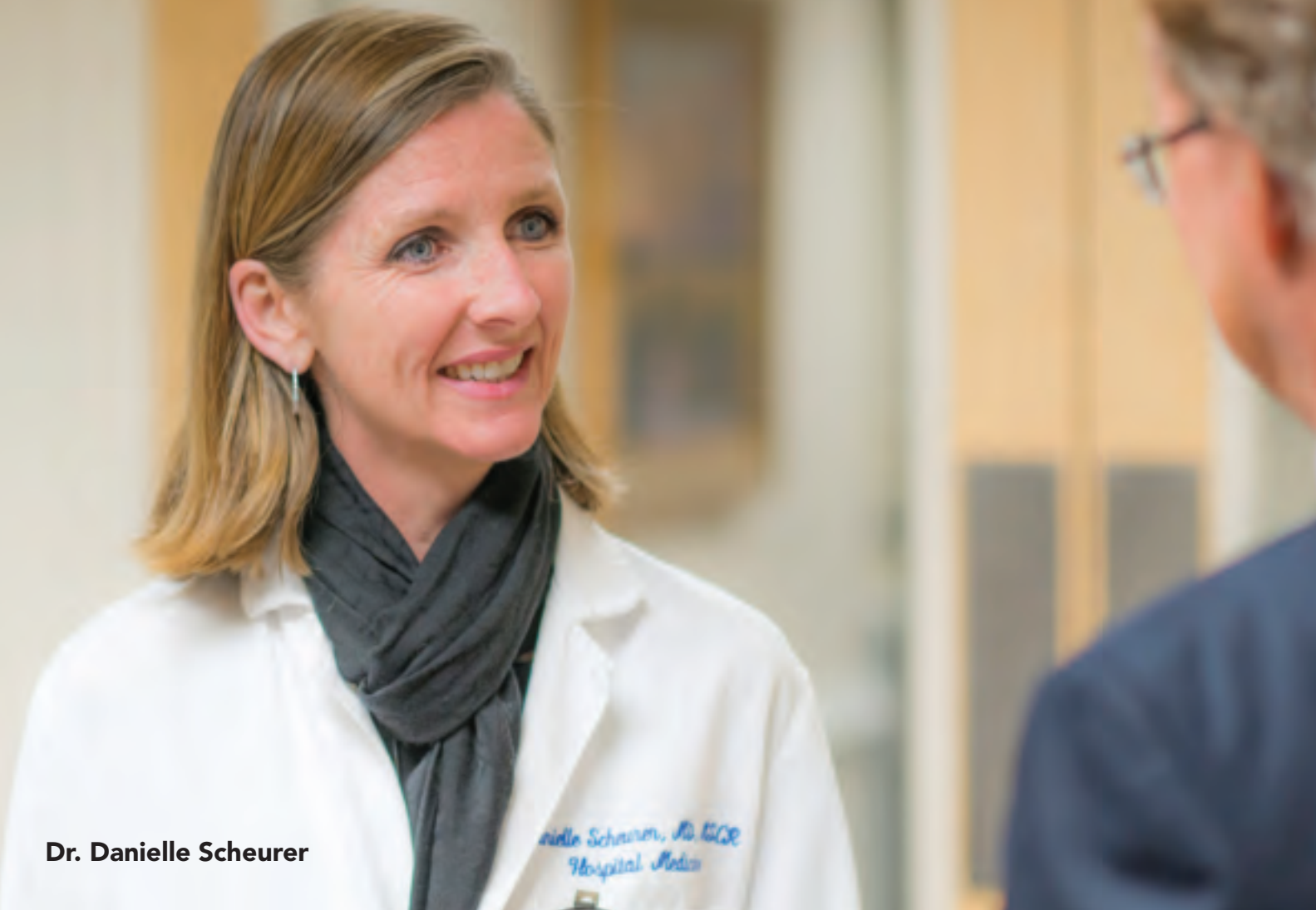


Meet the new SHM president: Danielle Scheurer, MD, MSCR, SFHM



Dr. Danielle Scheurer

Danielle Scheurer, MD, MSCR, SFHM, is the chief quality officer and professor of medicine at the Medical University of South Carolina, Charleston. She is the outgoing medical editor of *The Hospitalist*, and the new president of the Society of Hospital Medicine. She assumes the role from immediate past-president Christopher Frost, MD, SFHM.

As a hospitalist for 17 years, Dr. Scheurer has practiced in both academic tertiary care, as well as community hospital settings. As a chief quality officer, she has worked to improve quality and safety in all health care settings, including ambulatory care, nursing homes, home health, and surgical centers. She brings a broad experience in the medical industry to the SHM presidency.

At what point in your education/training did you decide to practice hospital medicine?

I always loved inpatient medicine throughout my entire med-peds residency training at Duke University, Durham, N.C. I honestly never had a doubt that hospital medicine was going to be my career. What appeals to me is that each hour and each day is different, which is invigorating.

What are your favorite aspects of clinical practice and of your administrative duties?

I like doing both administrative work and clinical work because I believe having a view of both worlds helps me to be a better physician and a better administrator. It greatly

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SURVEY INSIGHTS

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FACP**

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CEO CORNER

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MD, MHM**

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Dr. Eric Howell selected as next CEO of SHM

The Society of Hospital Medicine has announced that Eric Howell, MD, MHM, will become its next CEO effective July 1, 2020. Dr. Howell will replace Laurence Wellikson, MD, MHM, who helped to found the society, and has been its first and only CEO since 2000.

"On behalf of the SHM board of directors, we welcome Dr. Howell as the incoming CEO for our organization who, with the mission-driven commitment and dedication of SHM staff, will take SHM into the future," said Danielle Scheurer, MD, MSRC, SFHM, president-elect of SHM and chair of the CEO search committee. "With his broad knowledge of hospital medicine and extensive volunteer leadership at SHM, Dr. Howell's experience is a natural complement to SHM's core mission."

Dr. Howell has a long history with SHM and has a wealth of expertise in hospital medicine. Since July 2018, he has served as chief operating officer of SHM, leading senior management's planning and defining organizational goals to drive extensive, sustainable growth. Dr. Howell has also served as the senior physician adviser to SHM's Center for Quality Improvement, the society's arm that conducts quality improvement programs for hospitalist teams, since 2015. He is a past president of SHM's board of directors and currently serves as the course director for the SHM Leadership Academies.

"Having been involved with SHM in many capacities since first joining, I am truly honored to become SHM's CEO," Dr. Howell said. "I always tell everyone that my goal is to make the world a better place, and I know that SHM's staff will be able to do just that through the development and deployment of a variety of products, tools, and services to help hospitalists improve patient care."

In addition to serving in various capacities at SHM, Dr. Howell has been a professor of medicine in the department of medicine at Johns Hopkins University, Baltimore. He

has held multiple titles within the Johns Hopkins medical institutions, including chief of the division of hospital medicine at Johns Hopkins Bayview Medical Center in Baltimore, section chief of hospital medicine for Johns Hopkins Com-

munity Physicians, deputy director of hospital operations for the department of medicine at Johns Hopkins Bayview, and chief medical officer of operations at Johns Hopkins Bayview. Dr. Howell joined the Johns Hopkins Bayview hospitalist program in 2000, began the Howard County (Md.) General Hospital hospitalist program in 2010, and

oversaw nearly 200 physicians and clinical staff providing patient care in three hospitals.

Dr. Howell received his electrical engineering degree from the University of Maryland, which has proven instrumental in his mastery of managing and implementing change in the hospital. His research has focused on the relationship between the emergency department and medicine floors, improving communication, throughput, and patient outcomes.

The search process was led by a CEO search committee, composed of members of the SHM board of directors and assisted by the executive search firm Spencer Stuart. Launching a nationwide search, the firm identified candidates with the values and leadership qualities necessary to ensure the future growth of the organization.

"After a thorough search process, Dr. Eric Howell emerged as the right person to lead SHM," said SHM board president Christopher Frost, MD, SFHM, "His experience in hospital medicine and his servant leadership style make him an ideal fit to lead SHM to even greater future success."

In the coming weeks, the SHM board of directors will work with Dr. Howell and Dr. Wellikson on a smooth transition plan to have Dr. Howell assume the role on July 1, 2020.



Dr. Howell

PHYSICIAN EDITOR

Danielle Scheurer, MD, MSCR, SFHM;
scheured@muscedu

PEDIATRIC EDITOR

Anika Kumar, MD, FAAP, FHM
Anika.KumarMD@gmail.com

COORDINATING EDITORS

Dennis Chang, MD
THE FUTURE HOSPITALIST
Keri Holmes-Maybank, MD, FHM
KEY CLINICAL GUIDELINES

CONTRIBUTING WRITERS

Joshua Allen-Dicker, MD, MPH, SFHM;
Joséphine Cool, MD;
Jeff Craven; Randy Dotinga;
Nagendra Gupta, MD, FACP, CPE;
Brittne Halford, MD, MPH;
Jennifer Hu, MD; John Krisa, MD;
Anika Kumar, MD, FAAP;
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Brian Persaud, MD;
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Phone: 800-843-3360
Fax: 267-702-2690

Website: www.HospitalMedicine.org
Laurence Wellikson, MD, MHM, CEO
Vice President of Marketing & Communications

Lisa Zoks
lzoks@hospitalmedicine.org
Marketing Communications Manager
Brett Radler
bradler@hospitalmedicine.org
Marketing Communications Specialist
Caitlin Cowan
ccowan@hospitalmedicine.org

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Linda Wilson, 973-290-8243
lwilson@mdedge.com

Senior Director of Classified Sales

Tim LaPella, 484-921-5001
cell 610-506-3474 tlapella@mdedge.com

Advertising Offices 7 Century Drive,
Suite 302, Parsippany, NJ 07054-4609
973-206-3434, fax 973-206-9378

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Letters to the Editor: rpizzi@mdedge.com

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

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

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The
Hospitalist

Vineet Chopra, MD, MSc, FHM

Michigan hospitalist focused on improving patient safety

Vineet Chopra, MD, MSc, FHM, is associate professor of medicine and chief of the Division of Hospital Medicine at Michigan Medicine and the VA Ann Arbor (Mich.) Health System. A career hospitalist, Dr. Chopra's research is dedicated to improving the safety of hospitalized patients through prevention of hospital-acquired complications. His work has been focused on identifying and preventing complications associated with central venous catheters with a particular emphasis on peripherally inserted central catheters (PICCs).

Dr. Chopra is the recipient of numerous teaching and research awards, including the 2016 Kaiser Permanente Award for Clinical Teaching, the Jerome W. Conn Award for Outstanding Research in the Department of Medicine, the 2016 Society of Hospital Medicine Award for Excellence in Research, and the 2014 McDevitt Award for Research Excellence. He has published more than 100 peer-reviewed articles and has served as associate editor for the American Journal of Medicine and Journal of Hospital Medicine.

At what point in your education/training did you decide to practice hospital medicine? What about hospital medicine appealed to you?

I think I knew very early – toward the middle of my intern year – that I wanted to be a hospitalist. There was much that drew me to the field. First, I loved being in the inpatient setting. The tempo of work, the unexpected nature of what may come next, and the opportunity to truly have an impact on a patient's life at their time of greatest need appealed to me. I wasn't as inclined toward the procedural fields and also loved the cognitive aspects of general medicine – doing the workup on a difficult diagnosis or medically managing a patient with acute coronary syndrome came naturally. I found myself loving the work so much so that it didn't feel like work. And the rest was history!

What is your current role at Michigan Medicine?

I started at Michigan Medicine in 2008 as a full-time clinician taking care of patients on direct care and



Dr. Chopra

resident services. After 3 years of clinical work, I decided it was time to hone in on a specific skill set and went back to a research fellowship.

I became Michigan's first fellow in hospital medicine – the guinea pig – for what would turn out to be one of the best decisions in my life. After finishing fellowship, I switched my focus from clinical work to research and rose up the ranks to receive tenure as an associate professor of medicine. After attaining tenure, I was among a handful of people in the nation who had success in both the research and the clinical arenas and leadership opportunities began to come my way.

