

Hospitalist

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Dr. Andrew White,
University of
Washington Medical
Center, Seattle



The state of hospital medicine in 2018

Productivity, pay, and
roles remain center stage

By Larry Beresford

In a national health care environment undergoing unprecedented transformation, the specialty of hospital medicine appears to be an island of relative stability, a conclusion that is supported by the principal findings from SHM's 2018 *State of Hospital Medicine (SoHM)* report.

The report of hospitalist group practice characteristics, as well as other key data defining the field's current status, that the Society of Hospital Medicine puts out every 2 years reveals that overall salaries for hospitalist physicians are up by 3.8% since 2016. Although productivity, as measured by work relative value units (RVUs), remained largely flat over the same period, financial support per full-time equivalent (FTE) physician position to hospitalist groups from their hospitals and health systems is up significantly.

The median financial support

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Hospitalist movers and shakers

By Matt Pesyna

The Michigan chapter of the Society of Hospital Medicine has named **Peter Watson, MD, SFHM**, as state Hospitalist of the Year. Dr. Watson is the vice president of care management and outcomes for Health Alliance Plan (HAP) in Detroit. The Michigan chapter cited Dr. Watson's leadership in hospital medicine and "generosity of spirit" as reasons for his selection.

Dr. Watson oversees nurses, social workers, and support staff while also serving as HAP Midwest Health Plan's medical director. He's a founding member of the Michigan SHM chapter, which he formerly represented as president.

Dr. Watson spent 11 years overseeing the Henry Ford Medical Group's hospitalist program prior to joining HAP, and still works as an attending hospitalist for Henry Ford.



Dr. Cho

Hyung (Harry) Cho, MD, was named the inaugural chief value officer for NYC Health + Hospitals, which includes 11 hospitals in New York and is the largest

public health system in the United States. He will oversee systemwide initiatives in value improvement and the reduction of unnecessary testing and treatment.

Prior to this appointment, Dr. Cho served as an academic hospitalist at Mount Sinai Hospital for 7 years, leading high-value care initiatives. Currently, he is a senior fellow with the Lown Institute in Brookline, Mass., and director of quality improvement implementation for the High Value Practice Academic Alliance.



Dr. Fitterman

Nick Fitterman, MD, SFHM, has been promoted to executive director at Huntington (N.Y.) Hospital. Dr. Fitterman has been a long-time physician and administrator

at Huntington, serving previously as vice chair of medicine as well as head of hospitalists.

Dr. Fitterman has served as president of SHM's Long Island chapter.

Previously, Dr. Fitterman was chief resident at the State University of New York at Stony Brook, and he remains an associate professor at Hofstra University, Hempstead, N.Y.



Dr. Kachalia

Allen Kachalia, MD, was named director of the Armstrong Institute for Patient Safety and Quality and senior vice president of patient safety and quality for Johns

Hopkins Medicine in Baltimore. Dr. Kachalia is a general internist who has been an active academic hospitalist at Brigham and Women's Hospital in Boston.

Dr. Kachalia will oversee patient safety and quality across all of Hopkins Medicine. He also will guide academic efforts for the Armstrong Institute, formed recently thanks to a \$10 million gift.

In addition to his hospitalist work, Dr. Kachalia comes to Hopkins after serving as chief quality officer and vice president of quality and safety at Brigham Health.

Riane Dodge, PA, has been elevated to director of clinical education in physician assistant studies at Clarkson University, Potsdam, N.Y. The veteran physician assistant previously worked as a hospitalist in the Claxton Hepburn Medical Center in Ogdensburg, N.Y. There, she cared for patients in acute rehab, mental health, and on regular medical floors.

Ms. Dodge also has a background in urgent care and family medicine, and has experience as an emergency department technician.

The Journal of Hospital Medicine, the official peer-reviewed journal of SHM, has announced the appointment of **Samir S. Shah, MD, MSCE, SFHM** to editor-in-chief, effective January 1, 2019. Dr. Shah is a professor of pediatrics at the University of Cincinnati College of Medicine.

SHM also noted the appointment of **Jordan Messler, MD**, as Physician Blog Editor for *The Hospital Leader*, SHM's official blog. Dr. Messler is a hospitalist at Morton Plant Hospitalist group in Clearwater, Fla.

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Q&A

Defeating the opioid epidemic

The U.S. Surgeon General weighs in.

Vice Adm. Jerome M. Adams, MD, MPH, is the 20th Surgeon General of the United States, a post created in 1871.

Dr. Adams holds degrees in biochemistry and psychology from the University of Maryland, Baltimore County; a master's degree in public health from the University of California, Berkeley; and a medical degree from Indiana University, Indianapolis. He is a board-certified anesthesiologist and associate clinical professor of anesthesia at Indiana University.

At the 2018 Executive Advisory Board meeting of the Doctors Company, Richard E. Anderson, MD, FACP, chairman and chief executive officer of the Doctors Company, spoke with Dr. Adams about the opioid epidemic's enormous impact on communities and health services in the United States.



Dr. Anderson

Dr. Anderson: Dr. Adams, you've been busy since taking over as Surgeon General of the United States. What are some of the key challenges that you're facing in this office?

