incidence of intracranial hemorrhage and major bleeding among patients assigned to rivaroxaban at an annual rate of 1.8%, compared with 0.7% (hazard ratio, 2.72; 95% confidence interval, 1.68-4.39; *P* less than .001). Although the study utilized strict criteria to define ESUS, it is feasible that the lack of benefit may be due to heterogeneous arterial, cardiogenic, and paradoxical emboli with diverse composition and poor response to rivaroxaban.

BOTTOM LINE: Rivaroxaban does not confer protection from recurrent stroke in patients with embolic stroke of unknown origin and increases risk for intracranial hemorrhage and major bleeding.

CITATION: Hart RG et al. Rivaroxaban for stroke prevention after embolic stroke of undetermined source. *N Engl J Med.* 2018;378(23):2191-201.

11 Clopidogrel and aspirin in acute ischemic stroke and high-risk TIA

CLINICAL QUESTION: Is the combination of aspirin and clopidogrel effective in reducing stroke recurrence?

BACKGROUND: The risk of recurrent stroke varies from 3% to 15% in the 3 months after a minor ischemic stroke (NIH Stroke Scale score of 3 or less) or high-risk transient ischemic attack (ABCD2 score of 4 or less). Dual-antiplatelet therapy with aspirin and clopidogrel reduces recurrent coronary syndrome; therefore, this strategy can prevent recurrent stroke.

STUDY DESIGN: Prospective, randomized, double-blind, multicenter, placebo-controlled trial.

SETTING: 269 sites in 10 countries, mostly in the United States, from May 28, 2010, to Dec. 19, 2017.

SYNOPSIS: The POINT (Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke) trial enrolled 4,881 patients older than 18 years of age randomized to a loading dose of 600 mg of clopidogrel followed by 75 mg per day or placebo, and aspirin 162 mg daily for 5 days followed by 81 mg daily. The primary outcome was the risk of major ischemic events, including ischemic stroke, myocardial infarction, or death from ischemic vascular causes. Major ischemic events were observed in 5.0% receiving dual therapy and in 6.5% of those receiving aspirin alone (hazard ratio, 0.75; 95% confidence interval, 0.59-0.95; *P* = .02) with most occurring within a

Short Takes

Outbreak of coagulopathy associated with synthetic cannabinoids

The Centers for Disease Control and Prevention reports a recent outbreak of life-threatening coagulopathy associated with synthetic cannabinoid use, because of contamination with vitamin K antagonist agents. All patients who report synthetic cannabinoid use should be screened with INR testing, especially prior to procedures.

CITATION: CDC Health Alert Network. Outbreak of life-threatening coagulopathy associated with synthetic cannabinoids use. June 27, 2018.

week after the initial stroke. Major hemorrhage occurred in only 23 patients (0.9%), most of which were extracranial and nonfatal. One of the main limitations is the difficulty in objectively diagnosing TIAs, accounting for 43% of the patients in the study.

BOTTOM LINE: Dual-antiplatelet therapy with aspirin and clopidogrel is beneficial, mainly in the first week after a minor stroke or high-risk TIA with low risk of major bleeding.

CITATION: Johnston SC et al. Clopidogrel and aspirin in acute ischemic stroke and high-risk TIA. *N Engl J Med.* 2018;379:215-25.

Dr. Vela-Duarte is assistant professor of neurology at the University of Colorado, Denver.

Short Takes

Lumbar puncture safe when performed on patients on dual-antiplatelet therapy

In a retrospective review of 100 adult patients who underwent lumbar puncture procedures while taking dual-antiplatelet therapy with aspirin and clopidogrel, Mayo clinic investigators found no epidural hematomas or other serious complications with at least 3 months of follow-up. This study was not powered to detect the risk of spinal hematoma so caution and open discussion with patients still is recommended.

CITATION: Carabenciov ID et al. Safety of lumbar puncture performed on dual antiplatelet therapy. *Mayo Clin Proc.* 2018;93(5):627-9.

