

BRIAN HARTE, MD, SFHM

Embrace change as a  
hospitalist leader

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*Journal of Hospital Medicine*

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JOHN NELSON, MD, MHM

Effective hospitalist  
roles for NPs, PAs

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# The Hospitalist

VOLUME 21 No. 1 | JANUARY 2017

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## What lies ahead?

Uncertainty is the new normal – still, experts say  
hospitalists are primed to help shape American health care.

BY KELLY APRIL TYRRELL

**T**he New Year brings new leadership in the United States, with President-elect Donald J. Trump taking office later this month. With a Republican-controlled Congress, party leaders have the opportunity to shape the nation's policies around conservative ideals. This includes health care.

Since the Affordable Care Act (ACA) was passed in 2010, Republicans have vowed to repeal and replace it. This could be their opportunity.

However, while policy ideas proposed by House Speaker Paul Ryan (R-Wis.), and Tom Price – a Republican House representative, orthopedic surgeon, and Trump's appointed Health & Human Services secretary – could hold broad Republican appeal, "There is no clear coalescence around specific policy reforms that would replace the Affordable Care Act," says Christine Eibner, a senior economist at Rand and a professor at the Pardee Rand

Graduate School. "There are currently a lot of competing ideas floating around and Congress will need to settle on a single approach."

It's not clear whether Trump will agree with Congress. As a candidate, he did little to advance policy ideas around health care, though Price's selection "sends a strong signal that the Trump administration is serious about undoing the ACA," Eibner says.

"The Republicans now have a hard issue in their hands," says Allison Hoffman, JD, professor of law at UCLA School of Law and an expert on health care law and policy. "It was hard before the Affordable Care Act, and it will be hard after. There is not an easy solution."

By 2016, the ACA had expanded health coverage to 20 million people through Medicaid and private insurance on health care marketplaces. It extended the solvency of the Medicare Hospital Insurance Trust Fund. It accelerated the pace of delivery system and payment reform through creation of the Center for Medicare & Medicaid Innovation (CMMI).

The law has not been without its challenges.

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### PRACTICE MANAGEMENT

## Ready for post-acute care?

As PAC expands, hospital  
medicine's role – and  
leadership – will be key.

BY KAREN APPOLD

**T**he definition of "hospitalist," according to the SHM website, is a clinician "dedicated to delivering comprehensive medical care to hospitalized patients." For years, the hospital setting was the specialties' identifier. But as hospitalists' scope has expanded, and post-acute care (PAC) in the United States has grown, more hospitalists are extending their roles into this space.

PAC today is more than the traditional nursing home, according to Manoj K. Mathew, MD, SFHM, national medical director of Agilon Health in Los Angeles.

"Previously, physicians considered post-acute care only within the limited scope of what's

in their own care universe – such as skilled nursing facilities [SNFs], inpatient rehabilitation facilities [IRFs], long-term acute care hospitals [LTACHs], and home health visits," Dr. Mathew says. "But in today's world, PAC goes well beyond these types of facilities to include other types: postdischarge clinics, palliative care programs, chronic-care/high-risk clinics, home care, and telehealth."

Many of those expanded settings Dr. Mathew describes emerged as a result of the Affordable Care Act. Since its enactment in 2010, the ACA has heightened providers' focus on the "Triple Aim" of improving the patient experience (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.<sup>1</sup>

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Previously, physicians considered post-acute care only within the limited scope of what's in their own care universe – such as skilled nursing facilities, inpatient rehabilitation facilities, long-term acute-care hospitals, and home health visits.

—Manoj K. Mathew, MD, SFHM

Vishal Kuchaculla, MD, New England regional post-acute medical director of Boston-based TeamHealth, says new service lines also developed as Medicare clamped down on long-term inpatient hospital stays by giving financial impetus to discharge patients as soon as possible.

“Over the last few years, there’s been a major shift from fee-for-service to risk-based payment models,” Dr. Kuchaculla says. “The government’s financial incentives are driving outcomes to improve performance initiatives.”

Another reason for increased Medicare spending on PAC stems from the fact that patients no longer need to be hospitalized before going to a PAC setting.

“Today, LTACHs can be used as substitutes for short-term acute care,” says Sean R. Muldoon, MD, MPH, FCCP, chief medical officer of Kindred Healthcare in Louisville, Ky., and former chair of SHM’s Post-Acute Care Committee. “This means that a patient can be directly admitted from their home to an LTACH. In fact, many hospice and home-care patients are referred from physicians’ offices without a preceding hospitalization.”

## Hospitalists can fill a need

More hospitalists are working in PACs for a number of reasons. Dr. Mathew says that PAC facilities and services have “typically lacked the clinical structure and processes to obtain the results that

patients and payors expect.

“These deficits needed to be quickly remedied as patients discharged from hospitals have increased acuity and higher disease burdens,” he adds. “Hospitalists were the natural choice to fill roles requiring their expertise and experience.”

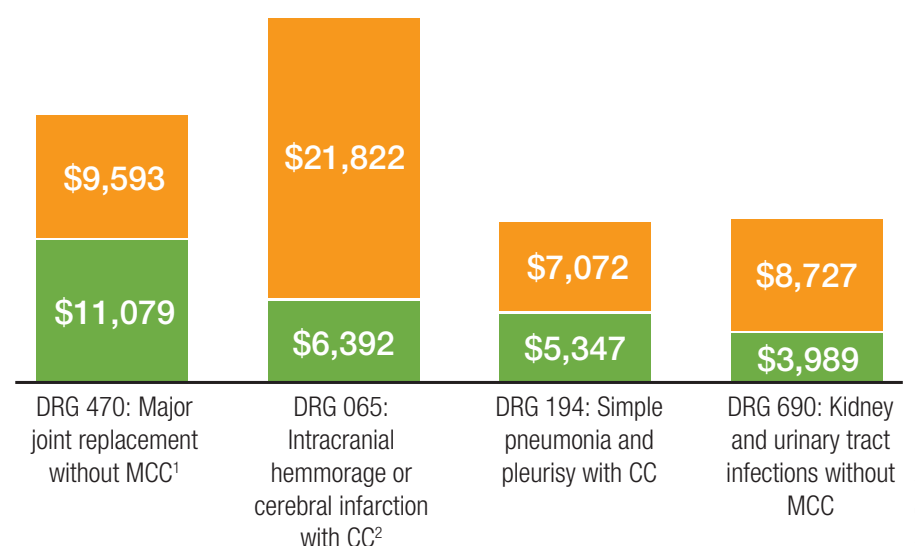
Dr. Muldoon considers the expanded scope of practice into PACs an additional layer to hospital medicine’s value proposition to the health care system.

“As experts in the management of inpatient populations, it’s natural for hospitalists to expand to other facilities with inpatient-like populations,” he says, noting SNFs are the most popular choice, with IRFs and LTACHs also being common places to work. Few hospitalists work in home care or hospice.

PAC settings are designed to help patients who are transitioning from an inpatient setting back to their home or other setting.

“Many patients go home after a SNF stay, while others will move to a nursing home or other longer-term care setting for the first time,” says Tiffany Radcliff, PhD, a health economist in the department of health policy and management at Texas A&M University School of Public Health in College Station. “With this in mind, hospitalists working in PAC have the opportunity to address each patient’s ongoing care needs and prepare them for their next setting. Hospitalists can manage medication or other care regimen changes

## Medicare claims for 30-day episodes beginning with hospitalization

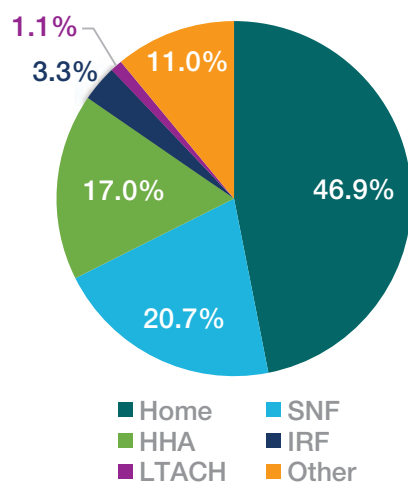


■ Initial acute stay ■ Postdischarge care

Source: Advisory Board

## Acute discharge destination

Hospital discharge disposition by post-acute care site, patients 65+



Source: DHG Healthcare - 2013 Medicare Standard Analytical File (SAF)

that resulted from an inpatient stay, reinforce discharge instructions to the patient and their caregivers, and identify any other issues with continuing care that need to be addressed before discharge to the next care setting.”

### Transitioning care

Even if a hospitalist is not employed at a PAC, it's important that they know something about them.

“As patients are moved downstream earlier, hospitalists are being asked to help make a judgment regarding when and where an inpatient is transitioned,” Dr. Muldoon says. As organizations move toward becoming fully risk capable, it is necessary to develop referral networks of high-quality PAC providers to achieve the best clinical outcomes, reduce readmissions, and lower costs.<sup>2</sup>

“Therefore, hospitalists should have a working knowledge of the different sites of service as well as some opinion on the suitability of available options in their community,” Dr. Muldoon says. “The hospitalist can also help to educate the hospitalized patient on what to expect at a PAC.”

If a patient is inappropriately prepared for the PAC setting, it could lead to incomplete management of their condition, which ultimately could lead to readmission.

“When hospitalists know how care is provided in a PAC setting, they are better able to ensure a smoother transition of care between settings,” says Tochi Iroku-Malize,

MD, MPH, MBA, FACP, SFHM, chair of family medicine at Northwell Health in Long Island, N.Y. “This will ultimately prevent unnecessary readmissions.”

Further, the quality metrics that hospitals and thereby hospitalists are judged by no longer end at the hospital's exit.

“The ownership of acute-care outcomes requires extending the accountability to outside of the institution's four walls,” Dr. Mathew says. “The inpatient team needs to place great importance on the transition of care and the subsequent quality of that care when the patient is discharged.”

Robert W. Harrington Jr., MD, SFHM, chief medical officer of Plano, Tex.-based Reliant Post-Acute Care Solutions and former SHM president, says the health system landscapes are pushing HM beyond the hospitals' walls.

“We're headed down a path that will mandate and incentivize all of us to provide more-coordinated, more-efficient, higher-quality care,” he says. “We need to meet patients at the level of care that they need and provide continuity through the entire episode of care from hospital to home.”

### How PAC settings differ from hospitals

Practicing in PAC has some important nuances that hospitalists from short-term acute care need to get accustomed to, Dr. Muldoon says. Primarily, the diagnostic capabilities are much more limited, as is the presence of high-level staffing. Further, patients are less resilient to medication changes and interventions, so changes need to be done gradually.

“Hospitalists who try to practice acute-care medicine in a PAC setting may become frustrated by the length of time it takes to do a work-up, get a consultation, and respond to a patient's change of condition,” Dr. Muldoon says. “Nonetheless, hospitalists can overcome this once recognizing this mind shift.”

According to Dr. Harrington, another challenge hospitalists may face is the inability of the hospital's and PAC facility's IT platforms to exchange electronic information.

“The major vendors on both sides need to figure out an interoperability strategy,” he says. “Currently, it often takes 1-3 days to receive a new patient's discharge summary. The summary may consist of a stack of paper that takes significant time to sort through and requires the PAC facility to perform duplicate data entry. It's a very

## The cost of care, and other PAC facts and figures

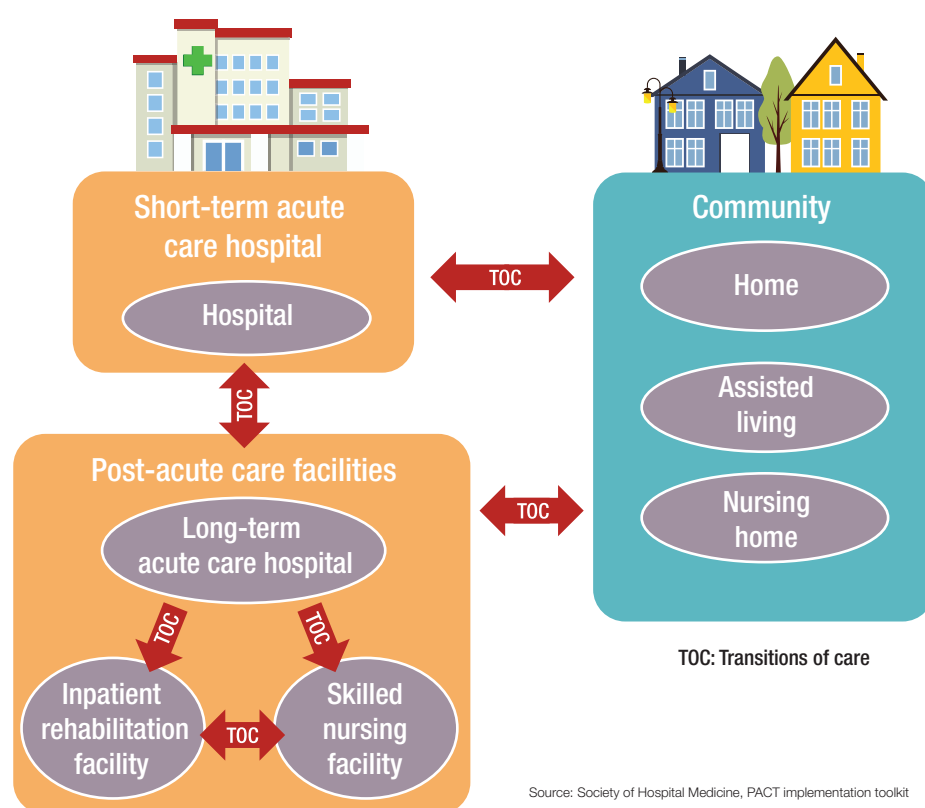
BY KAREN APPOLD

The amount of money that Medicare spends on post-acute care (PAC) has been increasing. In 2012, 12.6% of Medicare beneficiaries used some form of PAC, costing \$62 billion.<sup>2</sup> That amounts to the Centers for Medicare & Medicaid Services spending close to 25% of Medicare beneficiary expenses on PAC, a 133% increase from 2001 to 2012. Among the different types, \$30.4 billion was spent on skilled nursing facilities (SNFs), \$18.6 billion on home health, and \$13.1 billion on long-term acute care (LTAC) and

acute-care rehabilitation.<sup>2</sup>

It's also been reported that, after short-term acute-care hospitalization, about one in five Medicare beneficiaries requires continued specialized treatment in one of the three typical Medicare PAC settings: inpatient rehabilitation facilities (IRFs), LTAC hospitals, and SNFs.<sup>3</sup>

What's more, hospital readmission nearly doubles the cost of an episode, so the financial implications for organizations operating in risk-bearing arrangements are significant. In 2013, 2,213 hospitals were charged \$280 million in readmission penalties.<sup>2</sup>



highly inefficient process that opens up the doors to mistakes and errors of omission and commission that can result in bad patient outcomes.”

Arif Nazir, MD, CMD, FACP, AGSF, chief medical officer of Signature Health-CARE and president of SHC Medical Partners, both in Louisville, Ky., cites additional reasons the lack of seamless communication between a hospital and PAC facility is problematic. “I see physicians order laboratory tests and investigations that were already done in the hospital because they didn't know they were already performed or never received the results,” he says. “Similarly, I see patients continue to take medications prescribed in the hospital long term even though they were only supposed to take them short term. I've also seen patients come to a PAC setting from a hospital without any formal understanding of their rehabilitative period and expectations for recovery.”