I was fortunate to be recruited as the inaugural division chief of hospital medicine at Michigan Medicine in 2017. The Division of hospital medicine is the 13th in the department of medicine and the first one to be created in over 60 years. As division chief, I oversee all of our clinical, academic, research, and educational endeavors. Currently, we have approximately 130 hospitalists in our group and about 30 advanced practice providers (APPs) with a support and research staff of about 15 individuals. So I like to say we have a big family!

What are your favorite areas of clinical practice and/or research?

I am fortunate to have the ability to enjoy all that hospital medicine has to offer. I still appreciate the challenges that direct care brings, and I continue to do as much as I can in

this area. I also enjoy working with residents and medical students at the university and at our VA site – where much of my focus is devoted to making sure all learners on the team are growing while they provide excellent patient care. To meet a new patient and work to develop a therapeutic relationship with them such that we can make positive changes in their disease trajectory remains my favorite part of clinical work.

My research work remains closely linked to my clinical interests around preventing patient harm and improving patient safety – so studying hospital-acquired infections, coming up with new ideas and strategies, and then implementing them when on clinical service represents the perfect blend of the two. My research is largely focused on intravenous devices and catheters, and I focus my work on preventing harms such as bloodstream infection, venous thrombosis, and related adverse events. I have been fortunate to receive national and international attention for my research, including adoption of my work into guidelines and changes to national policies. I am honored to serve on the most important federal advisory committee that advises the government on health care infections (the committee is called HICPAC – Healthcare Infection Control Practice Advisory Committee).

What are the most challenging aspects of practicing hospital medicine? What are the most rewarding?

For me, the most challenging aspects are also the most rewarding. First and foremost, making a connection with a patient and their family to understand their concerns and define a therapeutic alliance is both challenging and rewarding. Second, ensuring that we have the ability to work efficiently and effectively to manage patient care is sometimes challenging but also the most rewarding aspect of the job. I am fortunate to work in a health system where I am surrounded by smart colleagues, important resources, advanced technology, and the support of nurses and advanced practice providers who share this zeal of patient care with me.

Finally, one the greatest challeng-

es and rewards remains time. Our work is hard and grueling, and it is often very challenging to get things done at different times of the day. But the ability to make a diagnosis or see a patient improve makes it all worth it!

How will hospital medicine change in the next decade or two?

I predict our work will shift from a model that is reactive – taking care of patients that are sick and need hospitalization – to a proactive approach where the focus will remain on keeping people out of the hospital. This doesn't necessarily mean that we will be out of a job – but I see the model of our work shifting to ensure that patients who are discharged remain healthy and well. This means we will need to embrace extensivist models, hospital at-home care, and aspects such as bridge clinics.

I also think our work will evolve to harness some of the incredible technology that surrounds us outside health care, but has not yet permeated our work flow. To that end, aspects such as virtual consultations and patient assessments, and remote monitoring that includes biometrics, will all fall into our workflow. And of course, let's not forget about the mighty electronic medical record and how that will affect our experience and work. I see much more of our work shifting toward becoming digital experts, harnessing the power of big data and predictive analytics to provide better care for patients. These are skills that are emerging in our field, but we have not yet mastered the art of managing data.

Do you have any advice for students and residents interested in hospital medicine?

I would highly recommend taking on a rotation with a hospitalist, carrying the pager and working side-by-side with someone who truly loves what they do. Many students and residents just see the on/off nature of the work, but that is truly skin deep in terms of attraction.

The beauty of hospital medicine is that you can be everything for a patient – their doctor, their health care navigator, their friend, and their partner during their hospital stay. Find that joy – you will not regret it!

What's in your wallet?

Trends in hospitalist compensation

By Linda M. Kurian, MD, SFHM, FACP

Ever wonder how your hospitalist group's compensation stacks up? Whether you're a practicing hospitalist curious about how competitive your compensation package is or a hospital medicine group leader performing an appraisal of your group's salary structure, chances are you're looking to fair-market benchmarks for hospitalist compensation. In the 2018 *State of Hospital Medicine (SoHM)* report, the Society of Hospital Medicine partners with the Medical

offer additional insight for a more comprehensive assessment of compensation.

A regional comparison of compensation per wRVU reveals that hospitalists in the West earn more per wRVU than their colleagues in other parts of the country, including the South. Specifically, compensation per wRVU in the West is \$86.57; in the South, \$59.38; in the East, \$65.74; and in the Midwest, \$73.08. A similar comparison of compensation per wRVU (see Figure 1) suggests that academic adult, academic pediatric, and nonacademic adult hospitalists are fairly evenly compensated

help create a more comprehensive model for structuring hospitalist compensation.

While it's important to understand compensation benchmarks in order to remain competitive as a hospital medicine group, money isn't everything. Group culture, professional development and growth opportunities, and schedules that afford better work-life integration are important factors that contribute to hospitalist "compensation" valuations. Arguably these factors are more valuable than any compensation package, but it's not easy to quantify their weight. Some indirect forms of compensation include paid time off, paid sick days, and support for professional development through allowances and protected time off for CME. Other indirect compensation includes tuition benefits for hospitalists and their family, retirement benefits programs, and the unicorn of benefits – pension plans. In the 2018 *SoHM* survey, the median employer contribution to retirement plans was reported to be \$19,875, with respondents in the Midwest receiving the highest retirement benefit of \$28,340.

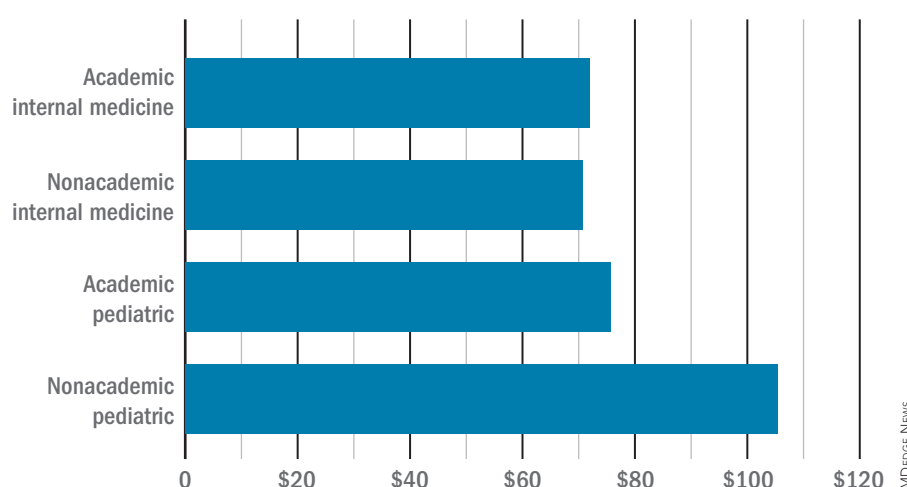
The good news is that hospitalist physician compensation has continued to rise, compared with previous years (see Figure 2), despite the relative flat trends in wRVUs and encounters. Among other reasons, this may reflect a shift from compensating hospitalists for volume toward compensation for their value.

The not-so-good news? In contrast to prior *SoHM* Surveys reporting compensation differences that increased at a rate of 8%-10% every 2 years, the difference in median com-



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

Figure 1. Average hospitalist compensation per wRVU



Source: 2018 *State of Hospital Medicine* report

Group Management Association to provide data on hospitalist compensation and productivity.

In 2018, the median compensation for adult hospitalist respondents was \$289,151, an increase of over \$10,000 from 2016. When comparing compensation across different regions, there appear to be remarkable differences across the nation. Not surprisingly, hospitalists in the South fare better than their colleagues in the East, with a reported median compensation difference of nearly \$33,000. Does that make you want to move to Texas? What about the even more striking difference between adult hospitalists and pediatric hospitalists, whose median compensation was reported to be \$205,342 in 2018?

A common pitfall in compensation analysis is comparing wages across regions and specialties without taking productivity into consideration. Reviewing compensation per work relative value units (wRVU) and compensation per encounter

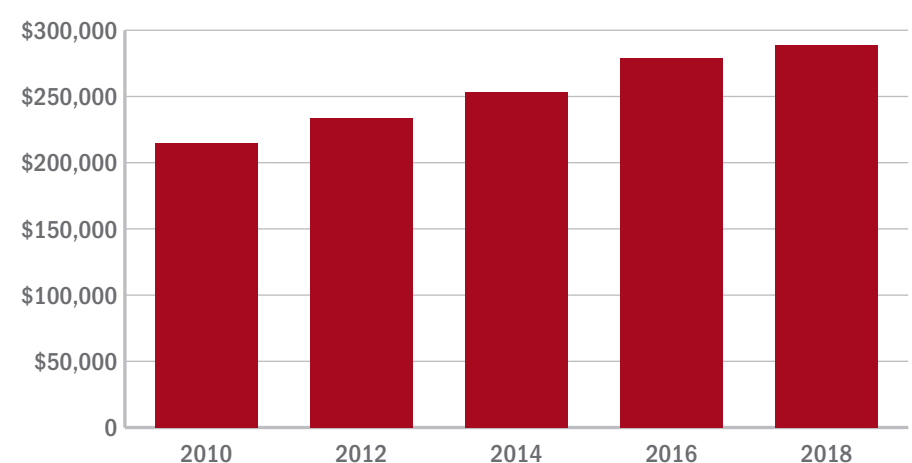
when considering productivity, but nonacademic pediatric hospitalist respondents earned significantly more per wRVU. From this perspective, pediatric hospitalists appear to be similarly compensated, if not better, than their adult hospitalist colleagues.

While differences in compensation per wRVU may be minimal between nonacademic and academic hospitalists, there remains a significant difference in total compensation. Median compensation for nonacademic internal medicine hospitalists was approximately \$63,000 more than that reported for academic internal medicine hospitalists. This doesn't come as a surprise since compensation tends to be lower in academic settings across all specialties. It could be valuable for future compensation and productivity assessments to define and measure academic and other forms of non-billable hospitalist productivity. Development of national standards for nonbillable productivity units could

compensation between 2016 and 2018 was 3.7%. Several factors could play into the slower acceleration rate, including differences in respondent groups between 2016 and 2018. It will be more intriguing to know whether we're starting to see hospitalist compensation leveling off.

As the 2020 *SoHM* surveying period just concluded, it remains to be seen how compensation has changed in the past 2 years and whether hospitalist compensation is starting to plateau. Stay tuned for the 2020 *SoHM* Report available later this year, which will offer invaluable insights into hospitalist compensation trends. You can sign up to be notified when it becomes available at www.hospitalmedicine.org/SoHM.

Figure 2. Trend in hospitalist physician compensation



Source: 2018 *State of Hospital Medicine* report

The wide-ranging impact of hospital closures

Clinicians struggle to balance priorities

By Jeff Craven

On June 26, 2019, American Academic Health System and Philadelphia Academic Health System announced that Hahnemann University Hospital, a 496-bed tertiary care center in North Philadelphia in operation for over 170 years, would close that September.

The emergency department closed 52 days after the announcement, which ended up leaving little time for physicians and staff to coordinate care for patients and secure new employment. The announcement was also made right at the beginning of the new academic year, which meant residents and fellows were forced to find new training programs. In total, 2,500 workers at Hahnemann, including more than 570 hospitalists and physicians training as residents and fellows, were displaced as the hospital closed – the largest such closing in U.S. history.

For most of its existence, Hahnemann was a teaching hospital. While trainees were all eventually placed in new programs thanks to efforts from the Accreditation Council for Graduate Medical Education, some of the permanent staff at Hahnemann weren't so lucky. A month after the announcement, Drexel University's president told university employees that 40% of the staff who worked at Hahnemann would be cut as a result of the closing. Drexel, also based in Philadelphia, had long had an academic affiliation agreement for training Drexel's medical school students as a primary academic partner. Overall, Drexel's entire clinical staff at Hahnemann was let go, and Tower Health Medical Group is expected to hire about 60% of the former Hahnemann staff.

Kevin D'Mello, MD, FACP, FHM, a hospitalist and assistant professor of medicine at Drexel University, said residents during Hahnemann's closure were essentially teaching themselves how to swim.

"There were just no laws, no rules," he said.