SHM aids collaborative national infection prevention and control effort

Multidisciplinary teams celebrate achievements in “getting to zero”

The Society of Hospital Medicine was a key partner in a 3-year national quality improvement program called STRIVE (States Targeting Reduction in Infections Via Engagement) that targeted opportunities to streamline and enhance infection prevention and control efforts in participating hospitals.

The STRIVE program was managed by the Health Research & Educational Trust, the not-for-profit research and education affiliate of the American Hospital Association. Other partners included the American Society for Healthcare Engineering, Association for Professionals in Infection Control and Epidemiology, University of Michigan, Ann Arbor, and experts from academic institutions and professional societies. SHM provided specific knowledge and experience on HAI prevention and helped develop the STRIVE curriculum and resources. Faculty coaches from SHM also supported STRIVE hospitals by presenting on webinars, attending in-person meetings, and consulting on calls.

Following the U.S. experience with Ebola, the Centers for Disease Control and Infection identified the critical importance of enhancing infection control for all infectious threats to protect both patients and health care personnel. The CDC also recognized that many state and regional organizations and agencies work with the same health care facilities in order to coordinate efforts to address infectious threats. The STRIVE

program provided resources to help communities strengthen relationships among organizations to maximize improvement and coordination.

Closely aligned with SHM’s mission to promote exceptional care for hospitalized patients, the CDC’s STRIVE program goals were:

- To expand the CDC’s Targeting Assessment for Prevention (TAP) strategy of using surveillance data to identify hospitals with a disproportionately high burden of health care-associated infections (HAIs),
- To build and strengthen relationships between state and regional organizations that help hospitals with infection control and prevention,
- To provide technical assistance to hospitals to improve implementation of infection control practices in existing and newly constructed health care facilities.

Participants in the program included 449 hospitals from 28 states and the District of Columbia. Short-stay and long-term acute care hospitals that had a high burden of *Clostridium difficile* infection, and a high burden of one or more of the following HAIs – central line-associated bloodstream infection, catheter-associated urinary tract infection, and health care-associated methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia – were targeted. Each participant had access to specific education modules, webinars, and learning networks designed to enhance collaboration, performance improvement,

and understanding of the successes and barriers to coordinating hospital- and community-based services. Hospitals joined the program in cohorts and engaged in a year-long effort to reduce infection burden. During the program implementation period, many hospitals showed measurable improvement by achieving an HAI-specific relative rate reduction or maintenance of a rate of zero between baseline and intervention periods.

Key successes of the program centered around development of multidisciplinary teams that engaged infection preventionists, environmental services, and other departments that may not have traditionally been included in infection prevention efforts. These teams focused on establishing trainings and processes for auditing competencies. One series of STRIVE resources helped hospitals learn new ways to implement best practices and communicate with diverse departments so every team member could participate in removing barriers to infection prevention in the hospital.

The program brought together state health departments, hospital associations, quality improvement organizations, and other agencies and health systems committed to infection prevention. The collaboration and partnerships helped minimize duplication of work and improve efficiency and effectiveness of infection prevention efforts lead by hospitals.

To learn more about the STRIVE resources, visit www.hret.org/quality/projects/strive.shtml.

Novel scoring system predicts inpatient seizure risk

By Sharon Worcester

MDedge News

LOS ANGELES – A novel scoring system based on six readily available seizure risk factors from a patient’s history and continuous electroencephalogram (cEEG) monitoring appears to accurately predict seizures in acutely ill hospitalized patients.

The final model of the system, dubbed the 2HELPS2B score, has an area under the curve (AUC) of 0.821, suggesting a “good overall fit,” Aaron Struck, MD, reported at the annual meeting of the American Academy of Neurology.

However, more relevant than the AUC and suggestive of high classification accuracy is the low calibration error of 2.7%, which shows that the actual incidence of seizures within a particular risk group is, on average, within 2.7% of predicted incidence, Dr. Struck of the University of Wisconsin, Madison, explained in an interview.