Despite some frustrations cited by others,

James D. Tollman, MD, FHM, president of Boxford, Mass.-based Essex Inpatient Physicians, believes working in a PAC setting can be a less-demanding environment for a hospitalist than an inpatient facility. “They have much more flexibility with their schedule,” he says. “In the hospital, hospitalists have longer, more physically demanding shifts. At SNFs, the level of decision making is often easier; usually they house lower-acuity patients. However, there might be more challenges with disposition, family issues, and follow-ups. Plus, you have to do more to coordinate care.”

### What's ahead?

Looking to the future, Surafel Tsega, MD, clinical instructor at Mount Sinai Hospital in New York, says he thinks there will be a move toward greater collaboration among inpatient and PAC facilities, particularly in the discharge process, given that hospitals have an added incentive to ensure

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These deficits needed to be quickly remedied as patients discharged from hospitals have increased acuity and higher disease burdens. Hospitalists were the natural choice to fill roles requiring their expertise and experience.

—Sean R. Muldoon, MD, MPH, FCCP

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# The Hospitalist



Hospitalists working in PAC have the opportunity to address each patient's ongoing care needs and prepare them for their next setting. Hospitalists can manage medication or other care regimen changes that resulted from an inpatient stay, reinforce discharge instructions to the patient and their caregivers, and identify any other issues with continuing care that need to be addressed before discharge to the next care setting.

—Tiffany Radcliff, PhD

#### CONTINUED FROM PAGE 3

safe transitions because reimbursement from the Centers for Medicare & Medicaid Services is tied to readmissions and there are penalties for readmission. This involves more comprehensive planning regarding “warm handoffs” (e.g., real-time discussions with PAC providers about a patient's hospital course and plan of care upon discharge), transferring of information, and so forth.

And while it can still be challenging to identify high-risk patients or determine the intensity and duration of their care, Dr. Mathew says risk-stratification tools and care pathways are continually being refined to maximize value with the limited resources available. In addition, with an increased emphasis on employing a team approach to care, there will be better integration of non-medical services to address the social determinants of health, which play significant roles in overall health and healing.

“Working with community-based organizations for this purpose will be a valuable tool for any of the population health-based initiatives,” he says.

Dr. Muldoon says he believes health care

reform will increasingly view an inpatient admission as something to be avoided.

“If hospitalization can't be avoided, then it should be shortened as much as possible,” he says. “This will shift inpatient care into LTACHs, SNFs, and IRFs. Hospitalists would be wise to follow patients into those settings as traditional inpatient census is reduced. This will take a few years, so hospitalists should start now in preparing for that downstream transition of individuals who were previously inpatients.” **TH**

Karen Appold is a freelance medical writer in Pennsylvania.

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—Robert W. Harrington Jr., MD, SFHM

## NEXT MONTH



**PART 2** of our series features “8 things post-acute care experts think hospitalists should know.”

# Infectious disease physicians: Antibiotic shortages are the new norm

BY SHARON WORCESTER

Frontline Medical News

AT IDWEEK 2016

**NEW ORLEANS** – Antibiotic shortages reported by the Emerging Infections Network (EIN) in 2011 persist in 2016, according to a web-based follow-up survey of infectious disease physicians.

Of 701 network members who responded to the EIN survey in early 2016, 70% reported needing to modify their antimicrobial choice because of a shortage in the past 2 years. They did so by using broader-spectrum agents (75% of respondents), more costly agents (58%), less effective second-line agents (45%), and more toxic agents (37%), Adi Gundlapalli, MD, PhD, reported at an annual scientific meeting on infectious diseases.

In addition, 73% of respondents reported that the shortages affected patient care or outcomes, reported Dr. Gundlapalli of the University of Utah, Salt Lake City.

The percentage of respondents reporting adverse patient outcomes related to shortages increased from 2011 to 2016 (51% vs. 73%), he noted at the combined annual meetings of the Infectious Diseases Society of America, the Society of Healthcare Epidemiology of America, the HIV Medicine Association, and the Pediatric Infectious Diseases Society.

The top 10 antimicrobials they reported as being in short supply were piperacillin-tazobactam, ampicillin-sulbactam, meropenem, cefotaxime, cefepime, trimethoprim-sulfamethoxazole (TMP-SMX), doxycycline, imipenem, acyclovir, and amikacin. TMP-SMX and acyclovir were in short supply at both time points.

The most common ways respondents reported learning about drug shortages

were from hospital notification (76%), from a colleague (56%), from a pharmacy that contacted them regarding a prescription for the agent (53%), or from the Food and Drug Administration website or another website on shortages (23%). The most common ways of learning about a shortage changed – from notification after trying to prescribe a drug in 2011, to proactive hospital/system (local) notification in 2016; 71% of respondents said that communications in 2016 were sufficient.

Most respondents (83%) reported that guidelines for dealing with shortages had been developed by an antimicrobial stewardship program (ASP) at their institution.

“This, I think, is one of the highlight results,” said Dr. Gundlapalli, who is also a staff physician at the VA Salt Lake City Health System. “In 2011, we had no specific question or comments received about [ASPs], and here in 2016, 83% of respondents’ institutions had developed guidelines related to drug shortages.”

Respondents also had the opportunity to submit free-text responses, and among the themes that emerged was concern regarding toxicity and adverse outcomes associated with increased use of aminoglycosides because of the shortage of piperacillin-tazobactam. Another – described as a blessing in disguise – was the shortage of meropenem, which led one ASP to “institute restrictions on its use, which have continued,” he said.

“Another theme was ‘simpler agents seem more likely to be in shortage,’” Dr. Gundlapalli said, noting ampicillin-sulbactam in 2016 and Pen-G as examples.

“And then, of course, the other theme across the board ... was our new asset,” he said, explaining that some respondents commented on the value of ASP pharma-

Of 701 network members who responded to the EIN survey in early 2016, 70% reported needing to modify their antimicrobial choice because of a shortage in the past 2 years.

—Adi Gundlapalli, MD, PhD

cists and programs to help with drug shortage issues.

The overall theme of this follow-up survey, in the context of prior surveys in 2001 and 2011, is that antibiotic shortages are the “new normal – a way of life,” Dr. Gundlapalli said.

“The concerns do persist, and we feel there is further work to be done here,” he said. He specifically noted that there is a need to inform and educate fellows and colleagues in hospitals, increase awareness generally, improve communication strategies, and conduct detailed studies on adverse effects and outcomes.

“And now, since ASPs are very pervasive ... maybe it’s time to formalize and delineate the role of ASPs in antimicrobial shortages,” he said.

The problem of antibiotic shortages “harkens back to the day when penicillin was recycled in the urine [of soldiers in World War II] to save this very scarce resource ... but that’s a very extreme measure to take,” noted Donald

Graham, MD, of the Springfield (Ill.) Clinic, one of the study’s coauthors. “It seems like it’s time for the other federal arm – namely, the Food and Drug Administration – to do something about this.”

Dr. Graham said he believes the problem is in part because of economics, and in part because of “the higher standards that the FDA imposes upon these manufacturing concerns.” These drugs often are low-profit items, and it isn’t always in the financial best interest of a pharmaceutical company to upgrade their facilities.

“But they really have to recognize the importance of having availability of these simple agents,” he said, pleading with any FDA representatives in the audience to “maybe think about some of these very high standards.”

Dr. Gundlapalli reported having no disclosures. Dr. Graham disclosed relationships with Astellas and Theravance Biopharma.

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## Long-term opioid use uncommon among trauma patients

BY MICHELE G. SULLIVAN

Frontline Medical News

AT THE ACS CLINICAL CONGRESS

**WASHINGTON** – Patients with traumatic injuries don’t appear to be at undue risk of sustained opioid use, a large database review has demonstrated.

More than half of the 13,000 patients in the study were discharged on opioids, but they were able to discontinue them fairly rapidly, Muhammad Chaudhary, MD, said at the annual clinical congress of the American College of Surgeons. Within 3 months, less than one-third were still using the drugs, and 1 year later, only 1% were still taking an opioid pain medication.

“We found that sustained opioid use was very uncommon among these patients with moderate-severe traumatic injuries,” said Dr. Chaudhary, a postdoctoral

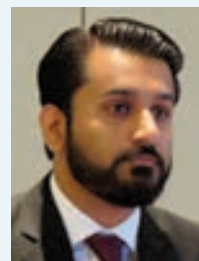
research fellow at Brigham and Women’s Hospital, Boston. “Furthermore, we didn’t find any association of opioid use with depression or anxiety.”

Dr. Chaudhary examined opioid use among 13,624 patients included in the Tricare military insurance database. The patients were treated for traumatic injuries they received during 2007-2013. Most of the patients were men (82%), and the largest age group was 18- to 24-year-olds (39%). Military rank was used as a proxy for socioeconomic status in this study: 15% of the cohort had an officer rank, while the rest were junior or senior enlisted personnel.

The group was very healthy, with a median Charlson Comorbidity Index score of 0. They were somewhat seriously injured, however. The median Injury Severity Score was 13, and the range was 9-17. Anxiety and depression were

uncommon (9% and 7%, respectively).

More than half the patients (54%) were discharged on an opioid medication. That percentage dropped very rapidly. By 90 days after discharge, just 9% of patients were still taking the drugs. By 1 year, only 1% were using opioids.



Dr. Chaudhary

Dr. Chaudhary conducted a multivariate analysis that controlled for a number of factors, including age, gender, marital status, rank, mental health status, injury severity, comorbidities, and treatment environment. Two factors – black race and younger age (18-24 years) – significantly increased the likelihood of early opioid

discontinuation (8% and 11%, respectively). There were no significant interactions with anxiety or depression.

Junior enlisted personnel – the proxy group for lower socioeconomic status – and those with a prolonged length of stay were significantly less likely to get off the medications, Dr. Chaudhary said.

“While we strongly believe that these factors should not be used to determine who can get opioids, it might make sense to enhance perioperative surveillance and engage pain management services early on in patients with risk factors, to reduce the risk of sustained opioid use,” he concluded.

Dr. Chaudhary had no financial disclosures.

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## Q&amp;A

# SHM member spotlight

Venkataraman Palabindala, MD, FHM, leads chapter development, lends expertise to SHM committees



Dr. Palabindala, FHM, is a hospitalist at the University of Mississippi Medical Center in Jackson. Dr. Palabindala is an active member of SHM's IT Committee and has been instrumental in growing the Gulf States Chapter.

By Brett Radler

**Editor's note:** Each month, SHM puts the spotlight on some of our most active members who are making substantial contributions to hospital medicine. Visit [www.hospitalmedicine.org/getinvolved](http://www.hospitalmedicine.org/getinvolved) for more information on how you can help SHM improve the care of hospitalized patients.

**Question:** What inspired you to begin working in hospital medicine and later join – and become so involved with – SHM?

**ANSWER:** I was exploring my options during my second year of residency at Greater Baltimore Medical Center as to what my final career path should be. I always loved inpatient medicine, mostly critical care, so I was thinking of completing a pulmonary critical-care fellowship. Completing a hospitalist rotation changed everything about how I saw my future and led me to specialize in hospital medicine.

Once I learned about SHM and the wealth of activities and opportunities membership offered from a few of my attendings, I applied to be part of the Leadership Committee. I attended every meeting and kept my committee work as a top priority. At the time, with little experience

SHM, I have become a Fellow in Hospital Medicine, attended two "Hill Days" to learn about the policies, and made a concerted effort to be present at as many meetings as possible, especially SHM's annual meetings. The networking, coupled with the workshops and lectures, is unparalleled. I have missed only one annual meeting, and I felt like I missed a Thanksgiving dinner with my family!

**Q:** Can you tell us about your role in the revitalization of the Gulf States Chapter and the Chapter Development Program?

**A:** During my time as a member of the SHM Leadership Committee, I quickly realized that hospitalists in small cities like Dothan, Ala., were not as exposed to networking and education activities as were those in big cities. To unite hospitalists in that area of the country, I founded the Wiregrass Chapter; obtaining 20 signatures to start it was an uphill task. After Dan Dressler, MD, [in Atlanta] and I gave a talk about updates in hospital medicine, the Wiregrass Chapter was awarded the Silver Chapter Award [after its first year in inception], and everything changed. The buzz around the chapter helped it continue to grow.

Now that hospitalists have left their stamp on inpatient medicine, specialties like critical care, nephrology, cardiology, and ob.gyn. are moving toward this model. We need to do everything we can to integrate them into our pool, move forward together, and learn from each other.

in hospital medicine, I knew I might not have as much to contribute as the rest, but my goal was to learn as much as I could. Never once did I feel that my voice was any more or less valuable than those of the rest of the committee members; our committee work was truly a collaborative effort.

As my career in hospital medicine has evolved, so have my contributions to SHM's committees; I now am a proud member of the IT Committee. We're currently working on a white paper about hospitalists' attitudes toward electronic health record (EHR) systems and look forward to sharing more about that next month.

In addition, throughout my time with

what we originally set out to do. By creating coupons to encourage membership and arranging more local meetings using this fund, we have been able to experience even more success. We are now recognizing that residents are very excited about SHM meetings and are identifying young leaders to be part of the hospital medicine movement.

**Q:** How has your participation in HMX – and, more broadly, engagement with SHM – helped you improve your practice?

**A:** HMX [[connect.hospitalmedicine.org](http://connect.hospitalmedicine.org)] is a great platform for asking questions and exchanging ideas. Being active on HMX has helped me learn important information about performance metrics, observation unit models, EHRs, coding and billing questions, and sometimes even ethical questions.

Although I still have mentors helping me, I know if I post a question on HMX, that I will get many ideas from hospitalists across the nation. I also make it a point to encourage friends every month to download the HMX app on their phones and present it as a valuable resource to my students and residents. As hospitalists, this is *our* forum with experts available all the time.

To encourage others to use the platform and make myself and fellow committee members accessible to other members, we actively take turns assuming responsibility for maintaining the momentum on HMX by finding intriguing topics of discussion.

**Q:** As we ring in 2017 after a year of many changes for HM and the health care system in general, what do you see as the biggest HM opportunities this year?

**A:** We know physician retention and burn-out are some of the biggest challenges in hospital medicine. Given the pace at which we are growing as a specialty, I would like to see more time dedicated to addressing and attempting to alleviate these specific issues.

Also, now that hospitalists have left their stamp on inpatient medicine, specialties like critical care, nephrology, cardiology, and ob.gyn. are moving toward this model. We need to do everything we can to integrate them into our pool, move forward together, and learn from each other.

Lastly, mentorship is of paramount importance as we head into the future. We must encourage young hospitalists to mentor students and residents and recruit them to be part of SHM when they return home. **TH**

Brett Radler is SHM's communications specialist.



# Sneak Peek: The Hospital Leader blog

Post election, what will change about how I treat at the bedside? Nothing.

BY JORDAN MESSLER, MD,  
SFHM

*To my next patient:*

I often avoid putting my politics on my sleeve, as I don't want that to get in the way of our relationship. I want you to know that I treat you as a fellow human being, no matter your race, gender, sexual orientation. With the election results, what will change about how I treat you at the bedside? Nothing.