Dr. Adams: You know, there are many challenges facing our country, but it boils down to a lack of wellness. We know that

only 10% of health is due to health care, 20% of health is genetics, and the rest is a combination of behavior and environment.

My motto is "better health through better partnerships" because I firmly believe that if we break out of our silos and reach across the traditional barriers that have been put up by funding, reimbursement, and infrastructure, then we can ultimately achieve wellness in our communities.

You asked what I've been focused on as Surgeon General. Well, I'm focused on three main areas.

No. 1 is the opioid epidemic. It is a scourge across our country. A person dies every 12½ minutes from an opioid overdose, and that's far too many. Especially when we know that many of those deaths can be prevented.

Another area I'm focused on is demonstrating the link between community health and economic prosperity. We want folks to invest in health because we know that not only will it achieve better health for individuals and communities but it will create a more prosperous nation, also.

And finally, I'm raising awareness about the links between our nation's health and our safety and security – particularly our national security. Unfortunately, 7 out of 10 young people between the ages of 18 and 24 years in our country are ineligible for military service. That's because they can't pass the physical, can't meet the educational requirements, or they have a criminal record.

So, our nation's poor health is not just a matter of diabetes or heart disease 20 or 30 years down the road. We are literally a less-safe country right now because we're an unhealthy country.



Dr. Jerome M. Adams

Dr. Anderson: Regarding the opioid epidemic, what would you like to see us do as a nation to respond to the epidemic?

Dr. Adams: Recently, I was at a hospital in Alaska where they have implemented a neonatal abstinence syndrome protocol and program that is being looked at around the country – and others are attempting to replicate it.

We know that if you keep mom and baby together, baby does better, mom does better, hospital stays are shorter, costs go down, and you're keeping that family unit intact. This prevents future problems for both the baby and the mother. That's just one small example.

I'm also very happy to see that the prescribing of opioids is going down 20%-25% across the country. And there are even larger decreases in the military and veteran communities. That's really a testament to doctors and the medical profession finally waking up. And I say this as a physician myself, as an anesthesiologist, as someone who is involved in acute and chronic pain management.

Four out of five people with substance use disorder say they started with a prescription opioid. Many physicians will say, "Those aren't my patients," but unfortunately when we look at the PDMP [prescription drug-monitoring program] data across the country, we do a poor job of predicting who is and who isn't going to divert. It may not be your patient, but it could be their son or the babysitter who is diverting those overprescribed opioids.

One thing that I really think we need to lean into as health care practitioners is providing medication-assisted treatment, or MAT. We know that the gold standard for treatment and recovery is

medication-assisted treatment of some form. But we also know it's not nearly available enough and that there are barriers on the federal and state levels.

We need you to continue to talk to your congressional representatives and let them know which barriers you perceive because the data waiver comes directly from Congress.

Still, any ER can prescribe up to 3 days of MAT to someone. I'd much rather have our ER doctors putting patients on MAT and then connecting them to treatment than sending them back out into the arms of a drug dealer after they put them into acute withdrawal with naloxone.

We also have too many pregnant women who want help but can't find any treatment because no one out there will take care of pregnant moms. We need folks to step up to the plate and get that data waiver in our ob.gyn. and primary care sectors.

Ultimately, we need hospitals and health care leaders to create an environment that makes providers feel comfortable providing that service by giving them the training and the support to be able to do it.

We also need to make sure we're coprescribing naloxone for those who are at risk for opioid overdose.

Dr. Anderson: Just so we are clear, are you in favor of regular prescribing of naloxone, along with prescriptions for opioids? Is that correct?

Dr. Adams: I issued the first Surgeon General's advisory in more than 10 years earlier this year to help folks understand that over half of our opioid overdoses occur in a home setting. We all know that an anoxic brain injury occurs in 4-5 minutes. We also know that most ambulances and first responders aren't going to show up in 4-5 minutes.

If we want to make a dent in this overdose epidemic, we need everyone to consider themselves a first responder. We need to look at it the same as we look at CPR; we need everyone carrying naloxone. That was one of the big pushes from my Surgeon General's advisory.

How can providers help? Well, they can coprescribe naloxone to folks on high morphine milligram equivalents (MME) who are at risk. If grandma has naloxone at home and her grandson overdoses in the garage, then at least it's in the same house. Naloxone is not the treatment for the opioid epidemic. But we can't get someone who is dead into treatment.

I have no illusions that simply making naloxone available is going to turn the tide, but it certainly is an important part of it.

This column was provided by the Doctors Company, the exclusively endorsed medical malpractice carrier for the Society of Hospital Medicine. Neither SHM nor Frontline Medical Communications was involved in its production.

per physician FTE was \$176,657 in 2018, 12% higher than in 2016, noted Leslie Flores, MHA, SFHM, of Nelson Flores Hospital Medicine Consultants, and a member of SHM's Practice Analysis Committee, which oversees the biennial survey. Compensation and productivity data were collected by the Medical Group Management Association and licensed by SHM for inclusion in its report.