The use of cEEG has expanded, largely because of a high incidence of subclinical seizures in hospitalized patients with encephalopathy; EEG features believed to predict seizures include epileptiform discharges and periodic discharges, but the ways in which these variables may jointly affect seizure risk have not been studied, Dr. Struck noted.

He and his colleagues used a prospective database to derive a dataset containing 24 clinical and electroencephalographic variables for 5,427 cEEG sessions of at least 24 hours each, and then, using a machine-learning method known as RiskSLIM, created a scoring system model to estimate seizure risk in patients undergoing cEEG.



Dr. Struck

The name of the scoring system – 2HELPS2B – represents the six variables included in the final model:

- 2 H is for frequency greater than 2.0 Hz for any periodic rhythmic pattern (1 point).
- E is for sporadic epileptiform discharges (1 point).
- L is for the presence of lateralized periodic discharges, lateralized rhythmic delta activity, or bilateral independent periodic discharges (1 point).
- P is for the presence of “plus” features, including superimposed, rhythmic, sharp, or fast activity (1 point).
- S is for prior seizure (1 point).
- 2B is for brief, potentially ictal, rhythmic discharges (2 points).

The predicted seizure risk rose with score, such that the seizure risk was less than 5% for a score of 0, 12% for 1, 27% for 2, 50% for 3, 73% for 4, 88% for 5, and greater than 95% for 6-7, Dr. Struck said. “Really,

anything over 2 points, you’re at substantial risk for having seizures.”

Limitations of the study, which are being addressed in an ongoing, multicenter, prospective validation trial through the Critical Care EEG Monitoring Research Consortium, are mainly related to the constraints of the database; the duration of EEG needed to accurately calculate the 2HELPS2B score wasn’t defined, and cEEGs were of varying length.

With validation, Dr. Struck said the 2HELPS2B score could ultimately be used to rapidly communicate seizure potential based on EEG severity and to guide decision making with respect to initiation of empiric antiseizure medication.

Findings from the validation study are “trending in the right direction,” but the confidence intervals are wide, as only 404 patients have been included at this point, Dr. Struck said.



HOSPITALISTS/ NOCTURNISTS NEEDED IN SOUTHEAST LOUISIANA



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

- Hospital Medicine was established at Ochsner in 1992. We have a stable 50+ member group
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- The only Louisiana Hospital recognized by US News and World Report Distinguished Hospital for Clinical Excellence award in 4 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

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

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

Reference # SHM2017.



Sorry, no opportunities for J1 applications.

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

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

Heather Gonroski • 973-290-8259 • hgonroski@mdedge.com or
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Physician Recruitment

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- Day and Nocturnist positions
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- Comprehensive care for all newborns and pediatric inpatients including:
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 - 302-bed community teaching hospital with residency programs
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 - A closed ICU/CCU
 - A full spectrum of Specialties to support the team
 - A major teaching affiliate of the University of Massachusetts Medical School and University of New England College of Osteopathic Medicine
- 7 on/7 off 12 hour shift schedule

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Interested candidates are invited to contact:

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

Applications accepted online at www.berkshirehealthsystems.org



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Lake Forest Hospital is located about 30 miles north of downtown Chicago. Care is provided through the main hospital campus in suburban Lake Forest and an outpatient facility in Grayslake, Illinois, which also includes a free-standing emergency room. Lake Forest Hospital is served by a medical staff of more than 700 employed and affiliated physicians. The hospital also received American Nurses Credentialing Center Magnet® re-designation in 2015, the gold standard for nursing excellence and quality care.

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To apply or for more information:

Contact Eileen Harpole
806-212-6965
Eileen.Harpole@bsahs.org

ACADEMIC NOCTURNIST HOSPITALIST

The Division of General Internal Medicine at **Penn State Health Milton S. Hershey Medical Center**, Penn State College of Medicine (Hershey, PA) is seeking a BC/BE Internal Medicine **NOCTURNIST HOSPITALIST** to join our highly regarded team. Successful candidates will hold a faculty appointment to Penn State College of Medicine and will be responsible for the care in patients at Hershey Medical Center. Individuals should have experience in hospital medicine and be comfortable managing patients in a sub-acute care setting.