I may know about your criminal past. I see that tattoo underneath your gown. I hear your profanity-filled screed because you won't get that MRI today. I know you don't follow the treatment plan, that you are here illegally, or that you are a refugee from another country.

I will still care for you no matter what. It's one of the blessed things we instill in each other in medicine.

I saw someone like you recently: 28 years old, working hard, with two jobs, neither of which provided insurance. She was doing well, without health problems, but then she

became fatigued and swollen. She came to the ER after weeks of suffering with what turned out to be failing kidneys. Lupus. She required expensive medications that would aim to reverse her kidney disease. She left the hospital not knowing what would happen next, as there was no way she could afford the treatment. The fates of medicine handed her an unexpected illness, and we had no good way to reassure her of what would come next. I am sorry that more patients without insurance will arrive, instead of the steady decline I had been used to the past few years.

You also remind me of another patient I saw last week. She was sweet in the face, smiling despite her travails, and wore the skimpy gown with pride. She had some fluid just outside her lung that shouldn't be there: a pleural effusion. We discussed the different possible diagnoses. She had cancer in the past, surgically treated and presumably cured. Was this the cancer back? Was it an infection, easily treated? We couldn't tell by the exam or the x-ray.

On Tuesday, we took the fluid out. The results trickled in slowly, and initial tests

suggested it was benign. We allowed a smile, but final tests were pending. What will turn up? When the final results return? Can we dance in the room with joy? Or will we hold hands, bear the cross, shed a tear, but then

lift our heads up and know we will fight for another day, and another day, and not stop fighting until the cancer upon us is gone?

Read the full post at [www.hospitalleader.org](http://www.hospitalleader.org).

## ALSO ON "THE HOSPITAL LEADER" BLOG

**POST:** An open letter to hospital executives about their hospitalist programs

By Leslie Flores, MHA, SFHM

**POST:** What's under the hood? A quick look at hospital expenses

By Brad Flansbaum, DO, MPH, MHM

**POST:** A quick lesson on bundled payments

By John Nelson, MD, MHM

**POST:** The ABIM Has new plans for MOC and wants your opinion. Give it to 'em!

By Burke Kealey, MD, SFHM

## NEWS & NOTES

### Trending at SHM

The latest news, events, programs, and SHM initiatives.

By Brett Radler

#### Unveiling the hospitalist specialty code

► The Centers for Medicare & Medicaid Services announced in November the official implementation date for the Medicare physician specialty code for hospitalists. On April 3, "hospitalist" will be an official specialty designation under Medicare; the code will be C6. Starting on that date, hospitalists can change their specialty designation on the Medicare enrollment application (Form CMS-855I) or through CMS' online portal (Provider Enrollment, Chain, and Ownership System, or PECOS).

Appropriate use of specialty codes helps distinguish differences among providers and improves the quality of utilization data. SHM applied for a specialty code for hospitalists nearly 3 years ago, and CMS approved the application in February 2016.

Stand with your fellow hospitalists and make sure to declare, "I'm a C6."

#### Develop curricula to educate, engage medical students and residents

► The ACGME requirements for training in quality and safety are changing – it is no longer an elective. As sponsoring institutions' residency and fellowship programs mobilize to meet these requirements, leaders may find few faculty members are comfortable enough with the material to teach and create educational content for trainees. These faculty need further development.

Sponsored by SHM, the Quality and Safety Educators Academy (QSEA) responds to that demand by providing medical educators with the knowledge and tools to integrate quality improvement and safety concepts into their curricula. The 2017 meeting is Feb. 26-28 at the Tempe Mission Palms Hotel in Arizona. This 2½ day meeting aims to fill the current gaps for faculty by offering basic concepts and educational tools in quality improvement and patient safety. Material is presented in an interactive way, providing guidance on career and curriculum development and establishing a national network of quality and safety educators.

For more information and to register, visit [www.shmqsea.org](http://www.shmqsea.org).

#### EHRs: blessing or curse?

► SHM's Health Information Technology (HIT) Committee invited you to participate in a brief survey to inform

your experiences with inpatient electronic health record (EHR) systems. The results will serve as a foundation for a white paper to be written by the HIT Committee addressing hospitalists' attitudes toward EHR systems. It will be released next month, so stay tuned then to view the final paper.

#### SHM chapters: Your connection to local education, networking, leadership opportunities

► SHM offers various opportunities to grow professionally, expand your CV, and engage with other hospitalists. With more than 50 chapters across the country, you can network, learn, teach, and continue to improve patient care at a local level. Find a chapter in your area or start a chapter today by visiting [www.hospitalmedicine.org/chapters](http://www.hospitalmedicine.org/chapters).

#### Enhance opioid safety for inpatients

► SHM enrolled 10 hospitals into a second mentored implementation cohort around Reducing Adverse Drug Events Related to Opioids (RADEO). The program is now in its second month as the sites work with their mentors to enhance safety for patients in the hospital who are prescribed opioid medications by:

- Developing a needs assessment.
- Putting in place formal selections of data collection measures.
- Beginning to take outcomes and process data collection on inter-

vention units.

- Starting to design and implement key interventions.

Even if you're not in this mentored implementation cohort, visit [www.hospitalmedicine.org/RADEO](http://www.hospitalmedicine.org/RADEO) and view the online toolkit or download the implementation guide.

#### Earn recognition for your research with SHM's Junior Investigator Award

► The SHM Junior Investigator Award was created for junior/early-stage investigators, defined as faculty in the first 5 years of their most recent position/appointment. Applicants must be a hospitalist or clinician-investigators whose research interests focus on the care of hospitalized patients, the organization of hospitals, or the practice of hospitalists. Applicants must be members of SHM in good standing. Nominations from mentors and self-nominations are both welcome.

The winner will be invited to receive the award during SHM's annual meeting, HM17, May 1-4, at Mandalay Bay Resort and Casino in Las Vegas. The winner will receive complimentary registration for this meeting as well as a complimentary 1-year membership to SHM.

For more information on the application process, visit [www.hospitalmedicine.org/juniorinvestigator](http://www.hospitalmedicine.org/juniorinvestigator).

Brett Radler is SHM's communications specialist.



# Sneak Peek: Journal of Hospital Medicine

Discharges against medical advice at a county hospital: Provider perceptions and practice

By Cordelia R. Stearns, MD,  
Allison Bakamjian, BA, Subrina  
Sattar, MD, Miranda Ritterman  
Weintraub, PhD, MPH

## FEATURED ABSTRACT

**BACKGROUND:** Patients discharged against medical advice (AMA) have higher rates of readmission and mortality than patients who are conventionally discharged. Bioethicists have proposed best practice approaches for AMA discharges, but studies have revealed that some providers have misconceptions about their roles in these discharges.

**OBJECTIVE:** This study assessed patient characteristics and provider practices for AMA discharges at a county hospital and provider perceptions and knowledge about AMA discharges.

**DESIGN:** This mixed-methods cross-sectional study involved chart abstraction and survey administration.

**PARTICIPANTS:** Charts were reviewed for all AMA discharges ( $n = 319$ ) at a county hospital in 2014. Surveys were completed by 178 health care providers at the hospital.

**RESULTS:** Of 12,036 admissions, 319 (2.7%) ended with an AMA discharge. Compared with conventionally discharged patients, patients who left AMA were more likely to be young, male, and homeless and less likely to be Spanish speaking. Of the AMA patients, 29.6% had capacity documented, 21.4% had medications prescribed, and 25.7% had follow-up arranged. Of patients readmitted within 6 months after AMA, 23.5% left AMA again at the next visit. Attending physicians and trainee physicians were more likely than nurses to say that AMA patients should receive medications and follow-up (94% and 84% vs. 64%;  $P$  less than .05).

**CONCLUSIONS:** Although providers overall felt comfortable determining capacity and discussing AMA discharges, they rarely documented these discussions. Nurses and physicians differed in their thinking regarding whether to arrange follow-up for patients leaving AMA, and in practice, arrangements were seldom made.

Read the full article at [journalofhospitalmedicine.com](http://journalofhospitalmedicine.com).

Also in the January 2017 issue of JHM...

### Characteristics and outcomes of fasting orders among medical inpatients

Authors: Atsushi Sorita, MD, MPH, Charat Thongprayoon, MD, John T. Ratelle, MD, Ruth E. Bates, MD, Katie M. Rieck, MD, Aditya P. Devalapalli, MD, Adil Ahmed, MD, Deanne T. Kashiwagi, MD

### The lived experience of the hospital discharge “plan”:

### A longitudinal qualitative study of complex patients

Authors: Soo Chan Carusone, PhD, Bill O’Leary, MSW, Simone McWatt, MPH, Ann Stewart, MSc, MD, Shelley Craig, MSW, PhD, David J. Brennan, MSW, PhD

### Do clinicians understand quality metric data? An evaluation in a Twitter-derived sample

Authors: Sushant Govindan, MD, Vineet Chopra, MD, MSc, Theodore J. Iwashyna, MD, PhD

### Routine replacement of peripheral intravenous catheters

Authors: Sanjay A. Patel, MD, Michael M. Alebich, DO, Leonard S. Feldman, MD

### Physicians are often incorrect about the telemetry status of their patients

Authors: Sajan Patel, MD, Sayumi De Silva, MD, Erin Dowling, MD

# 2017 HOSPITAL MEDICINE

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# Read the chart

Elevate your patients' confidence

It does not matter which technique you use. It simply matters that you take time to review your patient's chart prior to entering the room *and* that you verbalize what you have learned. In patients, this inspires confidence and trust and helps alleviate concerns that the physician does not know important information in their medical history.

By Trina Dorrah, MD, MPH

**Editor's note:** "Everything We Say and Do" is an informational series developed by SHM's Patient Experience Committee to provide readers with thoughtful and actionable communication tactics that have great potential to positively impact patients' experience of care. Each article will focus on how the contributor applies one or more of the "key communication" tactics in practice to maintain provider accountability for "everything we say and do that affects our patients' thoughts, feelings, and well-being."

## What I say and do

I inform my patients that I have reviewed their chart and that I am familiar with their diagnosis.

## Why I do it

In the hospital setting, in particular, patients are concerned about communication between their various health care professionals. Many times, the patient's primary-care provider works strictly in the outpatient setting, so the hospitalist is the person who assumes total care of the patient throughout hospitalization. This understandably creates anxiety for patients and families because they wonder if the hospitalist really knows their medical history. One way to alleviate this anxiety is to review your patients' charts prior to speaking with them *and* to verbally let your patients know you are familiar with their diagnoses.

## How I do it

**STEP 1:** Before entering the room, I review my patient's chart. If I am taking over the service from my colleague, I review all notes from the current hospitalization to ensure I understand everything that has happened. I also review tests, procedures, and radiographic studies. To gain a better understanding of my patient, I read the most recent discharge summary and outpatient clinic note. Likewise, if I am admitting a new patient to the hospital, before entering the room to do the history and physical examination, I review recent hospitalizations, clinic notes, and emergency department visits.

I also like to review the chart to see if I have taken care of the patient before. Patients often remember me even though I may not remember them, so reviewing my prior notes may be helpful. Thankfully, my electronic health record (EHR) has a search function where I can enter my name or any other keyword and it searches for patient records based on this keyword.

**STEP 2:** Even though reading the chart and being informed about my patient is important,



Thomas Northrup/Thinkstock

it is only the first step. The next step is to let my patient and family know that I have read the chart and that I am up-to-date on my patient's diagnosis. I feel it is very important for me to verbalize that I have read the chart because without doing this, my patients never really know that I took the time prior to entering the room to learn about them.

I might say:

- "I was reviewing your chart before I came in, and I saw that your daughter brought you to the hospital for chest pain."
- "I read your chart and saw that you have been to the emergency room twice in the last week."
- "I read your primary-care doctor's note, and I saw that she recently treated you for pneumonia."
- "I read your chart, and I wanted to confirm a few things I read to ensure we are on the same page."

There are many different ways you can phrase this, but the important point is to make sure your patients know you read the chart by specifically referencing something you learned. This helps your patients feel more confident that you know their medical history.

I know some of the doctors reading this column see patients in the outpatient setting. One way to help yourself remember pertinent facts about a patient's medical history is to include these facts in a specific

place in your clinic note. That way, prior to seeing the patient, you can always review your last note and know the important information about your patient's medical history will always be in the same place in each note. Another tip is to use your EHR's note function. My EHR has "sticky notes," and they provide a place for the PCP to store information about the patient without it becoming part of the permanent medical record.

These notes allow the PCP to record important events that happen between one clinic visit and the next. Thus, when the patient returns to the clinic, the PCP opens the chart, reviews the sticky note, and enters the exam room prepared to discuss significant events in the patient's recent medical history.

In the end, it does not matter which technique you use. It simply matters that you take time to review your patient's chart prior to entering the room *and* that you verbalize what you have learned. In patients, this inspires confidence and trust and helps alleviate concerns that the physician does not know important information in their medical history. **TH**

*Dr. Dorrah is regional medical director for quality and the patient experience at Baylor Scott & White Health in Round Rock, Tex. She is a member of SHM's Patient Experience Committee.*

CHECK OUT KEY COMMUNICATION TACTICS HIGHLIGHTED IN "Everything We Say and Do" at [the-hospitalist.org](http://the-hospitalist.org).

## IN THE LITERATURE



# ITL: Physician reviews of HM-centric research

By Jorge Florindez, MD; German Giese, MD; Raja Ramesh Gummalla, MD; Jessica Zuleta, MD, FHM; Maria Antonietta Mosetti, MD; Shreevinaya Menon, DO, MPH; Aymara Fernandez de la Vara, MD; and Alan Briones, MD, FHM

University of Miami Health System

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By Alan Briones, MD, FHM

### 1 Physicians and EHR time

**CLINICAL QUESTION:** How much time do ambulatory-care physicians spend on electronic health records (EHRs)?

**BACKGROUND:** There is growing concern about physicians' increased time and effort allocated to the EHR and decreased clinical face time and meaningful interaction with patients. Prior studies have shown that increased physician EHR task load is associated with increased physician stress and dissatisfaction.

**STUDY DESIGN:** Time and motion observation study.

**SETTING:** Ambulatory-care practices.

**SYNOPSIS:** Fifty-seven physicians from 16 practices in four U.S. states participated and were observed for more than 430 office hours. Additionally, 21 physicians completed a self-reported after-hours diary. During office hours, physicians spent 49.2% of their total time on the EHR and desk work and only 27% on face time with patients. While in the exam room, physicians spent 52.9% of the time on direct clinical face time and 37% on the EHR and desk work. Self-

reported diaries showed an additional 1-2 hours of follow-up work on the EHR. These observations might not be generalizable to other practices. No formal statistical comparisons by physicians, practice, or EHR characteristics were done.

**BOTTOM LINE:** Ambulatory-care physicians appear to spend more time with EHR tasks and desk work than clinical face time with patients.

**CITATION:** Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion studies in 4 specialties [published online ahead of print Sept. 6, 2016]. *Ann Intern Med.* 165(11):753-760.

### 2 Bundled payments reduce costs in joint patients

**CLINICAL QUESTION:** Does bundled payment for lower extremity joint replacement (LEJR) reduce cost without compromising the quality of care?