Ms. Flores

These findings – particularly the flat productivity – raise questions about long-term sustainability, Ms. Flores said. “What is going on? Do hospital administrators still recognize the value hospitalists bring to the operations and the quality of their hospitals? Or is paying the subsidy just a cost of doing business – a necessity for most hospitals in a setting where demand for hospitalist positions remains high?”

Andrew White, MD, FACP, SFHM, chair of SHM's Practice Analysis Committee and director of the hospital medicine service at the University of Washington Medical Center, Seattle, said basic market forces dictate that it is “pretty much inconceivable” to run a modern hospital of any size without hospitalists.

“Clearly, demand outstrips supply, which drives up salaries and support, whether CEOs feel that the hospitalist group is earning that support or not,” Dr. White said. “The unfilled hospitalist positions we identified speak to ongoing projected greater demand than supply.

That said, hospitalists and group leaders can't be complacent and must collaborate effectively with hospitals to provide highly valuable services.” Turnover of hospitalist



Dr. Chadha

positions was up slightly, he noted, at 7.4% in 2018, from 6.9% in 2016, reversing a trend of previous years.

But will these trends continue at a time when hospitals face continued pressure to cut costs, as the hospital medicine subsidy may represent one of their largest cost centers? Because the size of hospitalist groups continues to grow, hospitals' total subsidy for hospital medicine is going up faster than the percentage increase in support per FTE.

Understanding how hospitalists use the report

Dr. White called the 2018 SoHM report the “most representative and balanced sample to date” of hospitalist group practices, with some of the highest quality data, thanks to more robust participation in the survey by pediatric groups and improved distribution among hospitalist management companies and academic programs.

“Not that past reports had major flaws, but this version is more authoritative, reflecting an intentional effort by our Practice Analysis Committee to bring in more participants from key groups,” he said.

The biennial report has been around long enough to achieve brand recognition in the field as

the most authoritative source of information regarding hospitalist practice, he added. “We worked hard this year to balance the participants, with more of our responses than in the past coming from multi-hospital groups, whether 4 to 5 sites, or 20 to 30.”

Surveys were conducted online in January and February of 2018 in response to invitations mailed and emailed to targeted hospital medicine group leaders. A total of 569 groups completed the survey, representing 8,889 hospitalist FTEs, approximately 16% of the total hospitalist workforce. Responses were presented in several categories, including by size of program, region, and employment model. Groups that care for adults only represented 87.9% of the surveys, while groups that care for children only were 6.7% and groups that care for both adults

Dr. Chadha also uses the data to help answer compensation, scheduling, and support questions from his group's members.

Thomas McIlraith, MD, immediate past chairman of the hospital medicine department at Mercy Medical Group, Sacramento, Calif., said the report's value is that it allows comparisons of salaries in different settings, and to see, for example, how night staffing is structured. “A lot of leaders I spoke to at SHM's 2018 Leadership Academy in Vancouver were saying they didn't feel up to parity with the national standards. You can use the report to look at the state of hospital medicine nationally and make comparisons,” he said.

Calls for more productivity

Roberta Himebaugh, MBA, SFHM, senior vice president of acute care

Figure 2. Unfilled hospitalist positions

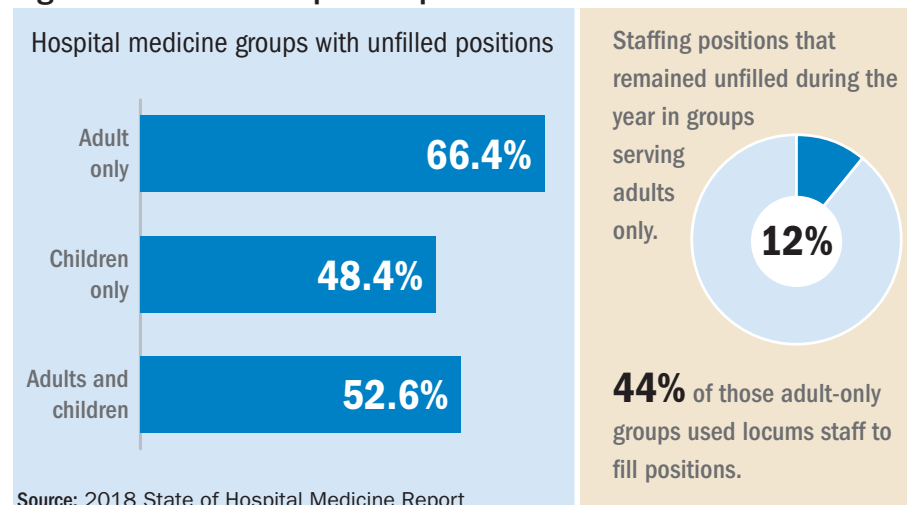
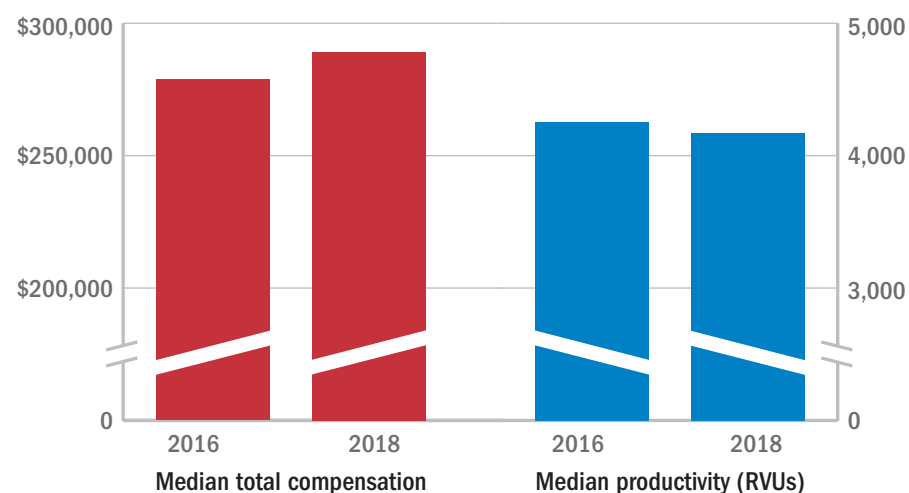