Our Nocturnists are a part of the Hospital Medicine program and will work in collaboration with advanced practice clinicians and residents. Primary focus will be on overnight hospital admission for patients to the Internal Medicine service. Supervisory responsibilities also exist for bedside procedures, and proficiency in central line placement, paracentesis, arthrocentesis, and lumbar puncture is required. The position also supervises overnight Code Blue and Adult Rapid Response Team calls. This position directly supervises medical residents and provides for teaching opportunity as well.

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Appropriate candidates must possess an MD, DO, or foreign equivalent; be Board Certified in Internal Medicine and have or be able to acquire a license to practice in the Commonwealth of Pennsylvania. Qualified applicants should upload a letter of interest and CV at:

<http://tinyurl.com/j29p3fz> Ref Job ID#4524

For additional information, please contact:

Brian Mc Gillen, MD — Director, Hospitalist Medicine
c/o Heather Peffley, PHR FASPR — Physician Recruiter
Penn State Health
hpeffley@pennstatehealth.psu.edu



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- Potential for growth into leadership roles;
- Competitive salary, comprehensive benefit package, relocation, and so much more!

What we're seeking:

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

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For more information please contact: Heather Peffley, Physician Recruiter at: hpeffley@pennstatehealth.psu.edu



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

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

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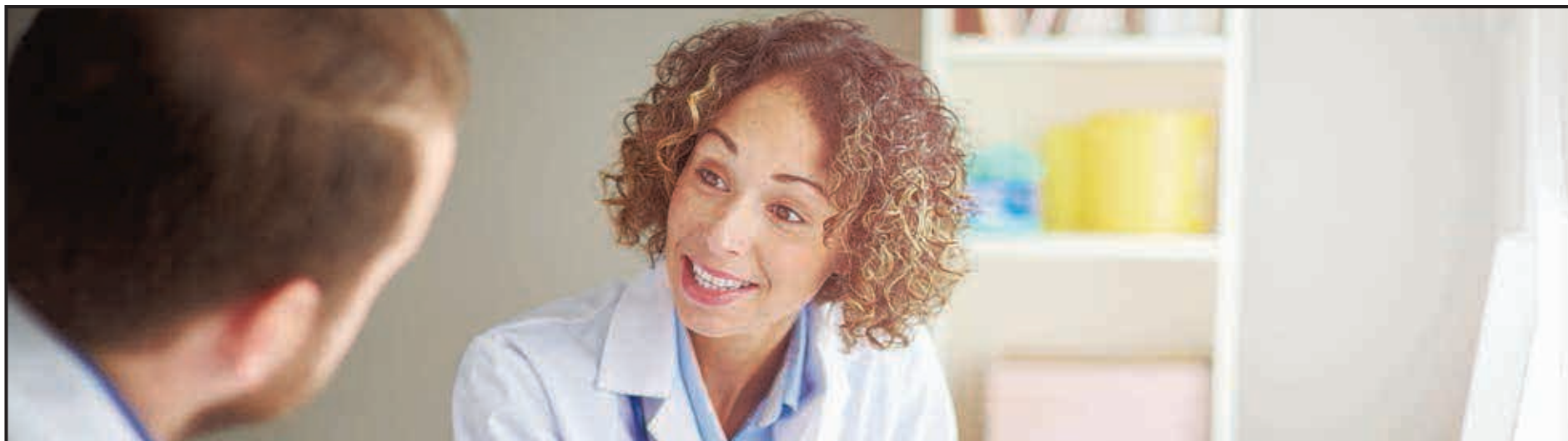
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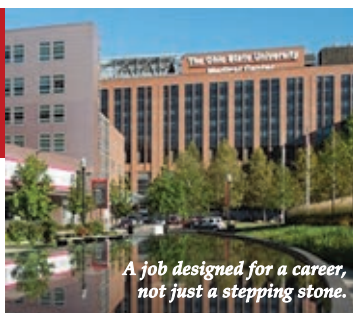
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We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status,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