**BACKGROUND:** Conventionally, Medicare makes separate payments to providers for the individual services rendered to patients. The Bundled Payments for Care Improvement (BPCI) program was developed to align incentives for provid-

ers across all specialties. LEJR is the most common Medicare inpatient procedure, costing more than \$6 billion in 2014.

**STUDY DESIGN:** Observational study.

**SETTING:** BPCI-participating hospitals.

**SYNOPSIS:** At BPCI-participating hospitals, there were 29,441 LEJR episodes in the baseline period and 31,700 episodes in the intervention period; these were compared with a control group of 29,440 episodes in the baseline period and 31,696 episodes in the intervention period. The BPCI initiative was associated with a significant reduction in Medicare per-episode payments, which declined by an estimated \$1,166 more (95% confidence interval, -\$1634 to -\$699; *P* less than .001) for the BPCI group than for the comparison group (between baseline and intervention periods).

There were no statistical differences in claims-based quality measures between the BPCI and comparison populations, which included 30- and 90-day unplanned readmissions, ED visits, and postdischarge mortality.

**BOTTOM LINE:** Bundled payments for joint replacements may have the potential to decrease cost while maintaining quality of care.

**CITATION:** Dummit L, Kahvecioglu D, Marrufo G, et al. Association between hospital participation in a Medicare bundled payment initiative and payments and quality outcomes for lower extremity joint replacement episodes. *JAMA.* 2016;316(12):1267-1278.

*Dr. Briones is an assistant professor at the University of Miami Miller School of Medicine and medical director of the hospitalist service at the University of Miami Hospital.*

By German Giese, MD

### 3 Nonischemic cardiomyopathy does not benefit from prophylactic ICDs

**CLINICAL QUESTION:** Do prophylactic implantable cardioverter defibrillators (ICDs) reduce long-term mortality in patients with symptomatic nonischemic systolic heart failure (NISHF)?

**BACKGROUND:** ICDs are associated with significant reductions in the rate of sudden cardiac death and mortality in NISHF patients. However, no trials of NISHF patients have shown an effect on total mortality.

**STUDY DESIGN:** Multicenter, nonblinded, randomized controlled prospective trial.

**SETTING:** Danish ICD centers.

**SYNOPSIS:** A total of 1,116 patients with symptomatic NISHF (left ventricular ejection fraction of less than 35%) were rand-

omized to either receive an ICD or usual clinical care. The primary outcome, death from any cause, occurred in 120 patients (21.6%) in the ICD group (4.4 events/100 person-years) and in 131 patients (23.4%) in the control group. The hazard ratio for death from any cause in the ICD group, as compared with the control group, was 0.87 (95% CI, 0.68-1.12; *P* = .28). The HR for death from any cause in the ICD group, as compared with the control group, was 0.87 (95% CI, 0.68-1.12; *P* = .28).

**BOTTOM LINE:** Prophylactic ICD implantation in patients with symptomatic NISHF does not reduce long-term mortality.

**CITATION:** Kober L, Thune JJ, Nielsen JC, et al. Defibrillator implantation in patients with nonischemic systolic heart failure. *N Engl J Med.* 2016;375:1221-1230.

### 4 Pulmonary embolism in COPD exacerbations

**CLINICAL QUESTION:** How frequent is pulmonary embolism (PE) in patients with unexplained acute chronic obstructive pulmonary disease (COPD) exacerbation?

**BACKGROUND:** Acute COPD exacerbations are highly inflammatory states, and since there is a well-known interaction between inflammatory pathways and thrombosis, PE occurs with increased prevalence, ranging from 18% to 25%. In approximately 30% of cases of acute exacerbations of COPD, no clear etiology is found.

**STUDY DESIGN:** Systematic review.

**SETTING:** U.S. hospitals and EDs.

**SYNOPSIS:** PE prevalence was 16.1% (95% CI, 8.3%-25.8%) in patients with unexplained COPD exacerbations. Thirty-two percent were subsegmental, 35% affected one of the main pulmonary arteries, and 32% were located in the lobar and interlobar arteries. Heterogeneity between the included studies was high. In-hospital and 1-year mortality were increased in patients with PE and COPD exacerbations in one study but not in another.

Signs of cardiac failure, hypotension, and syncope were more frequently found in patients with COPD exacerbation and PE, compared with patients with COPD exacerbation without PE.

**BOTTOM LINE:** PE is a common occurrence in patients with unexplained COPD exacerbations; two-thirds of those emboli involved segmental circulation and therefore were clinically relevant.

**CITATION:** Aleva FE, Voets LW, Simons SO, de Mast Q, van der Ven A, Heijdra YF. Prevalence and localization of pulmonary embolism in unexplained acute exacerbations of COPD: a systematic review and

CONTINUED ON PAGE 14

meta-analysis [published online ahead of print Aug. 11, 2016]. *Chest*. doi: 10.1016/j.chest.2016.07.034.

*Dr. Giese is an assistant professor at the University of Miami Miller School of Medicine and a hospitalist at the University of Miami Hospital and Jackson Memorial Hospital.*

**By Shreevinaya Menon, DO, MPH**

## 5 Evaluating the qSOFA

**CLINICAL QUESTION:** How does the quick Sepsis-Related Organ Failure Assessment (qSOFA) compare with other sepsis scoring tools?

**BACKGROUND:** The qSOFA score has been shown to be superior to the Sepsis-Related Organ Failure Assessment (SOFA) with respect to predicting in-hospital mortality outside of the ICU. It has not been compared to other scoring systems or tested among ED patients.

**STUDY DESIGN:** Single-center, retrospective analysis.

**SETTING:** Hospital ED in China.

**SYNOPSIS:** A total of 516 adult ED patients with clinically diagnosed infections were followed for 28 days. Calculated scores for qSOFA, SOFA, Mortality in ED Sepsis (MEDS), and Acute Physiology and Chronic Health Evaluation (APACHE) II were compared using ROC curves.

qSOFA was similar to the other scoring systems to predict ICU admission.

The area under the curve for qSOFA to predict 28-day mortality was lower than all other scoring systems but was statistically significant only when compared to MEDS. A qSOFA score of 2 had a positive likelihood ratio of 2.47 to predict mortality (95% CI, 2.3-5.4) and a positive likelihood ratio of 2.08 (95% CI, 1.7-4.1) to predict ICU admission.

**BOTTOM LINE:** qSOFA was similar to other scoring systems to predict 28-day mortality and ICU admission but slightly inferior than MEDS to predict mortality.

**CITATION:** Wang JY, Chen YX, Guo SB, Mei X, Yang P. Predictive performance of quick sepsis-related organ failure assessment for mortality and ICU admission in patients with infection at the ED. *Am J Em Med*. 2016;34(9):1788-1793.

## 6 Inpatient antibiotic use has not declined

**CLINICAL QUESTION:** How has inpatient antibiotic use changed in the United States in recent years?

**BACKGROUND:** Antibiotic resistance is a result of inappropriate antibiotic use. Understanding antibiotic trends will help improve antibiotic stewardship efforts.

**STUDY DESIGN:** Retrospective analysis.

**SETTING:** Adult and pediatric data from 300 acute-care hospitals, 2006-2012.

**SYNOPSIS:** Weighted extrapolation of data from a database was used to estimate national antibiotic use. Overall, 55.1% of discharged patients received antibiotics. The rate of antibiotic use was 755/1,000 patient-days over the study period. The small increase in antibiotic use over the years (5.6 days of ther-

apy/1,000 patient-days increase; 95% CI, -18.9 to 30.1;  $P = .65$ ) was not statistically significant. There was a significant decrease in the use of aminoglycosides, first- and second-generation cephalosporins, fluoroquinolones, sulfonamide, metronidazole, and penicillins. The use of third- and fourth-generation cephalosporins, macrolides, glycopeptides, beta-lactam/beta-lactamase inhibitor, carbapenems, and tetracyclines has increased significantly.

Limitations of the study include underrepresentation of pediatric hospitals and certain geographic regions.

**BOTTOM LINE:** Antibiotic-use rates have not changed during 2006-2012. However, broad-spectrum antibiotic use has increased significantly.

**CITATION:** Baggs J, Fridkin SK, Pollack LA, Srinivasan A, Jernigan JA. Estimating national trends in inpatient antibiotic use among US hospitals from 2006 to 2012. *JAMA Intern Med*. 2016;176(11):1639-1648.

*Dr. Menon is an assistant professor at the University of Miami Miller School of Medicine and a hospitalist at University of Miami Hospital and Jackson Memorial Hospital.*

**By Jorge Florindez, MD**

## 7 Instability of INRs

**CLINICAL QUESTION:** Does an initial stable international normalized ratio (INR) predict long-term stability?

**BACKGROUND:** Warfarin decreases stroke risk among patients with atrial fibrillation; however, it interacts with food and drugs and requires monitoring to achieve a therapeutic INR. It is unclear if patients on warfarin with an initial stable INR value remain stable over time. Additionally, it is controversial whether patients on warfarin with previously stable INRs should benefit from switching to a non-vitamin K oral anticoagulant.

**STUDY DESIGN:** Retrospective study.

**SETTING:** Outpatient clinics.

**SYNOPSIS:** Data were collected from the Outcomes Registry for Better Informed Treatment of Atrial Fibrillation. Included in the study were patients taking warfarin at baseline with three or more INR values in the first 6 months and six or more INR values in the subsequent year. Stability was defined as 80% or more INRs in therapeutic range (2.0-3.0).

Only 26% of patients taking warfarin had a stable INR during the first 6 months, and only 34% continued to have a stable INR in the subsequent year.

**BOTTOM LINE:** Initial stable INR within the first 6 months among patients taking warfarin does not predict long-term INR stability in the subsequent year.

**CITATION:** Pokorney SD, Simon DN, Thomas L, et al. Stability of international normalized ratios in patients taking long-term warfarin therapy. *JAMA*. 2016;316(6):661-663.

## 8 Blood thinning with bioprosthetic valves

**CLINICAL QUESTION:** Does anticoagulation prevent thromboembolic events in patients undergoing bioprosthetic valve implantation?

**BACKGROUND:** The main advantage of bioprosthetic valves, compared with mechanical valves, is the avoidance of long-term anticoagulation. Current guidelines recommend the use of vitamin K antagonist (VKA) during the first 3 months after surgery, which remains controversial. Two randomized controlled trials (RCTs) showed no benefit of using VKA in the first 3 months; however, other studies have reported conflicting results.

**STUDY DESIGN:** Meta-analysis and systematic review.

**SETTING:** Multicenter.

**SYNOPSIS:** This meta-analysis included two RCTs and 12 observational studies that compared the outcomes in group I (VKA) versus group II (antiplatelet therapy/no treatment). There was no difference in thromboembolic events between group I (1%) and group II (1.5%), but there were more bleeding events in group I (2.6%) versus group II (1.1%). In addition, no differences in all-cause of mortality rate and need for redo surgery were found between the two groups.

**BOTTOM LINE:** The use of VKA in the first 3 months after a bioprosthetic valve implantation does not decrease the rate of thromboembolic events or mortality, but it is associated with increased risk of major bleeding.

**CITATION:** Masri A, Gillinov M, Johnston DM, et al. Anticoagulation versus antiplatelet or no therapy in patients undergoing bioprosthetic valve implantation: a systematic review and meta-analysis [published online ahead of print Aug. 3, 2016]. *Heart*. doi: 10.1136/heartjnl-2016-309630.

## 9 Inhalers used incorrectly at least one-third of time

**CLINICAL QUESTION:** What are the most common errors in inhaler use over the past 40 years?

**BACKGROUND:** One of the reasons for poor asthma and COPD control is incorrect inhaler use. Problems with technique have been recognized since the launch of the metered-dose inhaler (MDI) in the 1960s. Multiple initiatives have been implemented, including the design of the dry powder inhaler (DPI); however, problems persist despite all corrective measures.

**STUDY DESIGN:** Meta-analysis.

**SETTING:** Multicenter.

**SYNOPSIS:** The most frequent MDI errors were lack of initial full expiration (48%), inadequate coordination (45%), and no postinhalation breath hold (46%). DPI errors were lower, compared with MDI errors: incorrect preparation (29%), no initial full expiration before inhalation (46%), and no postinhalation breath hold (37%).

The overall prevalence of correct technique was the same as poor technique (31%). There was no difference in the rates of incorrect inhaler use between the first and second 20-year periods of investigation.

**BOTTOM LINE:** Incorrect inhaler use in patients with asthma and COPD persists over time despite multiple implemented strategies.

**CITATION:** Sanchis J, Gich I, Pedersen S,

Aerosol Drug Management Improvement Team. Systematic review of errors in inhaler use: has the patient technique improved over time? *Chest*. 2016;150(2):394-406.

*Dr. Florindez is an assistant professor at the University of Miami Miller School of Medicine and a hospitalist at University of Miami Hospital and Jackson Memorial Hospital.*

By Raja Ramesh Gummalla, MD

## 10 Updated recommendations for managing gout

**CLINICAL QUESTION:** What are the new treatment options for gout?

**BACKGROUND:** The 2006 European League Against Rheumatism (EULAR) guidelines recommend that acute flares of gout be treated as early as possible with either oral colchicine, oral corticosteroids, or intra-articular corticosteroids. Experts recommend starting urate-lowering therapy (ULT) only when certain severe clinical features occur, such as recurrent acute attacks and tophi.

**STUDY DESIGN:** Systematic review.

**SETTING:** EULAR task force members from 12 European countries.

**SYNOPSIS:** Since the last guidelines, interleukin-1 blockers (IL-1) were found to play a crucial role in crystal-induced inflammation. IL-1, NSAIDs, and corticosteroids should be considered in patients with frequent flares and contraindications to colchicine.

Unlike in the previous guidelines, ULT should be considered from first presentation of gout; for severe disease, serum uric acid (SUA) levels should be maintained at less than 6 mg/dL and less than 5 mg/dL.

Allopurinol is recommended for first-line ULT, and if the SUA target cannot be reached, it should be switched to another xanthine oxidase inhibitor (febuxostat) or a uricosuric or combined with a uricosuric. Pegloticase is recommended for refractory gout.

**BOTTOM LINE:** The updated 2016 EULAR guidelines recommend new treatment options for gout and updated indications for ULT.

**CITATION:** Richette P, Doherty M, Pascual E, et al. 2016 updated EULAR evidence-based recommendations for the management of gout [published online ahead of print July 25, 2016]. *Ann Rheum Dis*. doi: 10.1136/annrheumdis-2016-209707.

## 11 Home treatment of PE remains rare

**CLINICAL QUESTION:** What is the prevalence of outpatient treatment of acute pulmonary embolism (PE)?

**BACKGROUND:** PE traditionally is perceived as a serious condition requiring hospitalization. Many studies, however, have shown that outpatient treatment of PE in low-risk, compliant patients is safe. Several scoring systems have been derived to identify patients with PE who are at low risk of adverse events and may be candidates for home treatment.

**STUDY DESIGN:** Retrospective cohort study.

**SETTING:** Five U.S. EDs.

**SYNOPSIS:** Among 983 patients diagnosed with acute PE, 237 (24.1%) were unstable and hypoxic. Only a small proportion

of patients (1.7%) were eligible for outpatient therapy, and an additional 16.2% of hospitalized patients were discharged early (2 days or less). Novel oral anticoagulants were administered to fewer than one-third of patients.