The vast majority of programs accepting applications from residents at Hahnemann were sympathetic and accommodating, he said, but a few programs applied "pressure tactics" to some of the residents offered a transfer position, despite graduate medical education rules in place to prevent such a situation from happening. "The resident says: 'Oh, well, I'm waiting to hear from this other program,'" said Dr. D'Mello. "They'd say: 'Okay, well, we're giving you a position now. You have 12 hours to answer.'"

Decision makers at the hospital also were not very forthcoming with information to residents, fellows and program directors, according to a recent paper written by Thomas J. Nasca, MD, current president and CEO of ACGME, and colleagues in the journal *Academic Medicine* (2019 Dec 17. doi: 10.1097/ACM.0000000000003133). When Dr. Nasca and colleagues went to investigate the situation at Hahnemann firsthand, "the team found that residents, fellows, and program directors alike considered their voices to have been ignored in decision making and deemed themselves 'out of the loop' of important information that would affect their career transitions."

While the hospital closed in September 2019, the effects are still being felt to this day. In Pennsylvania, the Medical Care Availability and Reduction of Error Act requires that hospitals and providers have malpractice insurance, including tail insurance for when a doctor's insurance policy expires. American Academic announced it would not be paying tail insurance for claims made while physicians were at Hahnemann. This

meant residents, fellows, and physicians who worked at Hahnemann during the closure would be on the hook for paying their own malpractice insurance.

"On one hand, the risk is very low for the house staff. Lawsuits that come up later for house staff are generally dropped at some point," said William W. Pinsky, MD, FAAP, FACC, president and CEO of the Educational Commission for Foreign Medical Graduates. "But who wants to take that risk going forward? It's an issue that's still not resolved."

The American Medical Association, Association of American Medical Colleges, the Philadelphia County Medical Society, and other medical societies have collectively put pressure on Hahnemann's owners to pay for tail coverage. Beyond a Feb. 10, 2020, deadline, former Hahnemann physicians were still expected to cover their own tail insurance.

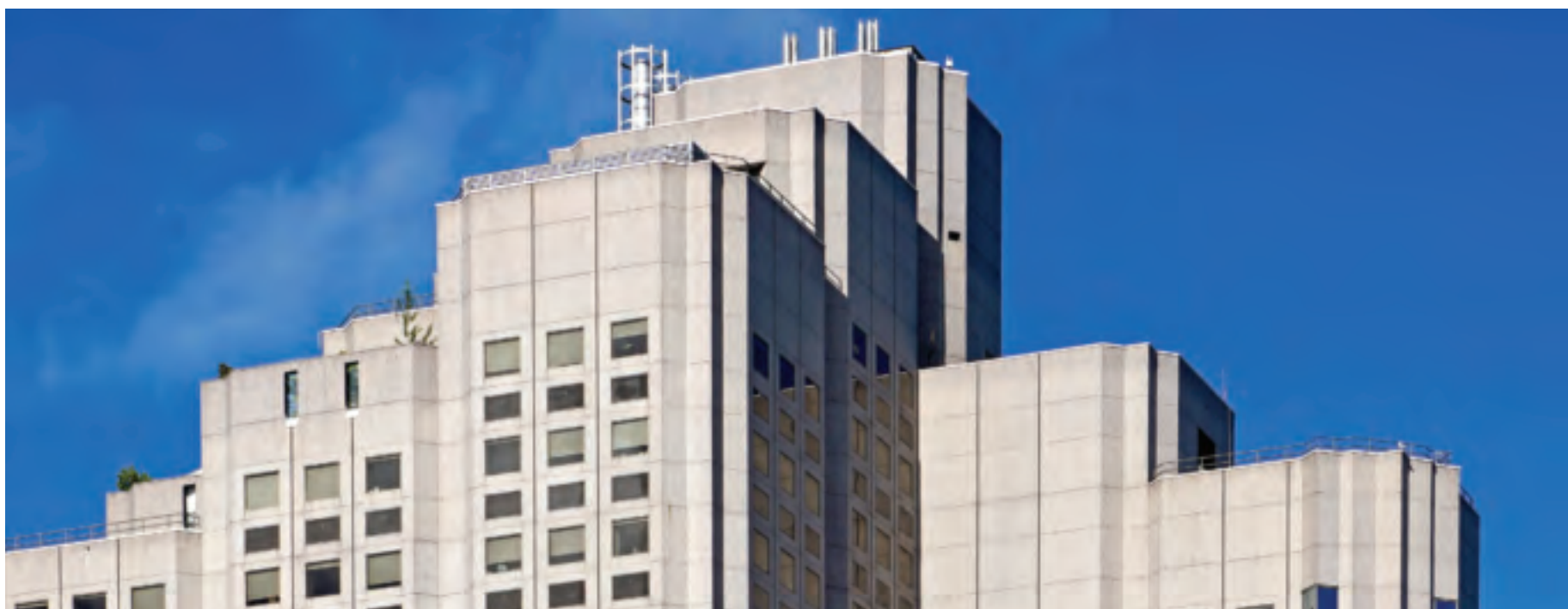
To further complicate matters, American Academic attempted to auction more than 570 residency slots at Hahnemann. The slots were sold to a consortium of six health systems in the area – Thomas Jefferson University Hospitals, Einstein Healthcare Network, Temple University Health System, Main Line Health, Cooper University Health Care, and Christiana Care Health System – for \$55 million. The Centers for Medicare & Medicaid Services opposed the sale, arguing that the slots are a contract that hospitals enter into with CMS, rather than an asset to be sold. An appeal is currently pending.

The case is being watched by former physicians at Hahnemann. "American Academic said, 'If we don't get this \$55 million, we're not going to be

Continued on page 12



Dr. Pinsky



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able to cover this tail insurance.' They're kind of linking the two things," said Dr. D'Mello. "To me, it's almost like putting pressure to allow the sale to happen."

Urban hospital closures disrupt health system balance

When an urban hospital like Hahnemann University Hospital closes, there is a major disruption to patient care. Patients need to relocate to other nearby centers, and they may not always be able to follow their physician to the next health center.

If patients have comorbidities, are being tracked across multiple care points, or change physicians during a hospital closure, details can be missed and care can become more complicated for physicians who end up seeing the patient at a new center. For example, a patient receiving obstetrics care at a hospital that closes will have to reschedule their delivery at another health center, noted Dr. Pinsky.

"Where patients get lost is when there's not a physician or an individual can keep track of all that, coordinate, and help to be sure that the pa-

tient follows through," he said.

Patients at a closing hospital need to go somewhere else for care, and patient volume naturally increases at other nearby centers, potentially causing problems for systems without the resources to handle the spike in traffic.

"I'm a service director of quality improvement and patient safety for Drexel internal medicine. I know that those sort of jumps and volumes are what increases medical errors and potentially could create some adverse outcomes," said Dr. D'Mello. "That's something I'm particularly worried about."

Physicians are also reconciling their own personal situations during a hospital closure, attempting to figure out their next step while at the same time helping patients figure out theirs. In the case of international medical graduates on J-1 or H1-B visas, who are dependent on hospital positions and training programs to remain in the United States, the situation can be even more dire.

During Hahnemann's closure, Dr. Pinsky said that the ECFMG, which represents 11,000 individuals with J-1 visas across the country, reached out to the 55 individuals on J-1 visas at the hospital and offered them assistance, including working

with the Department of State to ensure they aren't in jeopardy of deportation before they secure another training program position.

The ECFMG, AMA, AAMC, and ACGME also offered funding to help J-1 visa holders who needed to relocate outside Philadelphia. "Many of them spent a lot of their money or all their money just coming over here," said Dr. Pinsky. "This was a way to help defray some immediate costs that they might have."

Education and research, of which hospitalists and residents play a large role, are likewise affected during a hospital closure, Dr. Pinsky said. "Education and research in the hospital is an important contributor to the community, health care, and medical education nationally overall. When it's not considered, there can be a significant asset that is lost in the process, which is hard to ever regain."

"The hospitalists have an integral role in medical education. In most hospitals where there is graduate medical education, particularly in internal medicine or pediatrics, and where there is a hospitalist program, it's the hospitalists that do the majority of the in-hospital or inpatient train-

Continued on following page

Amit Vashist, MD, SFHM

Amit Vashist, MD, SFHM, is the senior vice president and chief clinical officer at Ballad Health, an integrated 21-hospital health system serving 29 counties of northeast Tennessee, southwest Virginia, northwest North Carolina, and southeast Kentucky.

Dr. Vashist, who is a member of The Hospitalist's editorial advisory board, focuses on clinical quality and safety, value-based initiatives to improve quality while reducing cost of care, performance improvement, and oversight of the enterprise-wide clinical delivery of care. He also provides administrative oversight of the Ballad Health Clinical Council – a model of physician partnership for clinical transformation and outcomes improvement.

Dr. Vashist is a dual board-certified internist and psychiatrist and an avid proponent of initiatives aimed at promoting quality, improving safety, reducing cost, and minimizing variation in the delivery of patient care across diverse settings. His work has been instrumental in improving outcomes and reducing mortality in patients with sepsis, earning him several local, regional, and national awards, and his work in promoting a zero-harm culture at Ballad Health has been instrumental in significantly reducing hospital-acquired infections systemwide.

Before he transitioned into the role of the chief clinical officer, Dr. Vashist served as the chair of the

Ballad Health Clinical Council and the system chair for Ballad Health's hospitalist division running a group of over 130 hospitalists.



Dr. Vashist

Why did you choose a career in medicine?

The ability to have a positive impact and help others. In addition to that, I love learning new information and skills, and medicine affords one the opportunity to be a lifelong learner.

What do you like most about working as a hospitalist?

The relatively fast-paced nature of the work and the ability to tie seemingly fragmented episodes of patient care together. I believe that no other specialty offers that 30,000-foot vantage view of things in clinical medicine.

What do you like the least?

The shift-worker mindset emanating from the traditional and rigid 7-on, 7-off model. A sense of team can be lost in this model and, contrary to conventional thinking, this model can accelerate hospitalist burnout.

What's the best advice you ever received?

"You've gotta learn to listen!"

What's the worst advice you ever received?

"Don't rock the boat." I strongly believe that frequent disruption is required to change the established status quo.

What aspect of patient care is most challenging?

A perceived disruption in the continuity of care by virtue of a new hospitalist seeing those patients, and the challenge to build the same level of trust and comfort as the outgoing hospitalist. Superior models of care have developed over the years promoting a better continuity of care but this domain continues to pose a challenge to proponents of hospital medicine.

What's the biggest change you've seen in hospital medicine in your career?

Hospitalists being increasingly perceived as the "quarterbacks" and gatekeepers of quality, costs of care, and clinical outcomes in our hospitals and health care systems.

What's the biggest change you would like to see in hospital medicine?

Inpatient volumes across the country continue to shrink, and this trend will not change for the foreseeable future. Hospitalists have got to embrace newer models of care faster, like hospitals at home, post-acute care, transitional care clinics,

etc. Remember what they say: "If you are not at the table, you are on the menu." Now is our time to be at the table, and be the champions of change and move to true value (quality plus experience/cost), or else, we could end up and vanish like Blockbuster.

Outside of patient care, tell us about your career interests.

I'm interested in implementing value-driven initiatives, pursuing endeavors aimed at cutting out waste and redundancy in health care, and developing a new generation of physician leaders with these skill sets.

Where do you see yourself in 10 years?

Leveraging my experience, training, and expertise in hospital medicine to design better systems of health care that transcend above and beyond the four walls of the hospital, and facilitate true consumerism and "patient centeredness."

What has been your most meaningful experience with SHM?

Attending the annual SHM meetings for the past several years, which have helped me to not only reap rewards from the numerous educational sessions but has also helped me develop a rich network of friends, colleagues, and mentors whose advice I solicit from time to time.

Continued from previous page
ing and education,” he added.

Rural hospital closures affect access to care

Since 2005, 163 rural hospitals have closed in the United States. When rural hospitals close, the situation for hospitalists and other physicians is different. In communities where a larger health system owns a hospital, such as when Vidant Health closed Pungo District Hospital in Belhaven, N.C., in 2014 before reopening a nonemergency clinic in the area in 2016, health care services for the community may have limited interruption.