Figure 1. Compensation and productivity

NONACADEMIC ADULT MEDICINE HOSPITALISTS



and children were 5.4%.

“This survey doesn't tell us what should be best practice in hospital medicine,” Dr. White said, only what is actual current practice. He uses it in his own health system not only to contextualize and justify his group's performance metrics for hospital administrators – relative to national and categorical averages – but also to see if the direction his group is following is consistent with what's going on in the larger field.

“These data offer a very powerful resource regarding the trends in hospital medicine,” said Romil Chadha, MD, MPH, FACP, SFHM, associate division chief for operations in the division of hospital medicine at the University of Kentucky and UK Healthcare, Lexington. “It is my repository of data to go before my administrators for decisions that need to be made or to pilot new programs.”

services for the national hospitalist management company TeamHealth, and co-chair of the SHM Practice Administrators Special Interest Group, said her company's clients have traditionally asked for greater productivity from their hospitalist contracts as a way to decrease overall costs. Some markets are starting to see a change in that approach, she noted.

“Recently there's been an increased focus on paying hospitalists to focus on quality rather than just productivity. Some of our clients are willing to pay for that, and we are trying to assign value to this nonbillable time or adjust our productivity standards appropriately. I think hospitals definitely understand the value of nonbillable services from hospitalists, but still will push us on the productivity targets,” Ms. Himebaugh said.

"I don't believe hospital medicine can be sustainable long term on flat productivity or flat RVUs," she added. "Yet the costs of burnout associated with pushing higher productivity are not sustainable, either." So what are the answers? She said many inefficiencies are involved in responding to inquiries on the floor that could have been addressed another way, or waiting for the turnaround of diagnostic tests.

"Maybe we don't need physicians to be in the hospital 24/7 if we have access to telehealth, or a partnership with the emergency department, or greater use of advanced care practice providers," Ms. Himebaugh said. "Our hospitals are examining those options, and we

have to look at how we can become more efficient and less costly. At TeamHealth, we are trying to staff for value – looking at patient flow patterns and adjusting our schedules accordingly. Is there a bolus of readmissions tied to emergency department shift changes, or to certain days of the week? How can we move from the 12-hour shift that begins at 7 a.m. and ends at 7 p.m., and instead provide coverage for when the patients are there?"

Mark Williams, MD, MHM, chief of the division of hospital medicine at the University of Kentucky, Lexington, said he appreciates the volume of data in the report but wishes for even more survey participants, which could make the breakouts for subgroups such as academic hospitalists more robust. Other current sources of hospitalist salary data include the Association of American Medical Colleges (AAMC), which produces compensation reports to help medical schools and teaching hospitals with benchmarking, and the Faculty Practice Solution Center developed jointly by AAMC and Vizient to provide faculty practice plans with analytic tools. The Medical Group Management Association (MGMA) is another valuable source of information, some of which was



Dr. McIlraith



Ms. Himebaugh



Dr. Williams

licensed for inclusion in the *SoHM* report.

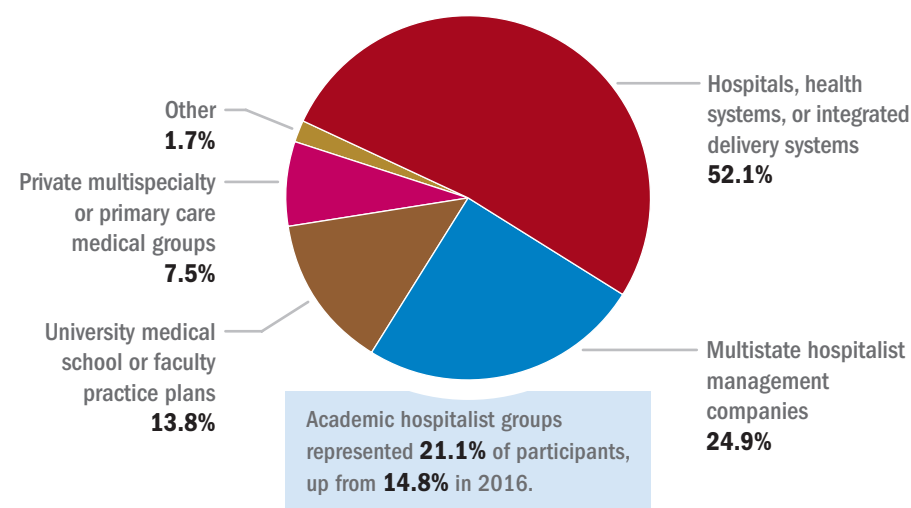
"There is no source of absolute truth that hospitalists can point to," Dr. Williams said. "I will present my data and my administrators will reply: 'We have our own data.' Our institution has consistently ranked first or second nationwide for the sickest patients. We take more Medicaid and dually eligible patients, who have a lot of social issues. They take a lot of time to manage medically and the RVUs don't reflect that. And yet I'm still judged by my RVUs generated per hospitalist. Hospital administrators understandably want to get the most productivity, and they are looking for their own data for average productivity numbers."