**BOTTOM LINE:** In the era of novel anticoagulants, the majority of patients with acute PE were hospitalized, and home treatment was infrequently selected for stable low-risk patients.

**CITATION:** Stein PD, Matta F, Hughes PG, et al. Home treatment of pulmonary embo-

to enoxaparin-warfarin therapy.

**CITATION:** Goette A, Merino JL, Ezekowitz MD, et al. Edoxaban versus enoxaparin-warfarin in patients undergoing cardioversion of atrial fibrillation (ENSURE-AF): a randomised, open-label, phase 3b trial. *Lancet*. 2016;388(10055):1995-2003.

## 13 Fecal transplant efficacy for *Clostridium difficile* infections

**CLINICAL QUESTION:** Is fecal microbiota transplantation (FMT) an efficacious

The use of VKA in the first 3 months after a bioprosthetic valve implantation does not decrease the rate of thromboembolic events or mortality, but it is associated with increased risk of major bleeding.

lism in the era of novel oral anticoagulants. *Am J Med*. 2016;129(9):974-977.

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By Aymara Fernandez de la Vara, MD

## 12 Non-vitamin K antagonist oral anticoagulants for planned atrial fibrillation cardioversions

**CLINICAL QUESTION:** How does edoxaban compare with enoxaparin-warfarin in patients with nonvalvular atrial fibrillation undergoing cardioversion?

**BACKGROUND:** Studies on non-vitamin K antagonist oral anticoagulants (NOACs) for patients with nonvalvular atrial fibrillation undergoing cardioversion are limited.

**STUDY DESIGN:** Multicenter, prospective, randomized trial.

**SETTING:** Nineteen countries at 239 study sites.

**SYNOPSIS:** This trial compared edoxaban with enoxaparin-warfarin. The study was stratified by cardioversion approach, anticoagulant experience, selected edoxaban dose, and region. There were 2,199 patients, mean age was 64, mean CHA<sub>2</sub>DS<sub>2</sub>-VASc score was 2.6, and mean therapeutic time on warfarin was 70.8%.

The primary efficacy endpoint was a composite of stroke, systemic emboli, myocardial infarction, and cardiovascular mortality, which occurred in 5 (1%) patients in the edoxaban group versus 11 (1%) in the enoxaparin-warfarin group (odds ratio, 0.46; 95% CI, 0.12-1.43).

The primary safety endpoint was major and clinically relevant nonmajor bleeding for patients receiving at least one dose of the study drug, occurring in 16 (1%) of 1,067 patients given edoxaban versus 11 (1%) of 1,082 patients given enoxaparin-warfarin (OR, 1.48; 95% CI, 0.64-3.55).

**BOTTOM LINE:** In patients with nonvalvular atrial fibrillation undergoing cardioversion, edoxaban had low rates of major bleeding and thromboembolism similar

and safe treatment approach for patients with recurrent *Clostridium difficile* infection (CDI)?

**BACKGROUND:** FMT restores the normal composition of gut microbiota and is recommended when antibiotics fail to clear CDI. To date, only case series and open-labeled clinical trials support the use of FMT.

**STUDY DESIGN:** Randomized, controlled, double-blinded clinical trial.

**SETTING:** Academic medical centers.

**SYNOPSIS:** This study included 46 patients with three or more recurrences of CDI who received a course of vancomycin for their most recent acute episode. FMTs with donor stool or patient's stool (autologous) were administered by colonoscopy.

The primary endpoint was resolution of diarrhea without anti-CDI therapy after 8 weeks of follow-up. In the donor FMT group, 90.9% achieved clinical cure, compared with 62.5% in the autologous group. Patients who developed recurrent CDI were free of further disease after subsequent donor FMT.

The study included only patients who experienced three or more recurrences but excluded immunocompromised and older patients (older than 75 years of age).

**BOTTOM LINE:** Donor stool administered via colonoscopy was more effective than autologous FMT in preventing further CDI episodes.

**CITATION:** Kelly CR, Khoruts A, Staley C, et al. Effect of fecal microbiota transplantation on recurrence in multiply recurrent *Clostridium difficile* infection: a randomized trial. *Ann Intern Med*. 2016;165(9):609-616.

*Dr. Fernandez de la Vara is an instructor at the University of Miami Miller School of Medicine and chief medical resident at the University of Miami Hospital.*

By Maria Antonietta Masetti, MD

## 14 Overnight extubations associated with worse outcomes

**CLINICAL QUESTION:** Are overnight extubations in intensive care units associated

with higher mortality rate?

**BACKGROUND:** Little is known about the frequency, safety, and effectiveness of overnight extubations in the ICU.

**STUDY DESIGN:** Retrospective cohort study.

**SETTING:** One-hundred sixty-five ICUs in the United States.

**SYNOPSIS:** Using the Project IMPACT database, 97,844 adults undergoing mechanical ventilation (MV) admitted to ICUs were studied. Overnight extubation was defined as occurring between 7 p.m. and 6:59 a.m. Primary outcome was reintubation; secondary outcomes were ICU and hospital mortality and ICU and hospital length of stay.

Only one-fifth of patients with MV underwent overnight extubations. For MV duration of at least 12 hours, rates of reintubation were higher for patients undergoing overnight extubation (14.6% vs. 12.4%; *P* less than .001). Mortality was significantly higher for patients undergoing overnight versus daytime extubation in the ICU (11.2% vs. 6.1%; *P* less than .001) and in the hospital (16.0% vs. 11.1%; *P* less than .001). Length of ICU and hospital stays did not differ.

**BOTTOM LINE:** Overnight extubations occur in one of five patients in U.S. ICUs and are associated with worse outcomes, compared with daytime extubations.

**CITATION:** Gershengorn HB, Scales DC, Kramer A, Wunsch H. Association between overnight extubations and outcomes in the intensive care unit. *JAMA Intern Med*. 2016;176(11):1651-1660.

## 15 Vent bundles and ventilator-associated pneumonia outcomes

**CLINICAL QUESTION:** Are the components of the ventilator bundles (VBs) associated with better outcomes for patients?

**BACKGROUND:** VBs have been shown to prevent ventilator-associated pneumonia (VAP). However, most of the studies have analyzed outcomes based on the whole bundle without considering each individual component.

**STUDY DESIGN:** Retrospective cohort study.

**SETTING:** Brigham and Women's Hospital in Boston.

**SYNOPSIS:** Individual VB components were investigated among 5,539 patients undergoing mechanical ventilation for at least three days. Outcomes reported were ventilator-associated events (VAEs), extubation alive versus ventilator mortality, and hospital discharge versus hospital death.

Spontaneous breathing trials were associated with lower hazards for VAEs (HR, 0.55; 95% CI, 0.40-0.76; *P* less than .001) and infection-related ventilator-associated complications (IVACs) (HR, 0.60; 95% CI, 0.37-1.00; *P* = .05). Head-of-bed elevation (HR, 1.38; 95% CI, 1.14-1.68; *P* = 0.001) and thromboembolism prophylaxis (HR, 2.57; 95% CI, 1.80-3.66; *P* less than .001) were associated with less time to extubation.

Oral care with chlorhexidine was associated with lower hazards for IVACs (HR, 0.60; 95% CI 0.36-1.00; *P* = .05) and for VAPs (HR, 0.55; 95% CI, 0.27-1.14; *P* = .11) but an increased risk for ventila-

CONTINUED ON PAGE 16

tor mortality (HR, 1.63; 95% CI, 1.15-2.31;  $P = .006$ ). Stress ulcer prophylaxis was associated with higher risk for VAP (HR, 7.69; 95% CI, 1.44-41.10;  $P = .02$ ). **BOTTOM LINE:** Standard VB components merit revision to increase emphasis on beneficial components and eliminate potentially harmful ones.

**CITATION:** Klompas M, Li L, Kleinman K, Szumita PM, Massaro AF. Association between ventilator bundle components and outcomes. *JAMA Intern Med.* 2016;176(9):1277-1283.

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## Low-risk FN patients in the ED received more aggressive treatment than recommended. Further research is needed to strategize means of better aligning FN management with standards of care.

By Jessica Zuleta, MD, FHM

### 16 Do not overtreat febrile neutropenia

**CLINICAL QUESTION:** Does emergency department management of patients with febrile neutropenia (FN) follow current guidelines?

**BACKGROUND:** Chemotherapy-related FN is an oncologic emergency frequently leading to hospitalization and intravenous antibiotics. Familiarity with FN guidelines allows risk stratification for inpatient versus outpatient therapy.

**STUDY DESIGN:** Single-center, retrospective, cohort study.

**SETTING:** Large, urban, tertiary-care academic hospital.

**SYNOPSIS:** Of 173 patient visits, 25% were risk stratified as eligible for outpatient treatment and 75% as inpatient care. All patient care was assessed for guideline concordance at the time of ED disposition and therapy.

Primary outcome analysis demonstrated management was guideline discordant in 98% of low-risk patients versus 7% of high-risk patients. Secondary 30-day clinical outcomes showed high-risk patients were more likely to have positive blood cultures (54%), sepsis-induced hypotension (9.3%),

and death (5.4%). Seventeen percent of all patients who received IV antibiotics were prescribed vancomycin without guideline support.

**BOTTOM LINE:** Low-risk FN patients in the ED received more aggressive treatment than recommended. Further research is needed to strategize means of better aligning FN management with standards of care.

**CITATION:** Baugh CW, Wang TJ, Caterino JM, et al. ED management of patients with febrile neutropenia: guideline concordant or overly aggressive [published online ahead of print Sept. 9, 2016]. *Acad Emerg Med.* doi: 10.1111/acem.13079.

### 17 What to do with isolated calf DVT

**CLINICAL QUESTION:** Does therapeutic anticoagulation of isolated calf deep vein thrombosis (DVT) decrease risk for proximal DVT or PE?

**BACKGROUND:** Optimal management of isolated calf DVT lacks consensus.

**STUDY DESIGN:** Single-center, retrospective, cohort study.

**SETTING:** Large academic hospital.

**SYNOPSIS:** Researchers evaluated 14,056 lower-extremity venous duplex studies and identified 243 patients with an intent to treat with therapeutic anticoagulation as well as 141 patients without anticoagu-

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lation. The primary outcome was radiographic confirmation of proximal DVT or PE within 180 days of initial study. Duration of anticoagulation, timing of radiographic follow-up, and frequency of follow-up within the first 180 days were varied. Nevertheless, 9.2% of control patients and 3.3% of exposure patients developed a

proximal DVT or PE. The anticoagulation group was associated with lower likelihood of proximal DVT or PE (risk ratio 0.36; 95% CI, 0.15-0.84) but an increased risk of bleeding (8.6%), compared with the nonexposure group (2.2%). Sensitivity analysis did not alter the observed association. **BOTTOM LINE:** Therapeutic anticoagulation

for isolated calf DVT may be warranted to decrease the risk for proximal DVT or PE but with an increased risk of bleeding. Randomized trials are needed to clarify the risk versus benefit. **CITATION:** Utter GH, Dhillon TS, Salcedo ES, et al. Therapeutic anticoagulation for isolated calf deep vein thrombosis. *JAMA*

*Surg.* 2016;151(9):e161770. doi: 10.1001/jamasurg.2016.1770. **TH**  
*Dr. Zuleta is an assistant professor and associate program director of the Jackson Memorial/University of Miami Internal Medicine residency training program and the site director of the program at University of Miami Hospital.*

# PEDIATRIC HM LITERATURE | By Weijen W. Chang, MD, FAAP, FACP, SFHM



Dr. Chang is pediatric editor of *The Hospitalist*. He is associate clinical professor of pediatrics at the University of Massachusetts, Worcester, and chief of pediatric hospital medicine at Baystate Children's Hospital, Springfield, Mass. Send comments and questions to Weijen.ChangMD@bhs.org.

## Pleth Variability Index shows promise for asthma assessments

Does pulse variability on plethysmography, or the Pleth Variability Index, correlate with disease severity in obstructive airway disease in children?

**CLINICAL QUESTION:** Does pulse variability on plethysmography, or the Pleth Variability Index (PVI), correlate with disease severity in obstructive airway disease in children?  
**BACKGROUND:** Asthma is the most common reason for hospitalization in the United States for children 3-12 years old. Asthma accounts for a quarter of ED visits for children aged 1-9 years old.<sup>1</sup> Although systems have been developed to assess asthma exacerbation severity and the need for hospitalization, many of these depend on reassessments over time or have been proven to be invalid in larger studies.<sup>2-4</sup> Pulsus paradoxus (PP), which is defined as a drop in systolic blood pressure greater than 10 mm Hg, correlates with the severity of obstruction in asthma exacerbations, but it is not practical in the children being evaluated in the ED or hospital.<sup>5,6</sup> PP measurement using plethysmography has been found to correlate with measurement by sphygmomanometry.<sup>7</sup> Furthermore, PVI, which is derived from amplitude variability in the pulse oximeter waveform, has been found to correlate with fluid responsiveness in mechanically ventilated patients. To this date, no study has assessed the correlation between PVI and exacerbation severity in asthma.  
**STUDY DESIGN:** Prospective observational study.  
**SETTING:** A 137-bed, tertiary-care children's hospital.  
**SYNOPSIS:** Over a 6-month period on weekdays, researchers enrolled patients aged 1-18 years evaluated in the ED for asthma exacerbations or reactive airway disease. ED staff diagnosed patients clinically, and other patients with conditions known to affect PP – such as dehydration, croup, and cardiac disease – were excluded. PVI was calculated by measuring the minimum perfusion index (Plmin) and the maximum perfusion index (Plmax) using the following formula:

$$PVI = \frac{Plmax - Plmin}{Plmax}$$

A printout of the first ED pulse oximetry reading was used to obtain the Plmax and Plmin as below:  
Researchers followed patients after

TABLE 1 Criteria for disposition from ED

Disposition location	Criteria
Discharge	<ul style="list-style-type: none"><li>➤ No oxygen requirement</li><li>➤ Inhaled bronchodilator therapy not more frequent than every 4 hours</li></ul>
General pediatrics floor	<ul style="list-style-type: none"><li>➤ FiO<sub>2</sub> requirement &lt;0.5</li><li>➤ Inhaled bronchodilator therapy required every 2-4 hours</li></ul>
ICU	<ul style="list-style-type: none"><li>➤ FiO<sub>2</sub> requirement ≥0.5</li><li>➤ Need for invasive or noninvasive positive pressure ventilation</li><li>➤ Inhaled bronchodilator therapy required more frequently than every 2 hours</li><li>➤ Need for bronchodilator infusion</li></ul>

TABLE 2 PVI according to disposition

Disposition	Median PVI
Discharged to home	0.27 (IQR, 0.19-0.39)
Admitted to general pediatrics floor	0.29 (IQR, 0.20-0.44)
Admitted to PICU	0.56 (IQR, 0.35-0.70)

the initial evaluation to determine disposition from the ED, which included either discharge to home, admission to a general pediatrics floor, or admission to the PICU. The hospital utilized specific criteria for disposition from the ED (see Table 1).  
Of the 117 patients who were analyzed after application of exclusion criteria, 48 were discharged to home, 61 were admitted to a general pediatrics floor, and eight were admitted to the PICU. The three groups were found to be demographically similar. Researchers found a significant difference between the PVI of the three groups, but pairwise analysis showed no significant difference between the PVI of patients admitted to the general pediatrics floor versus discharged to home (see Table 2).  
**BOTTOM LINE:** PVI shows promise as a tool to rapidly assess disease severity in pediatric patients being evaluated and treated for asthma, but further studies are needed to validate this in the ED and hospital setting.  
**CITATION:** Brandwein A, Patel K, Kline M, Silver P, Gangadharan S. Using pleth

variability as a triage tool for children with obstructive airway disease in a pediatric emergency department [published online ahead of print Oct. 6, 2016]. *Pediatr Emerg Care*. doi: 10.1097/PEC.0000000000000887. **TH**  
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3. Keogh KA, Macarthur C, Parkin PC, et al. Predictors of hospitalization in children with acute asthma. *J Pediatr*. 2001;139(2):273-277.  
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5. Guntheroth WG, Morgan BC, Mullins GL. Effect of respiration on venous return and stroke volume in cardiac tamponade. Mechanism of pulsus paradoxus. *Circ Res*. 1967;20(4):381-390.  
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7. Clark JA, Lieh-Lai M, Thomas R, Raghavan K, Sarnaik AP. Comparison of traditional and plethysmographic methods for measuring pulsus paradoxus. *Arch Pediatr Adolesc Med*. 2004;158(1):48-51.