However, if there isn't a nearby system to join, many doctors will end up leaving the area. More than half of rural hospitals that close end up not providing any kind of supplementary health care service, according to the NC Rural Health Research Program.

“A lot of the hospitals that have closed have not been owned by a system,” said George H. Pink, PhD, deputy director of the NC Rural Health Research Program at the University of North Carolina at Chapel Hill. “They’ve been independent, freestanding, and that perhaps is one of the reasons why they’re closing, is because they haven’t been able to find a system that would buy them out and inject capital into the community.”

This can also have an effect on the number of health care providers in the area, Dr. Pink said. “Their ability to refer patients and treat patients locally may be affected. That’s why, in many towns where hospitals have closed, we see a drop in the number of providers, particularly primary care doctors who actually live in the community.”

Politicians and federal entities have proposed a number of solutions to help protect rural hospitals from closure. Sen. Charles Grassley (R-Iowa), Sen. Amy Klobuchar (D-Minn.), and Sen. Cory Gardner (R-Colo.) have sponsored bills in the Senate, while Rep. Sam Graves (R-Mo.) has introduced legislation in the House. The Medicare Payment Advisory Commission has proposed two models of rural hospital care, and there are additional models proposed by the Kansas Hospital Association. A pilot program in Pennsylvania, the Pennsylvania Rural Health Model, is testing how a global budget by CMS for all inpatient and hospital-based outcomes might help rural hospitals.

“What we haven’t had a lot of action on is actually testing these models out and seeing whether they will work, and in what kinds of communities they will work,” Dr. Pink said.

Hospitalists provide community advocacy

Dr. D’Mello, who wrote an article for the Journal of Hospital Medicine on Hahnemann’s ownership by a private equity firm (doi: 10.12788/jhm.3378), said that the inherent nature of a for-profit entity trying to make a hospital profitable is a bad sign for a hospital and not necessarily what is in the best interest for an academic institution or for doctors who train there.

“I don’t know if I could blame the private equity firm completely, but in retrospect, the private equity firms stepping in was like the death knell of the hospital,” he said of Hahnemann’s closure.

“I think what the community needs to know – what the health care community, patient community, the hospitalist community need to know – is

that there’s got to be more attention paid to these types of issues during mergers and acquisitions to prevent this from happening,” Dr. Pinsky said.

One larger issue was Hahnemann’s position as a safety-net hospital, which partly played into American Academic’s lack of success in making the hospital as profitable as they wanted it to be, Dr. D’Mello noted. Hahnemann’s patient population consisted mostly of minority patients on Medicare, Medicaid, and charity care insurance, while recent studies have shown that hospitals are more likely to succeed when they have a larger proportion of patients with private insurance.

“Studies show that, to [make more] money from private insurance, you really have to have this huge footprint, because then you’ve got a better ability to negotiate with these private insurance companies,” Dr. D’Mello said. “Whether that’s actually good for health care is a different issue.”

Despite their own situations, it is not unusual for hospitalists and hospital physicians to step up during a hospital closure and advocate for their patients on behalf of the community, Dr. Pink said.

“When hospitals are in financial difficulty and there’s the risk of closure, typically, the medical staff are among the first to step up and warn the community: ‘We’re at risk of losing our service. We need some help,’” he said. “Generally speaking, the local physicians have been at the forefront of helping to keep access to hospital care available in some of these small communities – unfortunately, not always successfully.”

Dr. D’Mello, Dr. Pinsky, and Dr. Pink report no relevant conflicts of interest.



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“SHM has given me the platform to be a leader and identify challenges that were personally impacting me and thousands of other hospitalists. They make it a priority to do meaningful work that help hospitalists overcome the challenges we face daily.”

Ramesh Adhkari, MD, MS



ABIM and the future of maintaining certification

By **Nagendra Gupta, MD, FACP, CPE**

Given the unpredictability and wide range of patients and conditions physicians see in a hospital setting, keeping current with the latest trends and methods is essential. Until now, options for maintaining certification in Hospital Medicine were limited to American Board Of Internal Medicine's 10-year, traditional Maintenance of Certification (MOC) exam taken at a testing center. Beginning this year hospitalists will have a choice for how they maintain their certification with the introduction of the Knowledge Check-In (KCI) in Focused Practice in Hospital Medicine (FPHM). Physicians who are currently certified in internal medicine can also use the KCI to earn their FPHM certificate once they have been admitted into the FPHM program.

What is KCI for hospitalists?

The KCI is a shorter, lower-stakes assessment option that takes about 3 hours to complete. Similar to the traditional 10-year MOC exam, it includes access to UpToDate® without the need for a personal subscription. Physicians can choose to take the KCI at a test center or online, such as from their home or workplace. The test center experience resembles that

of the traditional 10-year MOC exam, with the main difference being the shorter testing format.

Since this is the first year the KCI is offered in FPHM, it is considered to be "no consequences," meaning that if a physician is unsuccessful they will continue to be publicly reported as certified as long as they are meeting all other MOC requirements, and their next assessment will be due 2 years later. However, the "no consequences" feature does not apply to physicians who are already in a grace period. Please refer to ABIM's policy on Traditional 10-Year MOC Exam Grace Period.

What is the longitudinal assessment option?

Responding to feedback from the community for an MOC program that is lower-stakes and more closely aligned with how physicians practice, in August 2019 ABIM announced it would develop a longitudinal assessment pathway for physicians to acquire and demonstrate current knowledge. Longitudinal assessment is a process that involves the administration of shorter assessments of specific content, such as medical knowledge, repeatedly over a period of time. A critical component of longitudinal is that it integrates education into the assessment experience.

What features can you expect with longitudinal assessment?

The new assessment pathway is anticipated to launch in 2022 in as many specialties as possible. As the program is being developed ABIM is engaging with the community to ensure it will meet their needs, and physicians are encouraged to join its Community Insights Network by visiting abim.org. With the new longitudinal assessment option physicians will be able to:

- Answer a question at any place or time
- Receive immediate feedback
- See references and rationales for each answer
- Access all the resources they use in practice, such as journals or websites

The traditional MOC Exam that is taken every 10 years will also remain an option, as some physicians have expressed a preference for a point-in-time exam taken less frequently.

What should you do now?

All current ABIM MOC program requirements and policies remain in effect while the new longitudinal assessment is being developed and ABIM will communicate any program changes as well as more details on the program in advance of implementation. If you have an assessment due in 2020 or 2021, you can



Dr. Gupta is a member of ABIM's Internal Medicine Board and a full-time hospitalist with Apogee Physicians. As a medical director, he currently runs the Hospitalist Program at Texas Health Arlington Memorial Hospital. He is also president of the SHM North Central Texas Chapter.

choose from the assessment options currently available in your discipline.

Registration for all 2020 MOC assessments opened Dec. 1, 2019. Be sure to check ABIM's website to see exam dates – and registration dates – for FPHM and any other certificates you are maintaining.

You can also find all of your MOC program requirements and deadlines by signing into your Physician Portal at abim.org.

HM20 canceled: SHM explains why

COVID-19 made holding meeting impossible

In mid-March, the Society of Hospital Medicine board of directors concluded that it was impossible for SHM to move forward with Hospital Medicine 2020 because of the continued spread of virus that causes Coronavirus Disease 2019 (COVID-19).

Given the most recent information available from the Centers for Disease Control and Prevention and the World Health Organization about the evolving global pandemic and the number of institutions that had travel bans in place, SHM leadership concluded that canceling the Annual Conference was the only path forward.

"Canceling the conference during this unprecedented time is the right thing to do," said Benji K. Mathews, MD, SFHM, CLHM, course director for HM20. "With the evolving circumstances out of our control, there were risks to our community as it would have gathered, communities we connect with on our travels, and our home communities

and hospitals – canceling was the best way to mitigate these risks. Through it all, I couldn't have asked for a better leadership team and the larger SHM community for their support."

Because hospitalists are on the front lines of patient care at their institutions, they will be needed more than ever as the pandemic continues to grow in order to manage care of hospitalized patients with COVID-19 and other illnesses. As the only medical society dedicated to hospital medicine, SHM will continue to support hospitalists with resources and research specific to COVID-19 and its impact on the practice of hospital medicine.

SHM is aware that this necessary cancellation impacts many from both a financial and logistical perspective. As such, SHM will refund all conference registration fees for HM20 in full. SHM is also providing the opportunity to defer your HM20 registration to HM21, taking place May 4-7, 2021, in Las Vegas, or Pediatric Hospital Medicine 2020, taking

place July 23-26, 2020, in Lake Buena Vista, Fla.

For accommodation or travel cancellations, SHM requests that individuals please refer to their respective hotel or carrier's customer service team and related cancellation policies.

To provide the world-class education that conference attendees have come to expect from SHM, the SHM team is exploring virtual options to offer select content originally anticipated at HM20. SHM also offers online education via the SHM Learning Portal and the new SHM Education app.

Visit shmannualconference.org/faqs for a full list of FAQs. For additional questions, please contact meetings@hospitalmedicine.org.

SHM will continue to monitor the COVID-19 pandemic and provide hospitalists with useful resources in this time of need at hospitalmedicine.org/coronavirus. For news coverage of COVID-19, visit <https://www.the-hospitalist.org/hospitalist/coronavirus-updates>.

Charu Puri, MD, FHM

Charu Puri, MD, FHM, is a hospitalist and medical informaticist at Sutter East Bay Medical Group in Oakland, Calif. She also serves as medical director for onboarding, mentoring, and physician development.

Dr. Puri has been a member of the Society of Hospital Medicine since 2009, and attended the Society's Leadership Academy, where she was



Dr. Puri

inspired to create a mentorship program at her own institution. She is a member of the San Francisco Bay chapter of SHM and serves on the Performance Measurement and Reporting Committee.

At what point in your education/training did you decide to practice hospital medicine? What about hospital medicine appealed to you?

It was early on in my residency that it became clear to me that I wanted to pursue the hospitalist track. It was a natural fit, and I gravitated toward the hospitalist side of medicine. What appealed to me most was that we had the opportunity and privilege to provide care to patients in their most vulnerable state and experience the effects of that care in real time. I found that very gratifying.

There is also a sense of community and camaraderie that comes with working in a hospital setting. Everyone is working together, trying to help patients. The collegiality and the relationships that develop are very rewarding. I have been fortunate enough to have

built strong friendships with the hospitalists in my group as well as colleagues from other disciplines in medicine that work in the hospital.

What is your current role at Sutter Health?

Alta Bates Summit Medical Center is part of the larger Sutter Health system. I have an administrative role with my medical group in addition to the clinical work I do at the medical center, although first and foremost I identify myself as a hospitalist. About 5 years ago I took on a role in clinical informatics, when our hospital implemented an EHR. Since then I have been working as an inpatient physician informaticist. Most recently I took on a new role as medical director for onboarding, mentoring, and physician development in my medical group.

How do you balance the different duties of your various roles?

I am full time in my administration role, between my informatics role and my onboarding role. I technically don't have to do clinical shifts if I don't want to, but it's important to me to continue clinical practice and maintain my skills and connection to the hospital and colleagues. I do about four clinical shifts a month, and plan to continue doing that. In our group you must do 14 shifts a month to be considered full time, so what I do could be considered about one-third of that.

What are your favorite areas of practice and/or research?

I haven't had a lot of research experience. My residency program was a community-based program, and my current setting is a community hospital. I haven't been involved much in the academic side of hospital medicine. As far as clinical practice goes, I think it's the diversity of hospital medicine that appeals to me. You really get to be a jack of all trades, and experience all the different disciplines of medicine.

Both my informatics and onboarding roles came out of a need that I identified, and just began doing the work before there was an official role. When we implemented our EHR, it was essential to get our doctors organized to make sure they were ready to take

care of patients that first day of go live. By the time our hospital went live on the EHR, I had a good understanding of how it worked, and so I was able to create a miniature curriculum for our physicians – templates, order sets, workflows, etc. – to help ensure everything went smoothly. A few months after we implemented the EHR, I was officially offered a physician informaticist role.