Ryan Brown, MD, specialty medical director for hospital medicine with Atrium Health in Charlotte, N.C., said that hospital medicine's flat productivity trends would be difficult to sustain in the business world. But there aren't easy or obvious ways to increase hospitalists' productivity. The *SoHM* report also shows that, as productivity increases, total compensation increases but at a lower rate, resulting in a gradual decrease in compensation per RVU.

Pressures to increase productivity can be a double-edged sword, Dr. Williams added. Demanding that doctors make more billable visits faster to generate more RVUs can be a recipe for burnout and turnover, with huge costs associated with recruiting replacements.

"If there was recent turnover of hospitalists at the hospital, with the need to find replacements, there may be institutional memory about that," he said. "But where are hospitals spending their money? Bottom line, we still need to learn to cut our costs."

Figure 3. Employment model for groups participating in the survey



Source: 2018 State of Hospital Medicine Report

How is hospitalist practice evolving?

In addition to payment and productivity data, the *SoHM* report provides a current picture of the evolving state of hospitalist group practices. A key thread is how the work hospitalists are doing, and the way they do it, is changing, with new information about comanagement roles, dedicated admitters, night coverage, geographic rounding, and the like.

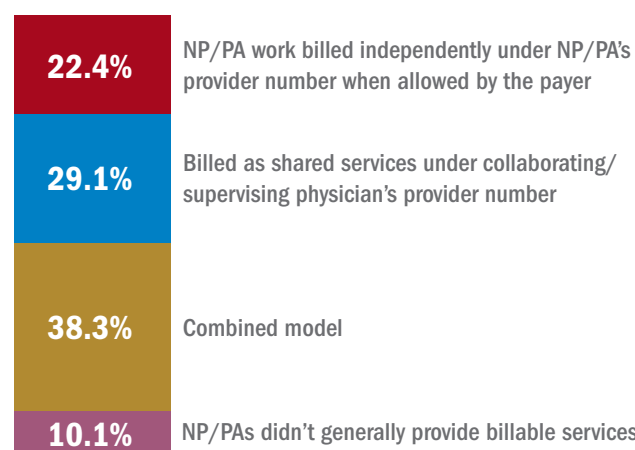
Making greater use of nurse practitioners and physician assistants (NPs/PAs), may be one way to change the flat productivity trends, Dr. Brown said. With a cost per RVU that's roughly half that of a doctor's, NPs/PAs could contribute to the

2016 to 75.7% in 2018. For adult-only groups, 76.8% had NPs/PAs, with higher rates in hospitals and health systems and lower rates in the West region. But a lot of groups are using these practitioners for nonproductive work, and some are failing to generate any billing income, Dr. Brown said.

"The rate at which NPs/PAs performed billable services was higher in physician-owned practices, resulting in a lower cost per RVU, suggesting that many practices may be underutilizing their NPs/PAs or not sharing the work." Not every NP or PA wants to or is able to care for very complex patients, Dr. Brown said, "but you want a system where the NP and PA can work at the highest level permitted by state law."

The predominant scheduling model of hospital medicine, 7 days on duty followed by 7 days off, has diminished somewhat in recent years. There appears to be some fluctuation and a gradual move away from 7 on/7 off toward some kind of variable approach, since the former may not be physically sustainable for the doctor over the long haul, Dr. Brown said.

Figure 4. How are NP/PA services billed?



Source: 2018 State of Hospital Medicine Report

bottom line. But he sees surprisingly large variation in how hospitalist groups are using them. Typically, they are deployed at a ratio of four doctors to one NP/PA, but that ratio could be two to one or even one to one, he said.

Use of NPs/PAs by academic hospitalist groups is up, from 52.1% in

Some groups are experimenting with a combined approach.

"I think balancing workload with manpower has always been a challenge for our field. Maybe we should be working shorter shifts or fewer days and making sure our hospitalists aren't ever sitting around idle," he said. "And could we come in on nonclinical days to do administrative tasks? I think the solution is out there, but we haven't created the algorithms to define that yet. If you could somehow use the data for volume, number of beds, nurse staffing, etc., by year and seasonally, you might be able to reliably predict census. This is about applying data hospitals already have in their electronic health records, but utilizing the data in ways that are more helpful."