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- Additional stipend for nights
- Attractive base compensation with incentive
- Excellent benefits, including malpractice, moving expenses, CME
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- Previous Hospitalist experience is preferred

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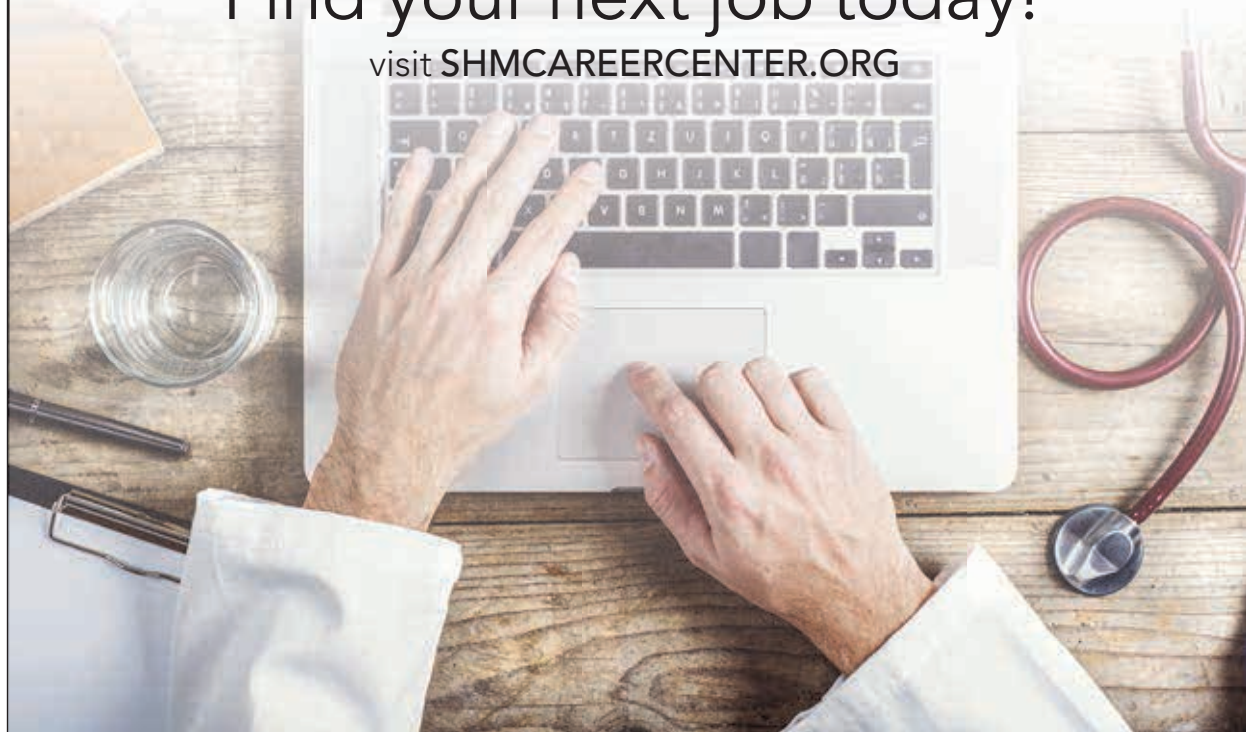
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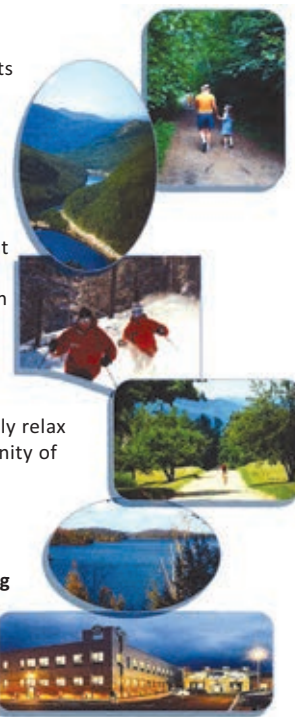
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Reviving rural health care

Hospitalists have an important role to play

By Jerome C. Siy, MD, SFHM

Health care in the United States has seen tremendous change in the last 2-3 decades, stemming from a dramatic push to contain spending, a call to action to improve quality and safety, and a boom in technology and medical advancement.