Dr. Spector

The onboarding role came about in an interesting way. I was participating in the leadership course offered by SHM and was lucky enough to be in the pilot for the Capstone course. That leadership course is focused around mentoring and sponsorship, and one of the faculty members was Nancy Spector, MD, the associate dean of faculty development at Drexel University, Philadelphia. She talked a lot about mentoring, and I was inspired to set up a mentoring program for our hospitalists. Dr. Spector graciously agreed to mentor me as I worked on my Capstone project, which was to create a mentoring program in a community-based hospitalist group. As I continued to work on the project, coincidentally our medical group decided to redesign our new physician onboarding process. Because I was already involved in the onboarding and training related to our EHR, I became very involved with our medical group's onboarding redesign.

My group's CEO decided to create a new directorship role for onboarding and mentoring, which I recently

interviewed for and was offered about 2 months ago.

I think setting up systems to support our doctors is the common thread between the informatics and the onboarding roles. I want to implement systems that support our doctors, help them succeed, and hopefully make their jobs easier.

What are the most challenging aspects of practicing hospital medicine? What are the most rewarding?

We practice in a very urban environment, with many low-income patients who have limited resources and access to health care. That can be very challenging. You always wonder if these patients have all the support they need after leaving the hospital. Sometimes I feel that I am just putting a band-aid on the medical problem, so to speak, but not solving the underlying issue. But it can be very rewarding when the hospital and the broader community can bring our resources together to create interventions to help at-risk patients. It doesn't happen as frequently as we would like, but when it does happen it feels good.

Another challenging aspect is related to perception. There are a lot of consultants in the hospital who view hospitalists as "house staff." That can be very frustrating, and it's important to steer the conversations away from that perspective, and really try to establish ourselves as colleagues and peers.

How will hospital medicine change in the next decade?

It's a relatively young field, and we're still figuring it out. I don't know how hospital medicine is going to change, but I do know that the field will continue to evolve, given the way health care is changing.

Do you have any advice for students and residents interested in hospital medicine?

It's a fun way to practice medicine and I would encourage students to go into hospital medicine. It's great for work/life balance. It is very important to get involved early in your career. Get involved in medical group or hospital committees. Stay away from the "shift mentality" – that can lead to early burnout, which is a real concern in our field now. Early engagement is essential, so you can help lead these conversations at your hospital.

Continuity rules

Simple operational adjustments your team can make

By John Krisa, MD

Although there are many benefits to the hospital medicine model of inpatient care, there is perhaps no greater Achilles heel than the discontinuity inherent to the care model. The trust and familiarity garnered from longitudinal patient-provider relationships is sacrificed for the benefits of focused practice, efficiency, and enhanced availability.

Any system involves competing priorities, and some degree of discontinuity is inevitable. Would it make sense for a hospitalist to stay on service until every panel patient is discharged? For obvious economic, lifestyle, and other reasons, of course not. Our charge then is not to make the perfect the enemy of the good, but to ensure thoughtful and consistent continuity for the good of the patient, the provider, and the hospital. The following tips should help your team achieve the best possible balance.

Avoid orphan rounding shifts

An "orphan" rounding shift refers to a single shift untethered to a stretch. For admitting or administrative duties, this generally poses no problem, but for a rounding shift it is undesirable. No matter how talented or industrious the provider, it is very difficult for them to effectively provide seamless care for a single day; such care is often disconcerting for patients, families, case managers, and consultants. In situations such as significant census spikes, this may be a necessary evil, but avoid this if you can.

Assign orphan shift duties

If you can't avoid an orphan rounding shift, be creative regarding which patients get assigned. Can that provider cover observation or simple short stay patients who may

be discharged, or consult follow-ups that may be signed off? Can they see stable long-stay patients where the plan isn't changing and the patient isn't going anywhere? (Think guardianships, chronic ventilated patients awaiting a facility, stable patients with a history of intravenous drug abuse who may not be safely discharged with a line, etc.) Can they do lab, culture, or path report follow-up calls? Getting creative in responsibilities for an orphan shift can benefit all involved.

Alternate rounding shifts and admitting shifts

Dedicated admitting and rounding shifts are the norm these days. But rather than a pure stretch of one or the other, consider a few days admitting followed by the rest of the stretch rounding. Particularly in a small- to mid-sized hospital, multiple admits done over a few days (and especially if also cross-covering floor calls) will mean many familiar cases when rounding thereafter.

Use standard sign-out that travels with patients

The hospital is a dynamic environment. Patients, providers, and staff move around a lot. Given this reality, the importance of a complete standardized and accessible sign-out is paramount.

Imagine a rounder starting their last day with 15 patients. By the end of the shift, some have been discharged, transferred to telemetry or the ICU, or left against medical advice, leaving seven patients to sign out. By the next day, there are eight new faces, including fresh admits or consults from the prior day, swing, and night providers as well as existing patients transferred from telemetry/ICU to the general medical ward. A practical solution incorporates an asynchronous sign-out that travels with the

patient regardless of geographic location or which provider(s) are following them. Billing software or census reports can typically achieve this. Allow for additional verbal communication as necessary and appropriate.

Bend for geographic rounds

Geographic rounds make sense most of the time. Less transit time and phone tag and more frequent interactions with the care team make for a more efficient day. But sometimes it's best to bend this rule.

A patient that you've seen for 5 days and was transferred off your telemetry floor to go home tomorrow might best be served by you trekking up a flight of stairs to do the discharge. Similarly, complicated medical, psychosocial, or other circumstances may argue for keeping the patient on your list despite a change in location.

Wind up, wind down

It's difficult to walk into a full panel of patients especially when many have been in house for a while. Consider overlapping providers coming onto and going off a shared service.

In a buddy arrangement the oncoming provider starting would take new patients from the outgoing provider finishing. The provider finishing discharges patients with long length of stays and continues to round on more-complicated patients with whom they are familiar. Opportunities for face-to-face verbal handover, and even bedside introduction to the provider starting, can improve care coordination and safety and enhance the patient experience.

Split rounding and admitting

Most physicians would attest that the second time seeing a patient is much easier than the first, the third easier than the second, and so on. This holds true even more so when



Dr. Krisa is a former regional medical director for a national hospitalist group and currently serves as a physician adviser for St. Peter's Health Partners, a large integrated health system in Albany, N.Y. You can contact him at johnkrisa@hotmail.com.

the first encounter is the history and physical, and the provider subsequently rounds on the patient for the duration of the hospitalization.

You know what the plan is because you made it; you are confident that the patient's leg with cellulitis looks better or the patient with congested lungs sounds clearer because the baseline against which you're comparing is your own. It can be a challenge to interrupt a busy day of clinical rounds, discharges, and interdisciplinary meetings to admit a patient. But the upstream investment pays rich downstream dividends.

Hospital medicine outcomes as measured by cost, quality, and patient and provider experience are often hampered by suboptimal continuity of care. With recognition of the problem and some simple operational adjustments as outlined above, your team can minimize negative impacts.

Hospitalist profile: Ilaria Gadalla, DMSc, PA-C

Ilaria Gadalla, DMSc, PA-C, is a hospitalist at Treasure Coast Hospitalists in Port St. Lucie, Fla., and serves as the physician assistant department chair/program director at South University, West Palm Beach, Fla., where she supervises more than 40 PAs, medical directors, and administrative staff across the South University campuses.

Dr. Gadalla is the chair of SHM's NP/PA Special

Interest Group, which was integral in drafting the society's recent white paper on NP/PA integration and optimization.

She continuously drives innovative projects for NPs and PAs to demonstrate excellence in collaboration by working closely with C-suite administration to expand quality improvement and education efforts. A prime example is the optimal communication system that she developed

within her first week as a hospitalist in the Port St. Lucie area.

At what point in your life did you realize you wanted to be a physician assistant?

I worked as a respiratory therapist and had a desire to expand my knowledge to manage critical care patients. I applied to Albany (N.Y.) Medical College,

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ERIC TAKAHASHI, DO
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where I received my PA training. I knew before PA school that I was passionate about the medical field and wanted to advance my education and training.

How did you decide to become a PA hospitalist?

From day one at my first job, I knew that I loved inpatient medicine. I had a unique position as a cardiology hospitalist in Baltimore. As a team of PAs, we worked closely with hospitalists in addition to the cardiologists. I enjoyed the acuity of hospital medicine, and the brilliant hospitalist colleagues I worked with. They fueled my clinical knowledge daily, and that drew me further into hospital medicine.

What is your current position?

I have a unique position. I work primarily in an academic role, as a program director and department chair of the physician assistant program at South University in West Palm Beach. I provide oversight for four PA program campuses located in Florida, Georgia, and Virginia. I also work clinically as a hospitalist at Treasure Coast Hospitalists in the Port St. Lucie area.

What are your favorite parts of HM work?

My favorite aspect within the academic environment is what I call the “lightbulb moment” – that instant when you see your students comprehending and applying critical thinking regarding patient care. In clinical practice, I really enjoy

educating and navigating a patient through their diagnosis and management. It’s like teaching, in that a patient can also have a lightbulb moment.

What are the most challenging aspects of practicing hospital medicine, from a PA’s perspective?

Medicine is an art, and each patient’s body is different. It’s a challenge to create individualized care in a system where metrics and templates exist. An additional challenge is simply navigating the culture of medicine and its receptiveness to physician assistants.



Dr. Gadalla

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

PAs in hospital medicine must excel in communication skills. We are frequently the primary liaison between families, patients, specialists, consultants, and various departments daily. PAs in other care settings also communicate with a broad variety of people, but in hospital medicine that communication is required to be much more rapid. Your skills must really rise to the next level.

There is also the opportunity for PAs to integrate within hospital committees and the C-suite.

How can PAs and nurse practitioners fit best into hospital medicine groups?

Initially, a hospital medicine group needs to identify their specific needs when deciding to integrate PAs and NPs. There must be a culture

of receptiveness, with proper onboarding. That is a vital necessity, because without a proper onboarding process and a welcoming culture, a group is set up to fail.

What kind of resources do hospitalist PAs require to succeed?

There is a big need for education that targets the hospital C-suite and our physician colleagues about the scope of practice and autonomy that a PA can have. There are significant misconceptions about the capabilities of hospitalist PAs, and the additional value we bring to a team. PAs do not want to replace our MD/DO colleagues.

What do you see on the horizon for PAs and NPs in hospital medicine?

As the chair of SHM’s NP/PA Special Interest Group, we see a significant need for onboarding resources, because there is a hospitalist staffing shortage in the United States, and that gap can be filled with NPs and PAs. There is a lack of understanding about how to onboard and integrate advanced practice providers, so we are working intently on providing a toolkit that will assist groups with this process.

Do you have any advice for students who are interested in becoming hospitalist PAs?

I would encourage students to seek mentoring from a hospitalist PA. This can help prepare you for the inpatient world, as it’s very different from outpatient medicine with a higher acuity of patient care.

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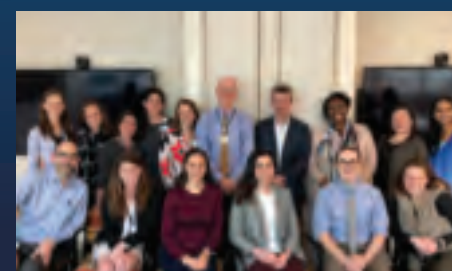
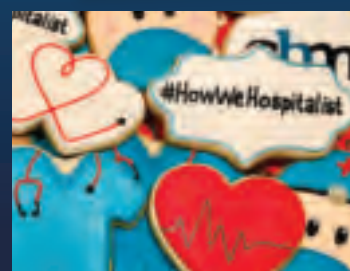
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Transitions: From editor to president

By Danielle Scheurer, MD,
MSCR, SFHM

As I transition out of the role of medical editor for *The Hospitalist*, and into the role of president of the Society of Hospital Medicine, it is a bittersweet but exciting transition.

In the relatively short time I have served as editor, so much has changed in our hospitalist community! In the last 4 years alone, we have increased:

- Membership from 14,000 to 20,000
- Chapters from 46 to 68
- Special Interest Groups from 8 to 22
- Subscribers to *The Hospitalist* from 15,000 to 30,000.

This is all a testimony to the engagement of our membership. SHM is clearly no ordinary specialty society; it is full of incredibly intelligent, invested, and talented members, who actively participate in the society for the betterment of their local teams and patients. It is such a privilege to lead this amazing team.