Dr. McIlraith added that a big driver of the future of hospital medicine will be the evolution of the EHR and the digitalization of health care, as hospitals learn how to leverage more of what's in their EHRs.

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“The impact will grow for hospitalists through the creation and maturation of big data systems – and the learning that can be extracted from what’s contained in the electronic health record.”

Another important question for hospitalist groups is their model of backup scheduling, to make sure there is a replacement available if a scheduled doctor calls in sick or if demand is unexpectedly high.

“In today’s world, this is how we have traditionally managed unpredictability,” Dr. Brown said. “You don’t know when you will need it, but if you need it, you want it immediately. So how do you pay for it – only when the doctor comes in, or also an amount just for being on call?” Some groups pay for both, he said, others for neither.



Dr. Brown

shifts in exchange for 2 weeks of backup. We have times with 25% usage of backup number 1, and 10% usage of backup number 2,” he noted. “But the goal is for our hospitalists to have assurances that there is a backup system and that it works.”



Dr. Huang

The presence of nocturnists in hospitals continues to rise, with 76.1% of adults-only groups having nocturnists, 27.6% of children-only groups, and 68.2% of adults and children groups. Geographic or unit-based hospital assignments have grown to 36.4% of adult-only groups.

What are hospitalists’ other new roles?

“We have a large group of 50 doctors, with about 40 FTEs, and we are evolving from the traditional generalist role toward more subspecialty

to be an academic hospitalist as our teaching roles have shrunk.”

Dr. Huang recently took on a new role as physician adviser for his hospital in such areas as utilization review, patient flow, and length of stay. “I’m spearheading a work group to address quality issues – all of which involve collaboration with other professionals. We also developed an admitting role here for a hospitalist whose sole role for the day is to admit patients.” Nationally up to 51.2% of hospitalist groups utilize a dedicated daytime admitter.

The report found that hospital services for which hospitalists are more likely to be attendings than consultants include GI/liver, 78.4%; palliative care, 77.3%; neurology/stroke, 73.6%; oncology, 67.8%; cardiology, 56.9%; and critical care, 50.7%. Conditions where hospitalists are more likely to consult rather than admit and attend include neurosurgery, orthopedics, general surgery, cardiovascular surgery, and other surgical subspecialties.

Other hospital services routinely provided by adult-only hospitalists include care of patients in an ICU setting (62.7%); primary responsibility for observation units (54.6%); primary clinical responsibility for rapid response teams (48.8%); primary responsibility for code blue or cardiac arrest teams (43.8%); nighttime admissions or tuck-in services (33.9%); and medical procedures (31.5%). For pediatric hospital medicine groups, care of healthy newborns and medical procedures were among the most common services provided, while for hospitalists serving adults and children, rapid response teams, ICUs, and specialty units were most common.

New models of payment for health care

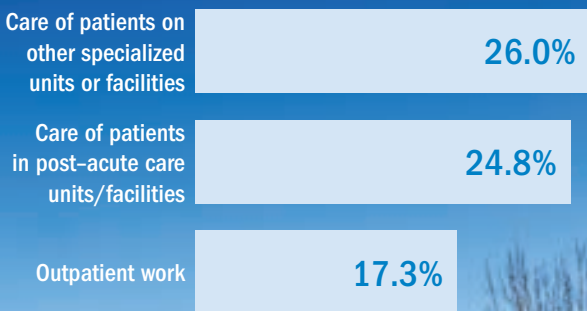
As the larger health care system is being transformed by new payment models and benefit structures, including accountable care organizations (ACOs), value-based purchasing, bundled payments, and other forms of population-based coverage – which is described as a

volume-to-value shift in health care – how are these new models affecting hospitalists?

Observers say penetration of these new models varies widely by locality but they haven’t had much direct impact on hospitalists’ prac-