# What lies ahead?

CONTINUED FROM PAGE 1

“It was a strong achievement to get 20 million people insured, but it’s not clear that it bent the cost curve,” says Dr. Eibner. “There are high premiums on the individual market and still 31 million people without coverage. There is still opportunity to improve.”

## Where we stand January 2017

Whether the Republicans can or will repeal the ACA in its entirety and improve it remains unknown. It could take months or even years to replace. But, the experts say, the landmark law has left its mark on the American health care system.

“Everyone is complaining about the uncertainty created by the election, but we have been dealing with a highly uncertain environment for many years,” says Ron Greeno, MD, FCCP, MHM, senior adviser for medical affairs at TeamHealth, chair of the SHM Public Policy Committee, and SHM president-elect. “There will be changes, but things were going to change no matter the outcome of the election. It continues to require tolerance for change and tolerance for uncertainty.”

In an analysis for the Commonwealth

Fund, Dr. Eibner investigated the economic implications of aspects of Mr. Trump’s plans as a candidate. Using a computer model that incorporates economic theory and data to simulate the effects of health policy changes, he found that Mr. Trump’s plans (full repeal alone or repeal with tax deductions for health care premiums, Medicaid block grants, or selling health insurance across state lines) would increase the number of uninsured people by 16 million to 25 million, disproportionately impact low-income and sicker patients, expose individual market enrollees to higher out-of-pocket costs, and increase the federal deficit by \$0.5 billion to \$41 billion.<sup>1</sup>

The Congressional Budget Office (CBO) estimates full repeal could increase the federal deficit by \$137 billion to \$353 billion by 2025.<sup>2</sup>

Rep. Ryan’s A Better Way plan and Price’s Empowering Patients First Act propose providing people more control over their health care, giving tax credits instead of subsidies for premiums, capping the employer-sponsored health insurance tax exclusion, and expanding use of health savings accounts.<sup>3</sup> However, specific details vary between them.

Experts say the plans put more onus on individuals and may raise their costs. For example, Price’s plan would offer premium tax credits based on age, rather than income, with a maximum of \$3,000 available to individuals older than 55 years.

“Young, healthy, and wealthy people may do quite well under this vision of health care reform,” Larry Levitt, a senior vice president at the nonpartisan Kaiser Family Foundation, told Politico in November. “But people who are older, poorer, and sicker could do a lot worse.”

“While the approach puts more risk on the consumer, it makes government spending more predictable than if the credit amount were tied to premium prices,” says Dr. Eibner. “By divorcing the credit amount from health care cost growth, the approach may help to constrain the growth of the deficit.”

Dr. Eibner says there is “a clear implication” that physicians may lose patients, care for a greater share who are uninsured, and see a return of higher rates of uncompensated hospital care. The experts say Republicans are unlikely to restore cuts to disproportionate-share hospitals that were made under the

ACA since more patients were insured.

Joshua Lenchus, DO, RPh, FACP, SFHM, a member of SHM’s Public Policy Committee, and hospitalist at the University of Miami/Jackson Memorial Hospital, is no fan of entitlement programs such as Medicaid but says, “The safety-net hospital where I work would rather have people covered with something than nothing.”

Dr. Lenchus is optimistic that economic reforms under Trump will lead to more jobs, increasing the number of people covered by employer plans. “The economy drives health care reform,” he says. “He has to up his ante now and show people that he can stimulate job growth in this country so we don’t have this middle class that is continuously squeezed.”

Dr. Greeno and Ms. Hoffman, who is also a faculty associate at the UCLA Center for Health Policy Research and vice chair of the Insurance Law Section of the Association of American Law Schools, suggest hospitalists get involved as rules are being shaped and written.

“We want to help reform the delivery system, and we want it to be done right and to be done fairly. We want to have say in how our patients are treated,” Dr. Greeno says.

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Everyone is complaining about the uncertainty created by the election, but we have been dealing with a highly uncertain environment for many years. There will be changes, but things were going to change no matter the outcome of the election. It continues to require tolerance for change and tolerance for uncertainty.

—Ron Greeno, MD, FCCP, MHM, senior adviser for medical affairs at TeamHealth, chair of the SHM Public Policy Committee, and SHM president-elect

### Key provisions: A delicate balance

Many people equate the ACA with the individual mandate, which requires nearly all Americans to purchase health insurance or pay a fine. The federal government provides subsidies to enrollees 138% - 400% of the federal poverty level so their out-of-pocket costs never exceed a defined threshold, even if premiums go up. These could be on the chopping block.

"The last bill Congress passed to repeal the Affordable Care Act, which Obama vetoed, repealed the individual mandate and subsidies for people to buy insurance," Ms. Hoffman says. "If they do repeal it, private insurance through the exchanges will crumble."

The tax deductions to offset premium costs that Trump proposed as a candidate are based on income, making them more generous for higher-income earners than low-income ones, Hoffman adds.

Additionally, "premiums go way up because many more people can't afford insurance, so those who choose to buy are the sickest," says Ms. Hoffman. "Risk pools get extremely expensive, and many more people see it as unaffordable." As a result, she says, people may choose high-deductible plans and face high out-of-pocket costs if they do seek care.

"It's asking individuals to save by deciding how they're going to ration care, where someone says they're not going to go to the doctor today or fill a prescription drug they need," she said.

Meanwhile, Mr. Trump has said he would like to keep the provision of the ACA that bans insurers from denying individuals with preexisting conditions. This, experts agree, may not be possible if other parts of the law are repealed and not replaced with similar protections for insurers.

"If you try to keep the rules about not including preexisting conditions and get rid of subsidies and the individual mandate, it just won't work," Ms. Hoffman says. "You end up with extraordinarily expensive health insurance."

Rep. Ryan's and Rep. Price's plans would prohibit insurers from denying patients with preexisting conditions but only if patients maintain continuous coverage, with a single open-enrollment period. Ryan has also promised to provide at least \$25 billion in federal funding for state high-risk pools.

Prior to the passage of the ACA, 35 states offered high-risk pools to people excluded from the individual market. The Kaiser Family Foundation shows the net annual losses in these states averaged \$5,510/enrollee in 2011. Premiums ranged from 100% to 200% higher than non-high-risk group coverage. Government subsidies to cover losses amounted to \$1 billion in each state.<sup>4</sup>

Meanwhile, both Mr. Trump and Rep. Ryan have proposed profound changes for

Medicaid. Dr. Greeno calls this a "massive political challenge" unless they can provide an alternative way to cover people who currently rely on the federal-state entitlement, as well as those who gained coverage through ACA expansion. Currently, 70 million people are enrolled in Medicaid and the Children's Health Insurance Program.<sup>5</sup>

Through Mr. Trump's suggested block grants, states would receive a fixed amount of money to administer their program with increased flexibility. Rep. Ryan's plan calls for enrollment caps that would distribute a dollar amount to each participant in the program with no limit on the number of enrollees. Either would be adjusted for inflation. Price may make it easier for states to obtain waivers.

Under Rep. Ryan's and Rep. Price's plans, states could implement work requirements for beneficiaries or ask them to pay toward their premiums. Expansion states could also lower the Medicaid threshold below 138%.

Some states will struggle to provide for all their enrollees, Ms. Hoffman says, particularly since health spending generally outpaces inflation. Dr. Lenchus is more optimistic. "I believe states that didn't expand Medicaid, one way or another, will figure out a way to deal with that population," he says.

### And ... Medicare

The other entitlement program facing abrupt change is Medicare, typically considered the third rail of American politics.

"This is the hot political moment," Ms. Hoffman says. "This is the point where the Republicans think they can tick off their wish list. For many Republicans, this kind of entitlement program is the opposite of what they believe in."

Though Mr. Trump has said before he would not alter Medicare, he remained quiet on this point in the aftermath of the election. Repealing the ACA would affect Medicare by potentially reopening the Part D prescription drug doughnut hole and eliminating some of the savings provisions in the law. In fact, the CBO estimates Medicare's direct spending would increase \$802 billion between 2016 and 2025.<sup>1</sup>

Rep. Ryan and Rep. Price have discussed privatizing Medicare by offering seniors vouchers to apply toward private insurance.

"At the highest level, it's moving Medicare from a defined benefit to a defined contribution program," Ms. Hoffman says. "It shifts financial risk from the federal government onto beneficiaries. If Medicare spending continues to grow faster than the rest of the economy, Medicare beneficiaries will pay more and more."

Seniors may also find themselves rationing or skimping on care.

Despite Rep. Ryan's statements to the contrary, Medicare is not broken because of the ACA, Ms. Hoffman says. Its solvency

was prolonged, and though the reasons are not clear, Medicare spending has slowed since the passage of the ACA.<sup>6</sup>

### MACRA launch

Another key factor in the health care policy landscape is MACRA, the Medicare Access and CHIP Reauthorization Act, which fundamentally shifts the way the government administers and reimburses physicians for health care. MACRA begins in 2017. Dr. Greeno is concerned that changes to the ACA will affect CMS' testing of payment models.

"There are hundreds of hospitals and

of the health benefits it required of plans on the individual market. For example, policy-makers might be allowed to strip the contraceptive coverage regulation, which provides for free birth control.

"The reality is a lot of things changing in health care now were changing before the Affordable Care Act passed – PQRS, value-based purchasing, hospital-acquired infections," Dr. Greeno says. "MACRA will continue the journey away from fee-for-service toward outcome-based models."

At such a pivotal time, he strongly encourages hospitalists to join SHM if they are not already members and to get involved



There is no clear coalescence around specific policy reforms that would replace the Affordable Care Act.

—Christine Eibner, PhD, a senior economist at Rand and a professor at the Pardee Rand Graduate School.

thousands of physicians already invested in different models, so I don't expect anybody has any desire to pull the rug from under physicians who are testing alternative payment models [APMs]," he says. "MACRA was passed on a strong bipartisan vote, and it created an APM track. Obviously, Congress intended APM models to continue to expand."

Testing of these models could slow if Republicans enact changes to CMMI, says Dr. Greeno.

Hospitalists are helping "shape these models," working with CMS and the Physician-Focused Payment Model Technical Advisory Committee "to ensure physicians participate in APMs and feel engaged rather than being a worker in a model someone else controls."

On the campaign trail, Mr. Trump spoke of importing pharmaceuticals from overseas in an effort to control high prices. This policy is no longer part of his online plan. He also proposes allowing the sale of health insurance across state lines.

"It would be giving enrollees in states with stricter regulations the opportunity to circumvent to a looser state, which undermines the state with the stricter regulations," Dr. Eibner says. "That would really create winners and losers. People who are healthy can buy a policy in a state with looser regulations, and their costs would likely fall. But someone sicker and older, it would be harder."

Ms. Hoffman defines such a plan as a "race to the bottom." Without well-established networks of physicians and hospitals, startup costs in new states are prohibitive, and many insurers may not wish to compete across state lines, she adds.

Repeal of the ACA could also limit some

in SHM's Grassroots Network.

"For a society of our age – young – and size, we've been tremendously impactful in helping with delivery system reform," Dr. Greeno says. "I think it's because we're supporting change, not trying to stop it. We just want it to be intelligent change."

He also is "convinced" hospitalists will be "critical to the redesign of the health care system. Since we are going to be taking care of the majority of hospitalized adult patients in hospitals, hospitalists want to have our say." **TH**

Kelly April Tyrrell is a freelance writer in Madison, Wis.

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# Heart failure readmission metric not linked to care quality

BY ALICIA GALLEGOS

Frontline Medical News

## FROM THE AHA SCIENTIFIC SESSIONS

**M**etrics used by the Centers for Medicare & Medicaid Services to determine penalties for heart failure hospital readmissions are not associated with quality of care or overall clinical outcomes, according to data presented at the annual scientific sessions of the American Heart Association.

Ambarish Pandey, MD, of the University of Texas Southwestern Medical Center in Dallas, and his colleagues analyzed data from centers participating in the American Heart Association's Get With The Guidelines-Heart Failure (GWTG-HF) registry linked to Medicare claims from July 2008 to June 2011. Centers were stratified as having low risk-adjusted readmission rates and high risk-adjusted readmission rates based on publicly available data from 2013.

The study included 171 centers with 43,143 patients. Centers were almost evenly split between low and high risk-adjusted 30-day readmission rates, with just a few more (51%) falling in the low risk-adjusted category.

Performance was nearly equal (95.7% for centers with a low risk-adjusted readmis-

sion rate vs. 96.5% for those with high risk-adjusted rate) for median adherence to all performance measures, as was the case for median percentage of defect-free care (90.0% vs. 91.1%, respectively) and composite

by CMS to determine readmission penalties are not associated with quality of care or overall clinical outcomes, Dr. Pandey and his colleagues wrote. Results showing higher 30-day readmissions do not neces-

**Taken together, the findings suggest the 30-day readmission metrics currently used by CMS to determine readmission penalties are not associated with quality of care or overall clinical outcomes.**

—Ambarish Pandey, MD

1-year outcome of death or all-cause readmission rates (median 62.9% vs. 65.3%, respectively). The higher readmission group had higher 1-year all-cause readmission rates (median, 59.1% vs. 54.7%), Dr. Pandey and his colleagues reported in the study that was published simultaneously in JACC: Heart Failure (2016 Nov 15. doi: org/10.1016/j.jchf.2016). One-year mortality rates were lower in the higher readmission group with a trend toward statistical significance (median, 28.2% vs. 31.7%;  $P = 0.07$ ).

Taken together, the findings suggest the 30-day readmission metrics currently used

sarily reflect poor quality of care and may be related to other factors.

"These findings question the usefulness of the [hospital readmission reduction program]

metric in identifying and penalizing hospitals with low quality of care," Dr. Pandey wrote, adding that the findings were consistent with previous studies that have demonstrated a lack of association between in-hospital quality of care and 30-day readmission rates.