As for *The Hospitalist*, I would like to warmly welcome Weijen Chang, MD, FACP, SFHM, as the incoming editor. Weijen served as the pediatrics editor for many years and has been extensively involved on



Dr. Chang

The Hospitalist's editorial advisory board for even longer. He also has a broad track record of experience as a hospitalist in many settings; that combined with an inquisitive mind and curious spirit makes him the ideal editor for *The Hospitalist*. He brings energy and enthusiasm and will serve us very well.

While I will miss being intimately involved with *The Hospitalist*, I am very much looking forward to serving in the role of SHM president starting this month. During this pivotal year, SHM will transition from our one-and-only CEO, Larry Wellikson, MD, MHM, to our newly minted CEO Eric Howell, MD, MHM, who

will officially transition in July 2020.

This is a very exciting time in the history of SHM, as we refocus on our mission, vision, values, and core activities. As a membership organization, our primary focus has been, and will always be, serving our member's needs! As a "Big Tent" organization, we have always supported a broad and diverse set of members, ranging far beyond physician hospitalists, to trainees, medical students, nurse practitioners, physician assistants, practice administrators, and other hospital-based specialists. Being in such a dynamic industry, our diverse members' needs are constantly and rapidly changing along with the dramatic transformations in the landscape, including profound shifts in care and reimbursement models that could change the very definition of a hospitalist.

While we continuously scour the landscape and anticipate our members' needs, we will never lose sight of our core mission, which is to promote exceptional care for hospitalized patients. We will continue to do this by supporting all of our members with tools and materials to help them be the very best they can, for all of our patients. As a humble and servant leader, I am prepared to



Dr. Scheurer is chief quality officer and professor of medicine at the Medical University of South Carolina, Charleston. She is the outgoing medical editor of *The Hospitalist*, and president-elect of SHM.

meet the demands and challenges of the year ahead, with energy and focus, and fulfill the needs of our members, so that together, we can make health care better for those we serve.

Thank you in advance for allowing me the great pleasure of serving this amazing and innovative organization!

SHM president

Continued from page 1

helps me bring realistic solutions to the front lines since I have a good understanding of what needs to be done, but also what is likely to actually work.

As president of SHM over the next year, what are your primary goals?

My primary goal is to deeply connect with the SHM membership and understand what their needs are. There is enormous change happening in the medical industry, and SHM should be a conduit for information sharing, resources, and most importantly, answers to all our difficult problems. Hospitalists are critical to success for our hospitals and our communities during the COVID-19 pandemic. We must be able to give and receive information

quickly and seamlessly to effectively help each other across the country and the world. SHM must be seen as a critical convener, especially in times of crisis.

You mention COVID-19. What resources will SHM offer to members?

We have opened up the SHM Learning Portal to help members and non-members address upcoming challenges, such as expanding ICU coverage or cross-training providers for hospital medicine. Several modules in SHM's "Critical Care for the Hospitalist" series may be especially relevant during the COVID-19 crisis:

- Fluid Resuscitation in the Critically Ill
- Mechanical Ventilation Part I –

The Basics

- Mechanical Ventilation Part II – Beyond the Basics
- Mechanical Ventilation Part III – ARDS

Finally, in this time when so many hospitalists are busy dealing with COVID-19, SHM is committed to offering valuable resources and is in the process of offering new material, including Twitter chats, webinars, blogs, and podcasts to help hospitalists share best practices. Please bookmark SHM's compilation of COVID-19 resources at hospitalmedicine.org/coronavirus.

We also continue to forge ahead with our publications, *The Hospitalist* and the *Journal of Hospital Medicine*, by adding online content as it becomes available. Visit the COVID-19 news feed on

The Hospitalist website at www.the-hospitalist.org/hospitalist/coronavirus-updates.

In this trying time, we can still connect as a community and continue to learn from each other. We encourage you to use SHM's online community, HMX, to share resources and crowd-source solutions. Ideas for SHM resources can be submitted via email at ideas@hospitalmedicine.org.

How will hospital medicine change in the next decade?

I believe one of the biggest changes we will see is the shift to ambulatory settings and the use of telehealth, and we all need to gain significant comfort with both to be effective.

Do you have any advice for students and residents interested in hospital medicine?

It is an incredibly dynamic and invigorating career; I can't imagine doing anything else.

Clinician reviews of HM-centric research

By Joséphine Cool, MD; Brittne Halford, MD, MPH; Jennifer Hu, MD; Monica Midha, MD, MBS; Brian Persaud, MD; Joshua Allen-Dicker, MD, MPH, SFHM

Beth Israel Deaconess Medical Center, Harvard Medical School, Boston

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By Joséphine Cool, MD

1 Hospital admissions of nursing home patients declined after ACA quality initiatives

CLINICAL QUESTION: Following the Patient Protection and Affordable Care Act (ACA), how have hospital transfer rates from nursing homes for patients with advanced medical conditions changed?



Dr. Cool

BACKGROUND: Following the ACA's implementation, several measures were introduced to reduce unnecessary admissions of long-term nursing home residents to hospitals. These measures included an initiative to enhance a nursing home's on-site capability to handle target populations; the accountable care organization

payment model; and the Hospital Readmissions Reduction Program.

STUDY DESIGN: Cross-sectional study using the claims-based nationwide Minimum Data Set during 2011-2016.

SETTING: Federally licensed nursing homes in the United States.

SYNOPSIS: The authors examined the number of transfers between federally funded nursing homes and the hospital settings (EDs, observation, or inpatient hospitalizations) for greater

than 460,000 long term-stay patients with advanced dementia, advanced heart failure, and/or advanced chronic obstructive pulmonary disease (COPD). A risk-adjusted model showed that, during 2011-2016, there were significant decreases in transfers rates for potentially avoidable conditions, measured as the mean number of transfers per person-year alive, for patients with advanced dementia (2.4 vs. 1.6), heart failure (8.5 vs. 6.7), and COPD (7.8 vs 5.5). Most of this decrease was linked to reductions in acute hospitalizations. Notably, hospice enrollment remained low throughout this time period, despite a high 1-year mortality.

BOTTOM LINE: During the 2011-2016 period, transfer rates for patients with advanced dementia, heart failure, and/or COPD from nursing homes to the hospital setting decreased.

CITATION: McCarthy EP et al. Hospital transfer rates among U.S. nursing home residents with advanced illness before and after initiatives to reduce hospitalizations. *JAMA Intern Med.* 2019 Dec 30. doi: 10.1001/jamainternmed.2019.6130.

2 Significant reduction of alcohol intake reduced AFib burden and recurrence

CLINICAL QUESTION: In patients with symptomatic paroxysmal or persistent AFib who report alcohol consumption of 10 or more standard drinks per week, how does reducing alcohol intake affect AFib outcomes?

BACKGROUND: Prior observational studies have suggested that a dose-dependent effect may exist between alcohol intake and incident AFib, recurrence after ablation, and cardiac structural changes.

STUDY DESIGN: Prospective, open-label, multicenter, randomized clinical trial, with an intention-to-treat analysis.

SETTING: Six tertiary care hospitals in Australia.

SYNOPSIS: Study authors enrolled 140 patients with symptomatic paroxysmal or persistent AFib and regular alcohol consumption of 10 or more standard drinks per week. Participants were randomized to alcohol abstinence or usual alcohol intake. They underwent comprehensive rhythm monitoring and alcohol intake assessment for 6 months with in-person visits and oral/electronic communication. Over the 6-month period, patients in the abstinence group reduced their mean drinks per week from approximately 17 to 2, with 61% achieving complete abstinence. Patients in the abstinence group had a significantly longer period before recurrence of AFib when compared with the control group. Furthermore, the AFib burden over 6 months was significantly lower in the abstinence group, compared with the control group (0.5% vs. 1.2%).

BOTTOM LINE: For patients with symptomatic paroxysmal or persistent atrial fibrillation and

regular alcohol consumption, reducing alcohol intake may significantly lower AFib burden and increase the time-to-recurrence of AFib at 6 months.

CITATION: Voskoboinik A et al. Alcohol abstinence in drinkers with atrial fibrillation. *N Engl J Med* 2020 Jan 2;382:20-8.

Dr. Cool is a hospitalist at Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, both in Boston.

By Brittne Halford, MD, MPH

3 High-flow nasal cannula improves dyspnea in palliative care patients with respiratory failure

CLINICAL QUESTION: Does a high-flow nasal cannula improve acute dyspnea in palliative care patients?

BACKGROUND: For patients receiving palliative care who develop respiratory distress, conventional oxygen therapy may not adequately relieve symptoms of dyspnea, and noninvasive ventilation may not promote comfort.

Few randomized controlled trials have investigated the use of high-flow nasal cannula (HFNC) for treatment of palliative care patients who present to the hospital with respiratory distress.

STUDY DESIGN: Randomized crossover study.

SETTING: Emergency department of a single institution.

SYNOPSIS: Forty-eight palliative care patients who presented to the ED with acute dyspnea were enrolled and randomized to receive HFNC for 1 hour, followed by conventional oxygen therapy for 1 hour, or vice versa. The authors found that patients using HFNC reported significantly less dyspnea on a breathlessness severity scale, compared with patients using conventional oxygen therapy. Additionally, patients using HFNC had significantly lower respiratory rates, and HFNC use was associated with significantly lower need for morphine in a 1-hour period. The study was limited because of its single institution and small sample size, and therefore the results may not be generalizable to other patient populations.

BOTTOM LINE: Treatment with a high-flow nasal cannula may improve symptoms of acute dyspnea in palliative patients when compared with conventional oxygen therapy.

CITATION: Ruangsomboon O et al. High-flow nasal cannula versus conventional oxygen therapy in relieving dyspnea in emergency palliative patients with do-not-intubate status: A randomized crossover study. *Ann Emerg Med.* 2019 Dec 18. doi: 10.1016/j.annemergmed.2019.09.009.



Dr. Halford

4 Postop palliative care may improve outcomes for those undergoing high-risk surgery

CLINICAL QUESTION: Does palliative care consultation improve perception of care for high-risk surgery patients?

BACKGROUND: In the final year before death, surgery is common for many patients. Prior studies have shown that fewer than 38% of surgical patients receive palliative care services before death. Palliative care involvement has been shown to improve quality of life and coordination of care in surgical patients.

STUDY DESIGN: Retrospective cross-sectional analysis of administrative data.

SETTING: 129 Veteran Affairs medical centers.

SYNOPSIS: In a retrospective review of 95,204 patients who underwent high-risk surgical procedures, the authors identified a 90-day mortality rate of 6.0%. Only 3.5% of patients received a perioperative palliative care consult. Multivariate analysis of bereaved family survey scores of patients who died within 90 days of surgery showed that families of patients who received a palliative care consult were significantly more likely to rate the care (odds ratio, 1.47), end-of-life communication (OR, 1.43), and support (OR, 1.31) as excellent, compared with those who did not. The use of survey responses and the Veteran Affairs population possibly introduces selection bias and limitations to the generalizability of the study.

BOTTOM LINE: Palliative care consultation for patients undergoing high-risk surgery remains underutilized but may be beneficial for patients.

CITATION: Yefimova M et al. Palliative care and end-of-life outcomes following high-risk surgery. *JAMA Surg.* 2020 Jan 2;155(2):138-46.

Dr. Halford is a hospitalist at Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, both in Boston.

By Jennifer Hu, MD

5 In acute lower GI bleeding, there may be no benefit to early colonoscopy

CLINICAL QUESTION: Does early colonoscopy within 24 hours of presentation for adults with acute lower gastrointestinal bleeding improve outcomes, compared with elective colonoscopy beyond 24 hours?



Dr. Hu

BACKGROUND: Current U.S. guidelines recommend colonoscopy within 24 hours for patients presenting with high-risk or severe acute lower gastrointestinal bleeding. However, prior meta-analyses of the timing of colonoscopy relied primarily on observational studies, and a recent multicenter randomized, controlled trial suggests no substantial benefit for early colonoscopy.

STUDY DESIGN: Systematic review and meta-analysis of randomized, clinical trials.

SETTING: English language literature search from MEDLINE, EMBASE, and Cochrane Central Register of Controlled Trials, performed in July 2019.