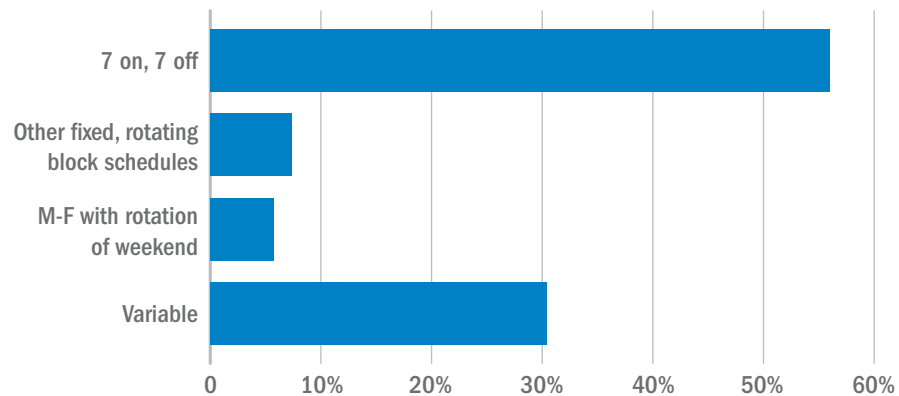
Figure 7. Outside the hospital

Care provided outside of the hospital by hospitalists



Source: 2018 State of Hospital Medicine Report

Figure 5. Predominant scheduling patterns for adult-only groups

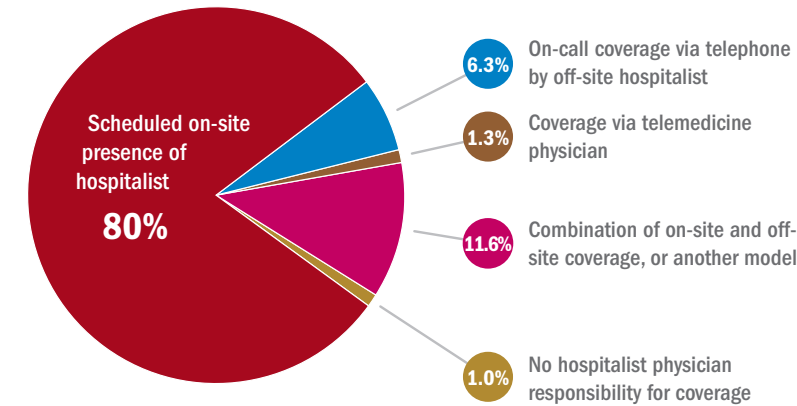


Source: 2018 State of Hospital Medicine Report

“We are a group of 70 hospitalists, and if someone is sick you can’t just shut down the service,” said Dr. Chadha. “We are one of the few to use incentives for both, which could include a 1-week decrease in clinical

comanagement,” said Bryan Huang, MD, physician adviser and associate clinical professor in the division of hospital medicine at the University of California–San Diego. “Our hospitalists are asking what it means

Figure 6. Predominant night coverage models for adult groups



Source: 2018 State of Hospital Medicine Report

tices – at least not yet. However, as hospitals and health systems find themselves needing to learn new ways to invest their resources differently in response to these trends, what matters to the hospital should be of great importance to the hospitalist group.

“I haven’t seen a lot of dramatic changes in how hospitalists engage with value-based purchasing,” Dr. White said. “If we know that someone is part of an ACO, the instinctual – and right – response is to treat them like any other patient. But we still need to be committed to not waste resources.”

Hospitalists are the best people to understand the intricacies of how the health care system works under value-based approaches, Dr. Huang said. “That’s why so many hospitalists have taken leadership positions in their hospitals. I think all of this translates to the practical, day-to-day work of hospitalists, reflected in our focus on readmissions and length of stay.”

Dr. Williams said the health care system still hasn’t turned the corner from fee-for-service to value-based purchasing. “It still represents a tiny fraction of the income of hospitalists. Hospitals still

Continued on following page

Continued from previous page

have to focus on the bottom line, as fee-for-service reimbursement for hospitalized patients continues to get squeezed, and ACOs aren't exactly paying premium rates either. Ask almost any hospital CEO what drives their bottom line today and the answer is volume – along with optimizing productivity. Pretty much every place I look, the future does not look terribly rosy for hospitals.”

Ms. Himebaugh said she is bullish on hospital medicine, in the sense that it's unlikely to go away anytime soon. “Hospitalists are needed and provide value. But I don't think we have devised the right model yet. I'm not sure our current model is sustainable. We need to find new models we can afford that don't require squeezing our providers.”

For more information about the 2018 State of Hospital Medicine Report, contact SHM's Practice Management Department at survey@hospitalmedicine.org or call 800-843-3360. See also <https://www.hospitalmedicine.org/practice-management/shms-state-of-hospital-medicine/>.

SHM announces National Hospitalist Day

Inaugural day of recognition to honor hospital medicine care team

By Brett Radler

The Society of Hospital Medicine is proud to announce the inaugural National Hospitalist Day, which is to be held on Thursday, March 7, 2019. Occurring the first Thursday in March annually, National Hospitalist Day will serve to celebrate the fastest-growing specialty in modern medicine and hospitalists' enduring contributions to the evolving health care landscape.

National Hospitalist Day was recently approved by the National Day Calendar and was one of approximately 30 national days to be approved for the year out of an applicant pool of more than 18,000.

“As the only national professional society dedicated to the specialty of hospital medicine, it is appropriate that SHM spearhead a national day to recognize the countless contributions of hospitalists to health care, from clinical, academic, and leadership perspectives and more,” said Larry Wellikson, MD, MHM, chief executive officer of SHM.

In addition to celebrating hospitalists' contributions to patient care, SHM will also be highlighting the diverse career paths of hospital medicine professionals, from frontline hospitalist physicians, nurse practitioners, and physician assistants to practice administra-

tors, C-suite executives, and academic hospitalists.

Highlights of SHM's campaign include the following:

- Downloadable customizable posters and assets for hospitals and individuals' offices to celebrate their hospital medicine team, available on SHM's website, hospitalmedicine.org.
- A series of spotlights of hospitalists at all stages of their careers in *The Hospitalist*, SHM's monthly news-magazine.
- A social media campaign inviting hospitalists and their employers to share their success stories using the hashtag #HowWeHospitalist, including banner graphics, profile photo overlays, and more.
- A social media contest to determine the most creative ways of celebrating with use of the hashtag.
- A Twitter chat for hospitalists to celebrate virtually with colleagues and peers from around the world.