While the specialty of hospital medicine in the United States matured in response to these calls to action, it mostly flourished amidst – and as a result of – market consolidation, cost containment, the rise in the underinsured, and the flight of primary care from hospitals.

Changes in the health care industry have paralleled other parts of our society. Health care organizations, like schools, churches, theaters, parks, and sports teams, are part of the social fabric of communities. They provide stability to communities as employers, educators, social supporters, and the provision of services. It is no wonder then, that smaller communities, rural areas in particular, flourish or wither when one or more of these institutions, especially health care, fail them.

Health disparities result from any number of factors but particularly when communities are destabilized. The Robert Wood Johnson Foundation has studied this across the United States. For example, in the Twin Cities of Minneapolis–St. Paul, Minn., where I live, life expectancy varies by over 10 years along the in-

terstate highway that runs through the metro area. Similarly, this disparity is seen between urban and rural Kentucky.

For sure, the confounding social determinants of health and the mitigating strategies for the communities are different in urban Minneapolis than in Wolfe County, Ky. However, much of the work around health care reform (and therefore, hospital medicine) has centered around urban populations such as Minneapolis rather than rural populations such as Wolfe County. While 80% of the U.S. population lives in urban centers, that still means that one in five people live in rural America – spread across 97% of the U.S. land mass. These rural populations are exceedingly diverse, and warrant exceedingly diverse solutions.

Eighteen years ago, when I started my career in hospital medicine, I would never have thought I would be a spokesman for rural care. I identified as an urban academic hospitalist at a safety net hospital known for serving the urban poor and diverse refugee populations. But I had not anticipated mergers involving urban and rural hospitals, nor our resulting responsibility for staffing several critical access hospitals in another state.

It was hard in the beginning to recruit hospitalists to rural areas, so I worked in those areas myself, and experienced the rich practice in non-urban centers. As our partners also

joined in our efforts to staff these hospitals, they had similar experiences. Now we can't keep physicians away. That is not to say that the challenges are over.

Since 2010, 26 states lost rural hospitals – over 80 hospitals in total. High premiums in the individual health insurance market have driven healthy people out of risk pools, pushed payers out of the market, driving premiums higher still, resulting in coverage deserts. Consolidation and alignment with urban and national health care organizations initially brought hope to cash-strapped rural hospitals. Instead of improving local access, however, referrals to urban centers drained rural hospitals of their sources of income.

Economic instability has further destabilized communities. Rural America is exceptionally diverse, and has higher rates of poverty and the working poor, a shrinking job market that still hasn't recovered from the 2008 recession, and higher rates of disability when compared to urban America. Do I even need to mention the rural opioid epidemic? Or the rural physician crisis, with a dwindling 12% of primary care and 8% of specialty care in these communities?

There is hope. During a late-night text conversation with a millennial nocturnist who splits his time between large and small hospitals, I received this message at 11:42 p.m.: "I think I feel more appreciated/valued/respected out here. You know



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how it is at the smaller hospitals."

This was a comment the young hospitalist made after he shared with me that, lately, he had been in a "funk." Innovations such as telemedicine have brought balance to overworked rural family doctors and excitement to young, tech-savvy hospitalists. Opportunities to educate rural nurses and increase the level of care, keeping patients local, have excited academic hospitalists and rural CFOs alike. For a physician in a high burnout specialty, a long peaceful drive through the country might be just what's needed to encourage a few moments of mindfulness.

Many of our urban health systems have combined with rural ones. It's time to embrace it. Ignoring the health disparities in rural America divides us and diminishes essential parts of our health care system. Calling the hospitals our patients are referred from "OSH" (Outside Hospitals) will only perpetuate that.

Hospitalists have an opportunity to play an important role in stabilizing rural communities, reviving rural health systems, and providing local access to health care. Let's embrace this opportunity to make a lasting impact on this frontier in hospital medicine.



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