SYNOPSIS: The authors identified four randomized, controlled trials that compared early colonoscopy (defined as within 24 hours) with elective colonoscopy (defined as beyond 24 hours) and/or other diagnostic tests for patients presenting with acute lower GI bleeding. They performed a meta-analysis, including 463 patients, which showed no significant difference in risk of persistent or recurrent bleeding for early versus elective colonoscopy. The authors also found no significant differences in secondary outcomes of mortality, endoscopic intervention, primary hemostatic intervention, or identification of bleeding source. Limitations of this research include the relatively small number of studies included, and potential for selection bias in the original studies. Notably two of the four studies included were prematurely terminated before their planned sample sizes were reached.

BOTTOM LINE: In patients hospitalized with acute lower GI bleeding, colonoscopy within 24 hours may not reduce further bleeding or mortality when compared with elective colonoscopy.

CITATION: Tsay C et al. Early colonoscopy does not improve outcomes of patients with lower gastrointestinal bleeding: Systematic review of randomized trials. *Clin Gastroenterol Hepatol.* 2019 Dec 13. doi: 10.1016/j.cgh.2019.11.061.

6 Electronic frailty index based on routine blood tests may help identify at-risk seniors

CLINICAL QUESTION: Can a frailty index using routine admission laboratory tests identify se-

Continued on following page

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Jeff Grill, MD, FAAP

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Continued from previous page

niors at increased risk for adverse outcomes after hospital admission?

BACKGROUND: Accurate identification of frail older patients at hospital admission may help target interventions; however, the extent to which risk prediction tools such as the frailty index can be utilized in the acute setting remains unclear.

STUDY DESIGN: Single-center prospective cohort study, during April 2015–January 2017.

SETTING: A tertiary care, academic medical center in the United Kingdom.

SYNOPSIS: This study enrolled 1,750 older adults, comprising 2,552 hospital admissions. For each admission, the authors generated a frailty index, called FI-Laboratory, based on the proportion of abnormal results from 27 of the most common admission laboratory tests. The authors found that an increase in the FI-Lab was significantly associated, independent of an existing chronic frailty score, with increased proportion of inpatient days, discharge to a higher level of care, readmission rates, and mortality. Notably, researchers were unable to calculate the FI-Lab score in 11.6% of cases because of insufficient laboratory information. The single-center design of this study may limit its generalizability.

BOTTOM LINE: The FI-Laboratory may provide information, complementary to existing frailty assessments, to help identify older adults at increased risk of inpatient adverse outcomes.

CITATION: Logan Ellis H et al. Complementing chronic frailty assessment at hospital admission with an electronic frailty index (FI-Laboratory) comprising routine blood test results. *CMAJ*. 2020;192(1):e3-8.

Dr. Hu is a hospitalist at Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, both in Boston.

By Monica Midha, MD, MBS

7 Hospital acquisition had no significant change in the rate of readmission or mortality

CLINICAL QUESTION: How do hospital acquisitions or consolidations affect patient satisfaction, the rate of readmission, and the mortality rate?



Dr. Midha

BACKGROUND: Prior studies have examined the impact of hospital system mergers on health care costs, but few studies have previously examined impact on quality and patient experience.

STUDY DESIGN: Retrospective, difference-in-difference analysis.

SETTING: 2,232 U.S. hospitals

during 2007-2016.

SYNOPSIS: The authors identified 2,232 hospitals, including 246 hospitals that were acquired between 2009 and 2013 and 1,986 control hospitals that were not acquired during this period. They used a difference-in-difference analysis to compare hospital performance on quality and patient experience measures from before and after an acquisition to concurrent changes in control hospitals. Hospital acquisition was associated with a significant decline in measured patient experience. There was no significant differential change in 30-day readmission or mortality. Although there was an association between acquisition and significant improvement in clinical process metrics, the authors found that this improvement occurred almost entirely prior to acquisition.

BOTTOM LINE: Hospital acquisition was associated with worse experience for patients and had no significant impact on readmission or mortality rates.

CITATION: Beaulieu ND et al. Changes in quality

of care after hospital mergers and acquisitions. *N Engl J Med*. 2020 Jan 2;382:51-9.

8 For patients with advanced CKD, low risk of nephrogenic systemic fibrosis with group II GBCAs

CLINICAL QUESTION: What is the risk of nephrogenic systemic fibrosis (NSF) with use of group II gadolinium-based contrast agents (GBCAs) in patients with chronic kidney disease (CKD) stages IV and V?

BACKGROUND: With more than 500 cases of NSF reported during 1997-2007, a black box warning advises against use of all GBCAs in at-risk CKD patients. However, newer literature has shown that group II GBCAs may have lower risks of causing NSF. The risk to patients with CKD IV and V is not clear.

STUDY DESIGN: Systematic review and meta-analysis.

SETTING: 2,700 citations were screened for eligibility, of which 16 studies were selected.

SYNOPSIS: The authors evaluated 4,931 administrations of group II GBCAs in patients with CKD stages IV and V to determine the pooled incidence of NSF in this population. The pooled incidence of NSF was 0% (0 out of 4,931) with an upper bound of the 95% confidence interval of 0.07%. The analysis did not examine sequential group II GBCA exposures or the use of group II GBCAs in the setting of acute kidney injury. The authors advocate that the harms of withholding group II GBCAs in patients with advanced CKD (e.g., underdiagnosis or delay in diagnosis) may outweigh the risk of group II GBCA administration in this population.

BOTTOM LINE: The risk of NSF with use of group II GBCAs in patients with advanced CKD is likely less than 0.7%.

SHORT TAKES

Brief smoking cessation intervention in ED patients awaiting care leads to higher quit rates

Patients in the ED who received brief “self-determination” smoking cessation interventions with four follow-up phone calls had significantly increased rates of biochemically validated abstinence at 6 months, compared with patients who received only a cessation pamphlet.

CITATION: Li WHC et al. Effectiveness of a brief self-determination theory-based smoking cessation intervention for smokers at emergency departments in Hong Kong: A randomized clinical trial. *JAMA Intern Med*. 2020;180(2):206-14.

Health outcomes and utilization similar for emergent surgery and acute medical illness

A retrospective review of Medicare patients undergoing emergent gen-

eral surgery showed similarly high rates of 1-year mortality, hospital days, and days away from home as seen in those patients hospitalized with pneumonia, heart failure, and acute MI.

CITATION: Lee KC et al. Mortality and health care utilization among Medicare patients undergoing emergency general surgery vs. those with acute medical conditions. *JAMA Surg*. 2019 Dec 26. doi: 10.1001/jamasurg.2019.5087.

USPSTF continues to recommend one-time AAA screening for older men who have ever smoked

In recently updated guidelines, the United States Preventative Services Task Force recommended that men aged 65-75 years who smoke or used to smoke would benefit from one-time abdominal aortic aneurysm (AAA) screening with ultrasonography; selective screening is also

recommended for men aged 65-75 years who have never smoked.

CITATION: Screening for abdominal aortic aneurysm: U.S. Preventative Services Task Force Recommendation Statement. *JAMA*. 2019 Dec 10;322(22):2211-18.

Patients need rapid follow-up after admission for e-cigarette or vaping product use-associated lung injury

Patients with e-cigarette or vaping product use-associated lung injury have a high risk of rehospitalization and death within 2 days of discharge; optimal outpatient follow-up should be scheduled within 48 hours of discharge to reduce the risk of rehospitalization and death.

CITATION: Siegel DA et al. Update: Interim guidance for health care professionals evaluating and caring for patients with suspected e-cigarette, or vaping, product use-asso-

ciated lung injury and for reducing the risk for rehospitalization and death following hospital discharge – United States, December 2019. *MMWR Morb Mortal Wkly Rep*. 2020;68:1189-94.

One in eight patients with atherosclerotic cardiovascular disease report medication cost as primary reason for nonadherence

A U.S. national survey of 14,279 adults with atherosclerotic cardiovascular disease found that 12.6% reported “cost-related nonadherence,” defined as skipping doses, taking less medication than prescribed, or delaying refills to save money.

CITATION: Khera R et al. Cost-related medication nonadherence in adults with atherosclerotic cardiovascular disease in the United States, 2013-2017. *Circulation*. 2019;140:2067-75.

CITATION: Woolen SA et al. Risk of nephrogenic systemic fibrosis in patients with stage 4 or 5 chronic kidney disease receiving a group II gadolinium-based contrast agent: A systematic review and meta-analysis. *JAMA Intern Med.* 2020;180(2):223-30.

Dr. Midha is a hospitalist at Beth Israel Deaconess Medical Center, instructor of medicine, Boston University, and part-time instructor in medicine, Harvard Medical School, all in Boston.

By Brian Persaud, MD

9 Hospital-level care at home for acutely ill adults may be as safe as inpatient care

CLINICAL QUESTION: Does hospital-level care at home reduce health care cost, usage, and readmission rates?

BACKGROUND: Providing hospital-level care at home for select patients has proven to reduce health care cost, usage, and readmission rates, while maintaining quality and safety in other developed countries but few studies exist in the United States.

STUDY DESIGN: Randomized, controlled, unblinded, parallel-design trial.

SETTING: Home hospital care versus inpatient care at two Boston academic hospitals, during June 2017–January 2018.

SYNOPSIS: The study enrolled 91 adult patients from the emergency department who were deemed appropriate for non-ICU admission for treatment of prespecified diagnoses (i.e., COPD exacerbation, heart failure exacerbation, etc.). Participants were randomized to

usual inpatient care or home hospital care. All home hospital patients received daily internist visits, twice-daily nursing visits, home access to additional services (physical/occupational therapy, social work, etc.), oxygen, IV medications, labs, radiology, and continuous monitoring. The authors found that home hospital care resulted in a lower total cost ($P < .001$), lower use of imaging and labs, and lower 30-day readmission rate, without appreciable differences in quality or safety between the two groups. Given that the study was performed at only two academic hospitals, it is unclear if these findings can be generalized to other health systems.

BOTTOM LINE: For the care of select illnesses, hospital-level care at home may be cheaper, may be just as safe, and reduced readmission rates when compared with inpatient care.

CITATION: Levine D et al. Hospital-level care at home for acutely ill adults. *Ann Intern Med.* 2020;172:77-85.

10 Early high-dose vitamin D₃ did not reduce mortality in critically ill, vitamin D-deficient patients

CLINICAL QUESTION: Does early administration of high-dose vitamin D₃ in critically ill, vitamin D-deficient patients reduce 90-day all-

cause mortality?

BACKGROUND: Critically ill patients are often vitamin D deficient, but no large randomized trials have investigated whether early vitamin D supplementation can affect clinical outcomes.

STUDY DESIGN: Multicenter, randomized, double-blind, placebo-controlled phase 3 trial.

SETTING: 44 U.S. hospitals, during April 2017–July 2018.

SYNOPSIS: The study enrolled 1,078 patients with 25-hydroxyvitamin D levels < 20 ng/mL who were critically ill (defined as patients being admitted to the ICU with one or more risk factor for lung injury or death). Participants were randomized to early administration of a single dose of 540,000 IUs of enteral vitamin D₃ or placebo. The authors did not identify a statistically significant difference in the 90-day all-cause mortality between the two groups. Additionally, there were no significant differences in length of stay, ventilator-free days or serious adverse outcomes between the two groups.

BOTTOM LINE: Early administration of high-dose enteral vitamin D₃ did not decrease 90-day all-cause mortality in critically ill, vitamin D-deficient patients.

CITATION: Ginde A et al. Early high-dose vitamin D₃ for critically ill, vitamin D-deficient patients. *N Engl J Med.* 2019 Dec 26; 281:2529-40.

Dr. Persaud is a hospitalist, Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, both in Boston.



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Pediatric ITL

Acute kidney injury in children hospitalized with diarrheal illness in the U.S.

By Anika Kumar, MD, FAAP

CLINICAL QUESTION: What are the incidence and consequences of acute kidney injury among children hospitalized with diarrheal illness in the United States?