CMS implemented the federal Hospital Readmissions Reduction Program (HRRP) in 2012 to provide financial incentives for hospitals to reduce readmissions. Under the program, CMS uses claims data to determine whether readmission rates for heart failure, acute myocardial infarction, and pneumonia at eligible hospitals are higher than would be predicted by CMS models. Centers with higher than expected readmission rates face up to a 3% reimbursement penalty.

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## Combine qSOFA and SIRS for best sepsis score

BY M. ALEXANDER OTTO

Frontline Medical News

### AT CHEST 2016

**LOS ANGELES** – Instead of replacing the Systemic Inflammatory Response Syndrome (SIRS) score with the new quick Sequential Organ Failure Assessment (qSOFA) score to identify severe sepsis patients, it might be best to use both, according to two studies presented at the American College of Chest Physicians annual meeting.

The gold standard 3rd International Consensus Definitions for Sepsis and Septic Shock Task Force recently introduced qSOFA to replace SIRS, in part because SIRS is too sensitive. With criteria that include a temperature above 38°C, a heart rate above 90 bpm, and a respiratory rate above 20 breaths per minute, it's possible to score positive on SIRS by walking up a flight of stairs, audience members at the study presentations noted.

The first study at the meeting session – a prospective cohort of 152 patients scored by both systems within 8 hours of ICU admission at the New York–Presbyterian Hospital – found that qSOFA was slightly better at predicting in-hospital mortality and ICU-free days, but no better than SIRS at predicting ventilator- or organ failure-free days.

However, of the 36% of patients (55) who met only one of the three qSOFA criteria – a respiratory rate of 22 breaths per minute, altered mental status, or a systolic blood pressure of 100 mg Hg or less – 6% (3) died in the hospital. Of those patients, two-thirds (2) were SIRS positive, meaning that they met two or more SIRS criteria.

"Having a borderline qSOFA of 1 point, which is considered negative, with the addition of having SIRS criteria, should raise concerns that patients need further evaluation. SIRS criteria should not be [entirely] discarded" in favor of qSOFA, said lead

investigator Eli Finkelsztain, MD, of the New York–Presbyterian Hospital.

The second study – a review of 6,811 severe sepsis/septic shock patients scored by both systems within 3 hours of emergency department admission at the University of Kansas Hospital emergency department in Kansas City – found that the two scores performed largely the same when it came to predicting ICU admission and 30-day mortality, but that people who met two or more criteria in both systems were of special concern.

Twenty-five percent of patients (1,713) scored 2 or more on both SIRS and qSOFA. These patients were more likely to be admitted to the ICU and be readmitted to the hospital after a month, compared with those patients who were positive in only one scoring system or negative in both. Additional factors associated with these patients were that they had the longest ICU and hospital lengths of stay. Two hundred (12%) of these patients scoring 2 or more on both SIRS and qSOFA died within 30 days.

"SIRS criteria continue to be more sensitive at identifying severe sepsis, but they are equally as accurate [as qSOFA criteria] at predicting adverse patient outcomes," said lead investigator and Kansas University medical student Amanda Deis.

SIRS and qSOFA take only a few seconds to assess at the bedside. Using both builds "a clinical picture," she said.

There was no industry funding for the work, and the investigators had no relevant financial disclosures.

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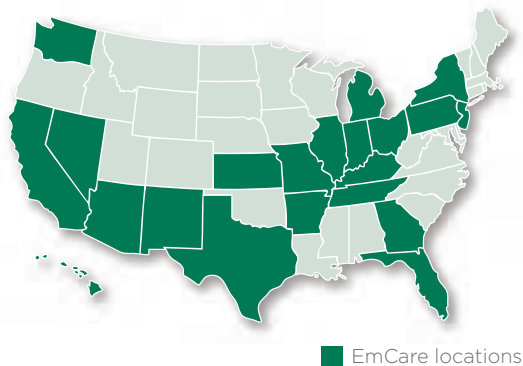
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The Division of Internal Medicine at Penn State Hershey Medical Center, The Pennsylvania State University College of Medicine, is accepting applications for **HOSPITALIST** positions. Successful candidates will hold a faculty appointment to Penn State College of Medicine and will be responsible for the care in patients at Penn State Hershey Medical Center. Individuals should have experience in hospital medicine and be comfortable managing patients in a sub-acute care setting. Hospitalists will be part of the post-acute care program and will work in collaboration with advanced practice clinicians, residents, and staff. In addition, the candidate will supervise physicians-in-training, both graduate and undergraduate level, as well as participate in other educational initiatives. The candidate will be encouraged to develop quality improvement projects in transitions of care and other scholarly pursuits around caring for this population. This opportunity has potential for growth into a leadership role as a medical director and/or other leadership roles.

Competitive salary and benefits among highly qualified, friendly colleagues foster networking opportunities. Relocation assistance, CME funds, Penn State University tuition discount for employees and dependents, LTD and Life insurance, and so much more!

Known for home of the Hershey chocolate bar, Hershey, PA is rich in history and offers a diverse culture. Our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Hershey, PA is home to the Hershey Bears hockey team and close to the Harrisburg Senators baseball team. The Susquehanna River, various ski slopes and the Appalachian Trail are in our backyard, offering many outdoor activities for all seasons.



The Penn State Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.

### Successful candidates require the following:

- Medical degree - M.D., D.O. or foreign equivalent
- Completion of an accredited Internal Medicine Residency program
- Eligibility to acquire a license to practice in the Commonwealth of Pennsylvania
- Board eligible/certified in Internal Medicine
- No J1 visa waiver sponsorships available

### For further consideration, please send your CV to:

Brian McGillen, MD – Director, Hospital Medicine  
Penn State Milton S. Hershey Medical Center  
c/o Heather Pefley, PHR FASPR – Physician Recruiter  
[hpeffley@hmc.psu.edu](mailto:hpeffley@hmc.psu.edu)



**Bassett Healthcare Network**  
**A.O. Fox Hospital**

## HOSPITALIST

**A.O. Fox Memorial Hospital**, an acute care community hospital and affiliate of the Bassett Healthcare Network, is seeking a BC/BE Hospitalist to provide quality patient care.

This Hospitalist position is located in Oneonta, NY. It will consist of a 7 on 7 off schedule with the option for other flexible scheduling. The unit consists of 53 bed med/surg beds. Subspecialty Services are available in Cardiology, Cancer Care and Orthopedics. A fully integrated EMR system is in place.

Nestled in the foothills of the Catskill Mountains, the City of Oneonta is characterized as a friendly community – one that is proud of its diversity, stability and beauty. The City is home to two colleges, State University of New York at Oneonta and Hartwick College, a private liberal arts college.

### For confidential consideration, please contact:

Debra Ferrari, Medical Staff Recruitment  
Bassett Healthcare Network  
One Atwell Road  
Cooperstown, NY, 13326  
phone: 607-547-6982; fax: 607-547-3651 or email:  
[debra.ferrari@bassett.org](mailto:debra.ferrari@bassett.org)  
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**LOAN FORGIVENESS PROGRAM:** An educational loan forgiveness program provides up to \$50,000 in loan forgiveness for qualifying educational loans.

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

### Send cover letter and CV to:

Laurence McMahon, MD, MPH  
Chief, Division of General Medicine  
300 North Ingalls, Room NI7C27  
Ann Arbor, MI 48109-0429  
FAX: 734-936-8944  
[squigley@umich.edu](mailto:squigley@umich.edu)

### To inquire please contact:

Scott Flanders, MD  
Director, Hospitalist Program  
Department of Internal Medicine  
734-647-2892  
[flanders@umich.edu](mailto:flanders@umich.edu)

Visit our website: <http://www.med.umich.edu/intmed/genmed/programs/HospitalistProgram.htm>



**Hospitalist Position** in Picturesque Bridgton, Maine: Bridgton Hospital, part of the Central Maine Medical Family, seeks BE/BC Internist to join its well-established Hospitalist program. Candidates may choose part-time (7-8 shifts/month) to full-time (15 shifts/month) position. Located 45 miles west of Portland, Bridgton Hospital is located in the beautiful Lakes Region of Maine and boasts a wide array of outdoor activities including boating, kayaking, fishing, and skiing.

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Interested candidates should contact

Julia Lauer, CMMC Physician Recruitment  
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email: [LauerJu@cmhc.org](mailto:LauerJu@cmhc.org)  
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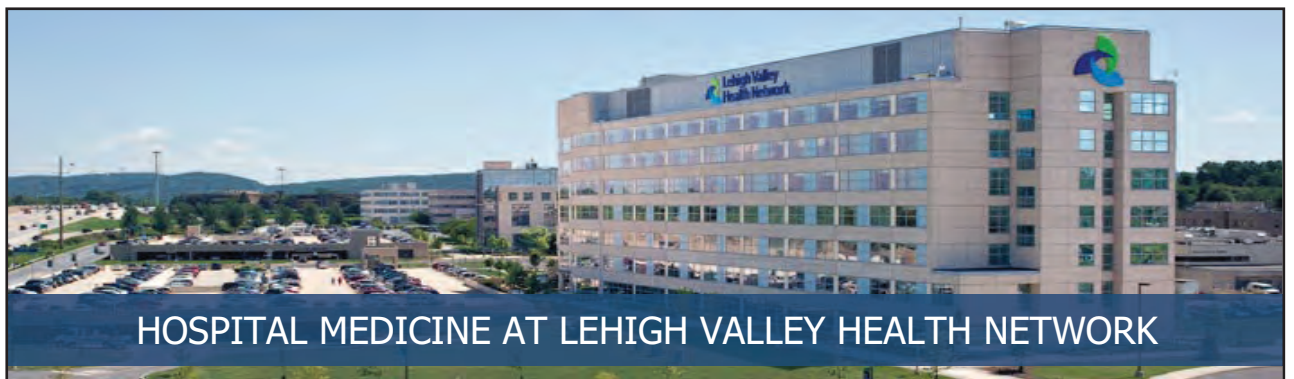
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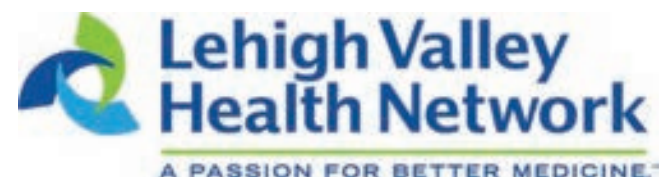
Lehigh Valley Health Network (LVHN) is a nonprofit community hospital system in eastern Pennsylvania. The 800-bed main campus, pictured above, is located one hour north of Philadelphia and 90 minutes west of NYC. Within a 50-mile radius there are 6 hospital campuses and a growing primary care referral base. U.S. News & World Report has ranked LVHN among America's Top Hospitals for 21 consecutive years and currently has two of our hospital campuses ranked in the top 10 hospitals in the state. The network is seeking board certified/eligible IM or FM physicians for Hospitalist positions. We offer candidates a dedicated home-base campus with little or no travel between sites. Basic details about our hospital medicine program are listed below.

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Please call 484-862-3202 or send  
CV to [Pamela.Adams@lvhn.org](mailto:Pamela.Adams@lvhn.org)  
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**Hospitalist/Nocturnist Opportunities**

Cambridge Health Alliance (CHA) is a well respected, nationally recognized and award-winning public healthcare system, which receives recognition for clinical and academic innovations. Our system is comprised of three campuses and an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston's Metro North Region. CHA is a teaching affiliate of both Harvard Medical School (HMS) and Tufts University School of Medicine and opportunities for teaching medical students and residents are plentiful.

We are currently recruiting **BC/BE Hospitalist/Nocturnist** to join our division of approximately 20 physicians to cover inpatient services at both our Cambridge and Everett campuses. This position has both day and night clinical responsibilities. Ideal candidates with be FT (will consider PT), patient centered, possess excellent clinical/communication skills and demonstrate a strong commitment to work with a multicultural, underserved patient population. Experience and interest in performing procedures, as well as resident and medical student teaching is preferred. **All of our Hospitalists/Nocturnist hold academic appointments at Harvard Medical School.** At CHA we offer a supportive and collegial environment, a strong infrastructure, a fully integrated electronic medical record system (EPIC) and competitive salary/benefits package.

Please send CV's to Deanna Simolaris, Department of Physician Recruitment, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139, via e-mail: [dsimolaris@challiance.org](mailto:dsimolaris@challiance.org), via fax (617) 665-3553 or call (617) 665-3555. [www.challiance.org](http://www.challiance.org) We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

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## Assistant Professor Hospitalist/Nocturnist

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**Department of Internal Medicine, Toledo, Ohio,**

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**Please forward letters of interest along with a copy of curriculum vitae to:**

**The University of Toledo Health Science Campus,**

**Department of Medicine, MS 1186, Toledo, Ohio 43614.**

**Telephone (419) 383-5149,**

**Email: [Basil.Akpunonu@UToledo.edu](mailto:Basil.Akpunonu@UToledo.edu)**

**The University of Toledo is an Affirmative Action/Equal Opportunity Employer.**



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Mountain State Health Alliance

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**Please Contact:**  
**Tina McLaughlin, CMSR, Johnston Memorial Hospital**  
**Office (276) 258-4580, [mclaughlint@msha.com](mailto:mclaughlint@msha.com)**



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**Joan Humphries | Manager, Physician Recruitment**

[Joan.Humphries@mercy.net](mailto:Joan.Humphries@mercy.net)

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## ACADEMIC NOCTURNIST HOSPITALIST

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

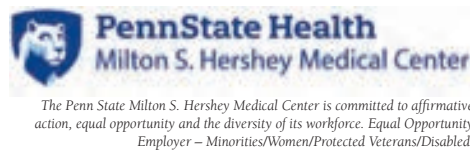
Our Nocturnists are a part of the Hospital Medicine program and will work in collaboration with advanced practice clinicians and residents. Primary focus will be on overnight hospital admission for patients to the Internal Medicine service. Supervisory responsibilities also exist for bedside procedures,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

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Appropriate candidates must possess an MD, DO, or foreign equivalent; be Board Certified in Internal Medicine and have or be able to acquire a license to practice in the Commonwealth of Pennsylvania. Qualified applicants should upload a letter of interest and CV at: <http://tinyurl.com/j29p3fz> Ref Job ID#4524

### For additional information, please contact:

Brian Mc Gillen, MD — Director, Hospitalist Medicine  
Penn State Milton S. Hershey Medical Center  
c/o Heather Peffley, PHR FASPR – Physician Recruiter  
[hpeffley@hmc.psu.edu](mailto:hpeffley@hmc.psu.edu)



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## Innovative Nocturnist Opportunities in Chicago's Northern Suburbs

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NorthShore's Nocturnist opportunities offer many advantages including competitive compensation, comprehensive benefits, flexible scheduling to accommodate various lifestyles, and a solid platform of support that allows physicians to focus on patient care. As the principal academic affiliate of the Pritzker School of Medicine at The University of Chicago, academic is available to qualified candidates.

NorthShore's four award-winning hospitals offer advanced technology, ideal locations, leadership in medicine, and a highly trained support staff. This is an excellent opportunity to provide quality patient care as part of a highly successful organization striving to preserve and improve human life.