BACKGROUND: Diarrheal illness is the fourth-leading cause of death for children younger than 5 years and the fifth-leading cause of years of life lost globally. In the United States, diarrheal illness remains a leading cause of hospital admission among young children. Complications of severe diarrheal illness include hypovolemic acute kidney injury (AKI). Hospitalized children who develop AKI experience longer hospital stays and higher mortality. Additionally, children who experience AKI are at increased risk for chronic kidney disease (CKD), hypertension, and proteinuria.

STUDY DESIGN: Retrospective cohort study.

SETTING: Kids' Inpatient Database (KID) from 2009 and 2012. The authors used secondary International Classification of Diseases, Ninth

Revision (ICD-9) diagnoses of AKI to identify patients.

SYNOPSIS: The authors reviewed all patients with diarrhea and found that the incidence of AKI in children hospitalized was 0.8%. Those with infectious diarrhea had an incidence of 1% and with noninfectious diarrhea had an incidence of 0.6%.

There was a higher incidence of dialysis-requiring AKI in patients with infectious diarrhea. The odds of developing AKI increased with older age in both infectious and noninfectious diarrheal illnesses. As compared with noninfectious diarrheal illness, infectious diarrheal illness was associated with higher odds of AKI (odds ratio, 2.1; 95% confidence interval, 1.7-2.7). Irrespective of diarrhea type, hematologic and rheumatologic conditions, solid-organ transplant, CKD, and hypertension were associated with higher odds of developing AKI.

AKI in infectious diarrheal illness was also associated with other renal or genitourinary abnormalities, whereas AKI in noninfectious diarrheal illness was associated with

diabetes and cardiovascular and neurologic conditions.

Hospitalizations for diarrheal illness complicated by AKI were associated with higher mortality, prolonged length of stay, and higher hospital cost with odds of death increased eightfold with AKI, mean hospital stay was prolonged by 3 days, and costs increased by greater than \$9,000 per hospital stay. The development of AKI in hospitalized diarrheal illness was associated with an up to 11-fold increase in the odds of in-hospital mortality for infectious (OR, 10.8; 95% CI, 3.4-34.3) and noninfectious diarrheal illness (OR, 7.0; 95% CI, 3.1-15.7).

The strengths of this study include broad representation of hospitals caring for children across the United States. The study was limited by its use of ICD-9 codes which may misidentify AKI. The authors were unable to determine if identifying AKI could improve outcomes for patients with diarrheal illness.

BOTTOM LINE: AKI in diarrhea illnesses is relatively rare. Close attention should be given to patients with



Dr. Kumar is a pediatric hospitalist at Cleveland Clinic Children's. She is a clinical assistant professor of pediatrics at Case Western Reserve University, and serves as the pediatrics editor for *The Hospitalist*.

certain serious comorbid illnesses.

CITATION: Bradshaw C et al. Acute kidney injury in children hospitalized with diarrheal illness in the United States. *Hosp Pediatr*. 2019 Dec;9(12):933-41.

Fight COVID-19 myths and misinformation

By Randy Dotinga

Misinformation about COVID-19 travels faster than the virus and complicates the job of doctors who are treating those infected and responding to concerns of their other patients.

An array of myths springing up around this disease can be found on the Internet. Widespread misinformation hampers public health efforts to control the disease outbreak, confuses the public, and requires medical professionals to spend time refuting myths and re-educating patients.

Know what physicians can do to counter misinformation

Pulmonologist and critical care physician Cedric "Jamie" Rutland, MD, FCCP, who practices in Riverside, Calif., sees misinformation about the novel coronavirus every day. His patients worry that every-

one who gets infected will die or end up in the ICU. His neighbors ask him to pilfer surgical masks to protect them from the false notion that Chinese people in their community posed some kind of COVID-19 risk.

As he pondered how to counter myths with facts, Dr. Rutland turned to an unusual resource: his 7-year-old daughter. He explained to her how COVID-19 works and found that she could easily understand the basics. Now, Dr. Rutland draws upon the lessons from chats with his daughter as he explains COVID-19 to his patient audience on his YouTube channel "Medicine Deconstructed." Simplicity, but not too much simplicity, is key, he said.

Make sure all staff get reliable information

Hospitals are scrambling to keep staff safe with up-to-date directives and debunk false narratives about

the virus. Keeping all hospital staff informed with verified and authoritative facts about the coronavirus is a key objective of the Massachusetts General Hospital's Center for Disaster Medicine. The Center's coronavirus educational materials are distributed to all staffers from physicians to janitors.

Use patience with your patients

Boston cardiologist Haider Warraich, MD, of Brigham and Women's Hospital, said it's important to "put medical information into a greater human context." For example, he has told patients that he's still taking his daughter to school despite COVID-19 risks. "I take the information I provide and apply it to my own life," he said.

The Washington State Department of Health offers this advice to physicians to counter false information and stigma: "Stay updated and informed on COVID-19 to avoid

miscommunication or inaccurate information. Talk openly about the harm of stigma. View people directly impacted by stigma as people first. Be conscious of your language. Acknowledge access and language barriers."

Use public health organizations to fight the 'infodemic'

The World Health Organization identified early in the COVID-19 outbreak the global wave of misinformation about the virus and dubbed the problem the "infodemic." The WHO "Q & A" page on COVID-19 is updated frequently and addresses myths and rumors currently circulating.

The CDC has followed with its own "frequently asked questions" page to address questions and rumors. State health agencies have put up COVID-19 pages to address public concerns and offer advice on prevention.



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The Division of Hospital Medicine at Penn State Health is made up of five teaching teams, five attending teams, two nocturnists, one consult team and one triage team. Together they provide inpatient care to 140+ hospitalized patients per day. The discipline of hospital medicine grew out of the increasing complexity of patients requiring hospital care and the need for dedicated clinicians to oversee their care. There are plans to further expand the number of providers, presenting a tremendous opportunity for a visionary leader to establish a national presence.



PennState Health
Milton S. Hershey Medical Center

**INQUIRIES, NOMINATIONS AND EXPRESSIONS OF INTEREST, INCLUDING A CURRICULUM VITAE AND COVER LETTER, SHOULD BE SUBMITTED CONFIDENTIALLY VIA EMAIL TO
Heather Peffley, PHR FASPR: hpeffley@pennstatehealth.psu.edu.**

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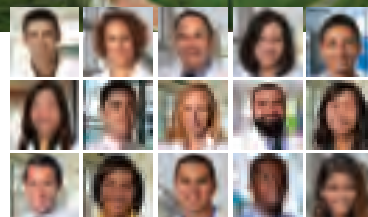
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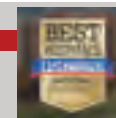
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Attn: Vice Chairman, Dept of Medicine-Hospital Operations

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What We're Offering:

- Academic Hospitalist and Nocturnist positions (Hershey, PA)
- Community Setting Hospitalist opportunities (Lancaster and Berks County positions)
- We'll foster your passion for patient care and cultivate a collaborative environment rich with diversity
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- Experienced hospitalist colleagues and collaborative leadership
- Salary commensurate with qualifications
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What We're Seeking:

- Completion of an accredited training program
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- BE/BC in Family Medicine or Internal Medicine (position dependent)

No J1 visa waiver sponsorships available

What the Area Offers:

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For more information please contact:

Heather J. Peffley, PHR FASPR, Penn State Health Physician Recruiter

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The future of hospital medicine

Ensured? Or a definite maybe?

By Laurence Wellikson, MD, MHM

When I started at SHM in 2000, there were fewer than 1,000 hospitalists in the United States, and now there are more than 60,000. SHM (back then, we were the National Association of Inpatient Physicians) had about 300 members; now, we have more than 20,000.

Today, hospitalists are part of the medical staff at virtually every hospital in the country, and hospital medicine is recognized as a unique medical specialty with our own knowledge base, textbooks, competencies, meetings, and medical professional society. In a health care environment swirling with change, we are one of the few specialties forged with the ability to adapt and,

“In a health care environment swirling with change, we are one of the few specialties forged with the ability to adapt and, at times, lead this change.”

at times, lead this change. Yet there is so much disruption and instability that there are still many twists and turns in the road that will affect hospitalists' ability to carve out an even brighter future.

Consolidation has come to health care on a large scale. Hospitals are merging. Health insurers are combining, and even large hospital medicine companies like TeamHealth, Sound, Envision, and others are merging, growing, and acquiring.

At the same time, outside forces from industries not usually associated with health care or inpatient care are swarming into our world: CVS acquires Aetna and aims to reshape primary care; Amazon dominates health care supply chains and moves into pharmacy benefits, and even gets into health care delivery via their partnership with Berkshire Hathaway and JP Morgan; Walmart merges with Humana to create one of the biggest players in Medicare; and Apple expands their inroads into wearables and chronic disease management.

Employment of clinicians has grown logarithmically, especially with inpatient physicians, reshaping the medical staff compensation and accountability. At the same time, payers, both government and private, are evolving into population health with an emphasis not so much on transactions (visits and procedures), but more aligned with outcomes, effectiveness, and efficiency.

All of this leads to a new paradigm of what is important and a new set of values that seems

at times more like corporate America where the loyalty of employees can be torn between their employer and the patient. This is especially troublesome in a field traditionally based on the primacy of the doctor-patient relationship. This can put the hospitalist right in the middle at the time when the patient can be most vulnerable.

This has led to new ways to deliver the care that hospitalists provide. First as a pilot and now moving more mainstream, patients with several diagnoses (e.g., heart failure, dehydration, or pneumonia) are now managed not in bricks and mortar hospitals, but in “hospitals at home.” The last few days of a typical hospitalization now take place outside the hospital in a skilled nursing facility (SNF). Fear of uncompensated and unnecessary readmissions leads hospitals to engage hospitalists to handle the first few postdischarge outpatient visits.

This is just a small part of the expanding scope for hospitalists. In addition to managing SNFs and the discharge clinic, hospitalists are now the major providers of perioperative care and play a growing role in palliative care, especially for inpatients. As other specialties that abut hospital medicine have increasing demands and yet fewer new specialists, hospitalists are taking on more critical care and geriatrics, providing procedures, and occupying an evolving role in the emergency room.

There is a lot of work coming toward hospital medicine, and to expand our workforce, hospital medicine groups have incorporated advanced practice providers, including nurse practitioners and physician assistants. But building a true team of health professionals is not seamless or easy with each constituency having a unique scope of practice, limits on their licensure, their own culture, and a distinct training background.

“In the end, this all comes back to how hospitalists add value, how we can create a career that is rewarding, and how we can help hospitalists be resilient and avoid burnout.”

But wait. There will be more new players on the hospital medicine team going forward – some we cannot even anticipate at the present time. In the future, the hospitalist may not even touch the electronic health record. Clinicians have never excelled at data entry or analysis, and it is time to use a combination of artificial intelligence (AI), voice-activated gathering of history into the record, and staff trained to manage the EHR on both the input and the output sides.

While there may be cheering for this new



Dr. Wellikson is the CEO of SHM and is retiring from his role in 2020. This article is the second in a series celebrating Dr. Wellikson's tenure as CEO.

approach to the EHR – especially because it is a major factor in hospitalist burnout – this will refocus the role and work of the hospitalist to be more of a reviewer and integrator of data, and a strategist and decision maker overseeing 30 or more patients. As Amazon, CVS, and Walmart move into health care, they will look for the best way to utilize the \$300-400/hour hospitalist to the top of our skill level.

In the end, this all comes back to how hospitalists add value, how we can create a career that is rewarding, and how we can help hospitalists be resilient and avoid burnout.


The good news is that hospitalists will not be replaced by AI, nor should we expect to have our incomes cut as less well-trained alternatives replace highly compensated physicians in other specialties. This is a real prospect for many other specialties like dermatology, radiology, pathology, anesthesiology, and even cardiology. But hospitalists will need to adapt to changes in what is valued (i.e., how you can be the most effective and efficient) and to a new job description (i.e., overseeing more patients and managing a team that does more of the H&P, data collecting, and bedside work).

After 20 years of coming out of nowhere to being in the middle of everything in health care, I am confident that hospitalists, with the help of SHM, can continue to forge a path where we can be key difference makers and where we can create a rewarding and sustainable career. It won't “just happen.” It is not inevitable. But if the past 20 years is any example, we are well positioned to make the adaptation to succeed in the next 20 years. It is up to all of us to make it happen.

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