Qualified candidates should submit their CV to:  
Kimberly Kitchell, Physician Talent Management Specialist  
9977 Woods Drive, Skokie, IL 60077  
Email: [kkitchell@northshore.org](mailto:kkitchell@northshore.org) • Phone: (847) 663-8145

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# Embrace change as a hospitalist leader

Tales from an insightful dive into SHM leadership training



*Dr. Harte is a practicing hospitalist, president of the Society of Hospital Medicine, and president of Hillcrest Hospital in Mayfield Heights, Ohio, part of the Cleveland Clinic Health System. He is associate professor of medicine at the Cleveland Clinic Lerner College of Medicine in Cleveland.*

At Leadership Academy and beyond, I implore hospitalists to look for opportunities to change during this time of New Year's resolutions and to take the opposite posture and *want* to change – change how we think, act, and respond; change our roles to take on new, uncomfortable responsibilities; and change how we view change itself.

**W**e work in complex environments and in a flawed and rapidly changing health care system. Caregivers, patients, and communities will be led through this complexity by those who embrace change. Last October, I had the privilege of attending and facilitating the SHM Leadership Academy in Orlando, which allowed me the opportunity to meet a group of people who embrace change, including the benefits and challenges that often accompany it.

SHM Board member Jeff Glasheen, MD, SFHM, taught one of the first lessons at Leadership Academy, focusing on the importance of meaningful, difficult change. With comparisons to companies that have embraced change, like Apple, and some that have not, like Sears, Jeff summed up how complacency with “good” and a reluctance to tackle the difficulty of change keeps organizations – and people – from becoming great.

“Good is the enemy of great,” Jeff preached.

He largely focused on hospitalists leading organizational change, but the concepts can apply to personal change, too. He explained that “people generally want things to be different, but they don’t want to change.”

## Leaders in training

Ten emerging hospitalist leaders sat at my table, soaking in the message. Several of them, like me 8 years ago, had the responsibilities of leadership unexpectedly thrust upon them. Some carried with them the heavy expectations of their colleagues or hospital administration (or both) that by being elevated into a role such as medical director, they would abruptly be able to make improvements in patient care and hospital operations. They had accepted the challenge to change – to move out of purely clinical roles and take on new ones in leadership despite having little or no experience. Doing so, they gingerly but willingly were following in the footsteps of leaders before them, growing their skills, improving their hospitals, and laying a path for future leaders to follow.

A few weeks prior, I had taken a new leadership position myself. The Cleveland Clinic recently acquired a hospital and health system in Akron, Ohio, about 40 miles away from the city. I assumed the role of president of this acquisition, embracing the complex challenge of leading the process of integrating two health systems. After 3 years overseeing a different hospital in the health system, I finally felt I had developed the people, processes, and culture that I had been striving to build. But like the young leaders at Leadership Academy, I had the opportunity to change, grow, develop, take on new risk, and become a stronger leader in this new role. A significant part of the experience of the Leadership Academy involves table exercises. For the first few



exercises, the group was quiet, uncertain, tentative. I was struck both by how early these individuals were in their development and by how so much of what is happening today in hospitals and health care is dependent upon the development and success of individuals like these who are enthusiastic and talented but young and overwhelmed.

I believe that successful hospitalists are, through experience, training, and nature, rapid assimilators into their environments. By the third day, the dynamic at my table had gone from tentative and uncertain to much more confident and assertive. To experience this transformation in person at SHM’s Leadership Academy, you are

welcome to join us Scottsdale, Ariz., later this year. Learn more about the program at [www.shmleadershipacademy.org](http://www.shmleadershipacademy.org).

At Leadership Academy and beyond, I implore hospitalists to look for opportunities to change during this time of New Year’s resolutions and to take the opposite posture and *want* to change – change how we think, act, and respond; change our roles to take on new, uncomfortable responsibilities; and change how we view change itself.

We will be better for it both personally and professionally, and we will stand out as role models for our colleagues, coworkers, and hospitalists who follow in our footsteps. **TH**

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# Have you Googled yourself lately?

With a majority of patients relying on physician ratings, hospitalists might consider countermeasures



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The online rating business is proliferating in the medical industry. This should really come as no surprise as health care is a service industry and online ratings have long been a staple in most other service industries. It has become routine practice for most of us to search such online reviews when seeking a pair of shoes, a toaster, or a restaurant; we almost can't help but scour these sites to help us make the best decision possible.

Many of these reviews come in quantitative and qualitative forms, for example, stars

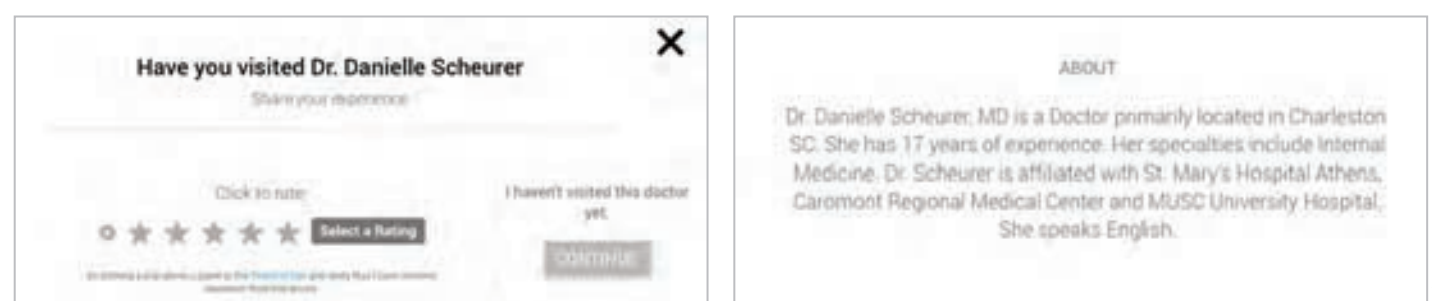
tisements and turns a sizable profit every year. Other profitable health care rating sites include Healthgrades, Yelp, Zocdoc, and WebMD.

When I Google my own name, for example, Vitals.com is the first ratings website that appears in the search results. The first pop-up asks you to rate me and then it takes you to a site with all sorts of facts about me (most of which are notably inaccurate. If I had any online ratings (which I do not currently), you would then see my star ratings and any comments.

care systems in the past few years primarily to take control of the conversation and to not cede patient decision making to third-party sites.

My health care system proposed rolling out a similar online rating system, and it was met with great skepticism from many physicians. There were two primary concerns:

- They felt it was “tacky” and that the profession of medicine should not be relegated to oversimplified service ratings.
- They worried that they would feel pres-



or numerical ratings, along with qualitative comments. Of course, when seeking out products and services, these ratings are not usually the sole mechanism that we use to make decisions. For example, with the toaster analogy, I would not only be influenced by the reviews but also by the cost and the accessibility of the toaster (for example, when I can get it shipped or if it is available in a nearby store).

Not dissimilarly, patients these days seek care and make decisions by using a variety of inputs, including:

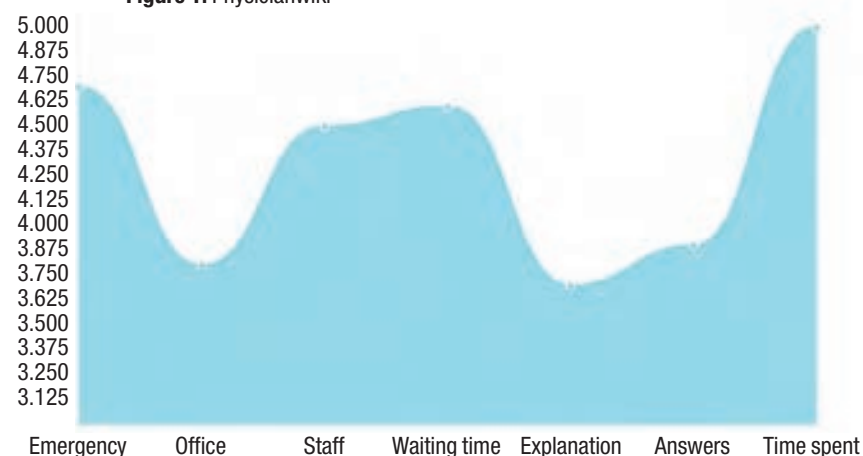
- Anticipated cost (is the physician or practice in or out of network?).
- Availability or access to the service (location of the practice and how long it will take to be seen).
- How good the services and care will be when they get there.

A study in *JAMA* found the top two factors influencing the selection of physicians were whether they accept a patient's insurance and whether their location is convenient.<sup>1</sup> But the study also found that 59% of American adults considered online ratings “somewhat important” or “very important” when choosing physicians.

That same article found that, for those who used online physician ratings, about one-third had selected a physician based on good ratings, and about one-third had avoided a physician based on poor ratings. So patients do seem to be paying attention to these sites and seeking or avoiding care based on what information they find.

Based on that evidence, it is not surprising that so many physician rating sites have sprung up; not only is there a market demand for the availability of this information, the rating sites are also profitable for the host companies. Vitals.com, for example, makes most of its revenue from adver-

Figure 1. Physicianwiki



The second rating site that comes up for me via Google search is PhysicianWiki.com. There is a whole host of information on me (most of which is accurate), along with a set of personal ratings, including my office, my staff, and my waiting times (which, of course, do not make any sense given I am a hospitalist!). It is unclear how those ratings were generated or what volume of responses they represent.

Because of such limitations with the online rating business for physicians, some health care systems have tried to “take control of the conversation” by posting their own internally collected quantitative and qualitative feedback from patients. The University of Utah was one of the first in the nation to create its own internal site for star ratings and comments.<sup>2</sup> What you see on its site is detailed information about the physicians (clinical profile, academic profile, education, contact information, etc.), their patient ratings on nine different questions (displayed as star ratings), the number of total ratings, and a line listing of patient comments (ordered by date). Such sites have proliferated among many health

sured to please the patient rather than “do the right thing” for the patient. For example, they would be less likely to give difficult advice (such as lose weight or stop smoking) or to resist prescribing medications that they deemed unnecessary or frankly dangerous (for example, antibiotics or narcotics).

Although these are valid concerns, it is hard to ignore the proliferation and traffic of these online websites. For you and your team, I would recommend taking a look at what is online about the members of your group and thinking about online strategies to take control of the conversation.

I don't think the controversy over online physician ratings will wane anytime soon, but there is no doubt that they are profitable for companies and are therefore highly likely to continue to multiply. **TH**

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# Effective hospitalist roles for NPs, PAs

Single-site study offers success story, isn't one-size-fits-all solution



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## JOHN NELSON, MD, MHM

I'm often asked about effective roles for nurse practitioners (NPs) and physician assistants (PAs), collectively known as advanced practice clinicians (APCs). My first response is always the same: They have much to contribute and can be effective members of hospitalist groups. Most hospital medicine groups (HMGs) should think about having them in their staffing mix if they don't already.

Yet despite all that NPs/PAs can offer, my experience is that many (even most) hospitalist groups fail to develop roles that optimize their APCs' skills.

An October 2016 study in the *Journal of Clinical Outcomes Management* adds additional data to help think about this issue. You may have seen the study mentioned in several news articles and blogs. Most summarized the study along the lines of "using high levels of PA staffing results in lower hospital costs per case." Framing it this way is awfully misleading, so I'll go a little deeper here.

### Study context

The study, "A Comparison of Conventional and Expanded Physician Assistant Hospitalist Staffing Models at a Community Hospital," is a retrospective analysis of performance measures from two hospitalist groups at Anne Arundel Medical Center (AAMC) in Annapolis, Md.<sup>1</sup> One HMG is employed by the hospital. The other, called MDICS, is a private company that contracts with AAMC as well as approximately 13 other hospitals and 40 rehabilitation facilities. Tim Capstack, MD, is the AAMC medical director for MDICS and lead author of the study (representing a potential conflict of interest acknowledged in the article). Barry Meisenberg, MD, is a coauthor, a hospitalist in the AAMC-employed group, and chair for quality improvement and health care systems research at AAMC.

Tim told me by phone that both groups have practiced at AAMC for more than 10 years and enjoy a collegial relationship. Both groups employ PAs and pair them with a single physician in a dyad arrangement each day. Tim's MDICS group, the "expanded PA" group, staffs each day shift with three physicians and three PAs, compared with the nine physicians and two PAs in the hospital-employed "conventional" group. The MDICS PAs are responsible for more patients each day than their conventional-group counterparts and, during the January 2012 to July 2013 study period, averaged 14.2 patients versus 8.3, respectively.

Over the course of the study, PAs in the expanded PA group saw and billed 36% of patient visits independently, compared with 5.9% for the conventional group.

### Notable study findings

I think the main value of this study is in showing that the expanded PA group had rates of readmission, inpatient mortality, length of stay, and consultant use that weren't statistically different from the conventional group.

The workloads and years of experience of doctors and PAs in each group were similar. And while there were some differences in the patients each group cared for, they seem unlikely to have a significant influence on outcomes. Clearly, there are many unmeasured variables (e.g., culture, morale, and leadership) in each group that could have influenced the outcomes, so this one study at one hospital doesn't provide a definitive answer about appro-

regarding the training background of the APCs they hire; he suspects an identical study with NPs rather than PAs in each hospitalist group would probably yield very similar results. I see this the same way. Although there are differences in background and training between NPs and PAs, I think personal traits like years of experience in various health care settings and the ability to work efficiently are more important than training background.

### A practical approach

Any group who thinks this study is evidence that adding more APCs and having them manage a higher number of patients relatively independently will go well in any setting is mistaken. But it does offer a story

Any group who thinks this study is evidence that adding more APCs and having them manage a higher number of patients relatively independently will go well in any setting is mistaken. But it does offer a story of one place where, with careful planning and execution, it went OK.

appropriate APC staffing levels. However, it didn't uncover big differences in the measured outcomes.

And this study did show that higher levels of PA staffing were associated with lower hospital charges per case. Although the difference was a modest 3%, it was statistically significant ( $P$  less than .001). I'm skeptical there is causation here; this more likely is just correlation.

It would be great to see a larger study of this.

### Information applications

So does this study support the idea that HMGs can or should increase APC staffing and workload significantly to realize lower hospital cost per case and not harm patient outcomes? Not so fast!

This study compared only two hospitalist groups at one hospital. It's probably not very generalizable.

And as described in the paper, and stressed by Tim talking with me by phone, the outcomes of their expanded PA model likely have a lot to do with their very careful recruiting and screening of experienced PAs before hiring them, not to mention a lengthy and deliberate on-boarding process (summarized in the article) to support their ability to perform well. Groups that are not as thoughtful and deliberate in how they hire and position APCs to contribute to the practice may not perform as well.

Why study only PAs? What about NPs? Tim told me that his group is agnostic

of one place where, with careful planning and execution, it went OK.

In my view, the real take-home message is to think carefully to ensure any APCs in your group have professionally satisfying roles that position them to contribute effectively. While common, I think configuring APCs and physicians as rounding dyads often ends up underperforming and not working out well because of inefficiency. When well executed, as is apparently the case in this study, it can be fine. But my experience is that positioning APCs to assume primary responsibility for some clinical activities, such as covering the observation unit or serving as an evening admitter/cross-cover provider (all with appropriate physician collaboration and backup), more reliably turns out well. **TH**

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