“Hospitalists innovate, lead, and push the boundaries of clinical care and deserve to be recognized for their transformative contributions to health care,” said Eric E. Howell, MD, MHM, chief operating officer of SHM.

For more information, visit www.hospitalmedicine.org/hospitalistday.

Mr. Radler is marketing communications manager at the Society of Hospital Medicine.

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Key Clinical Question

When is it safe to resume anticoagulation in my patient with hemorrhagic stroke?

Balancing risk is critical to decision making

By Demetra Gibson, MD, MPH; Daniel Restrepo, MD; Saranya Sasidharan, MD; and Farrin A. Manian, MD, MPH

Department of Medicine, Massachusetts General Hospital, Boston

Case

A 75-year-old woman with a history of hypertension, diabetes mellitus, heart failure, and nonvalvular atrial fibrillation (CHA₂DS₂-VASc score, 8) on anticoagulation is admitted with weakness and dysarthria. Exam is notable for hypertension and right-sided hemiparesis. CT of the head shows an intraparenchymal hemorrhage in the left putamen. Her anticoagulation is reversed and blood pressure well controlled. She is discharged 12 days later.

Brief overview of the issue

Intracranial hemorrhage (ICH) is the second most common cause of stroke and is associated with high morbidity and mortality.¹ It is estimated that 10%-15% of spontaneous ICH cases occur in patients on therapeutic anticoagulation for atrial fibrillation.² As our population ages and more people develop atrial fibrillation, anticoagulation for primary or secondary prevention of embolic stroke also will likely increase, placing more people at risk for ICH. Even stringently controlled therapeutic international normalized ratios (INRs) between 2 and 3 may double the risk of ICH.³

Patients with ICH require close monitoring and treatment, including blood pressure control, reversal of anticoagulation, reduction of intracranial pressure, and at times, neurosurgery.⁴ Although anticoagulation is discontinued and reversed at the onset of ICH, no clear consensus exists as to when it is safe to resume it. Although anticoagulation

decreases the risk of stroke/thromboembolism, it may also increase the amount of bleeding associated with the initial ICH or lead to its recurrence.

Factors that may contribute to rebleeding include uncontrolled hypertension, advanced age, time to resumption of anticoagulation, and lobar location of ICH (i.e., in cerebral cortex and/or underlying white matter).^{5,6} Traditionally, lobar ICH has high incidence of cerebral amyloid angiopathy and has been associated with higher bleeding rates than has

deep ICH (i.e., involving the thalamus, basal ganglia, cerebellum, or brainstem) where cerebral amyloid angiopathy is rare and ICH is usually from hypertensive vessel disease. However, in patients with active thromboembolic disease, high-risk atrial fibrillation, and mechanical valves, withholding anticoagulation could place them at high risk of stroke.

Two questions should be addressed in the case presented: Is it safe to restart therapeutic anticoagulation; and if so, what is the optimal time interval between ICH and reinitiation of anticoagulation?

Overview of the data

There is limited guidance from major professional societies regarding the reinitiation of anticoagulation and the optimal timing of safely resuming anticoagulation in patients with prior ICH.

Current European Stroke Organization guidelines provide no specific recommendations for anticoagulation resumption after ICH.⁷ The American Heart Association/American Stroke Association guideline has a class IIA (weak) recommendation to avoid anticoagulation in spontaneous lobar ICH and a class IIB (very weak) recommendation to consider resuming anticoagulation in nonlobar ICH on a case-by-case basis.⁴

Two recent meta-analyses have examined outcomes of resuming anticoagulation after ICH. In a



Dr. Gibson



Dr. Restrepo



Dr. Sasidharan



Dr. Manian

Dr. Gibson, Dr. Restrepo, Dr. Sasidharan, and Dr. Manian are hospitalists at Massachusetts General Hospital, Boston.

meta-analysis of 5,300 patients with nonlobar ICH involving eight retrospective studies, Murthy et al. evaluated the risk of thromboembolic events (described as a composite outcome of MI and stroke) and the risk of recurrent ICH.⁸ They reported that resumption of therapeutic anticoagulation was associated with a decrease in the rate of thromboembolic events (6.7% vs. 17.6%; risk ratio, 0.35; 95% confidence interval, 0.25-0.45) with no significant change in the rate of repeat ICH (8.7% vs. 7.8%).

A second meta-analysis conducted by Biffi et al. of three retrospective trials examined anticoagulation resumption in 1,012 patients with ICH solely in the setting of thromboprophylaxis for nonvalvular atrial fibrillation.⁹ Reinitiation of anticoagulation after ICH was associated with decreased mortality (hazard ratio, 0.27; 95% CI, 0.19-0.40; *P* less than .0001), improved functional outcome (HR, 4.15; 95% CI, 2.92-5.90; *P* less than .0001), and reduction in

Continued on page 14

Key Points

- Robust scientific data on when to resume anticoagulation after ICH do not exist.
- Retrospective studies have shown that anticoagulation resumption after 4-8 weeks decreases the risk of thromboembolic events, decreases mortality, and improves functional status following ICH with no significant change in the risk of its recurrence.
- Prospective, randomized controlled trials are needed to explore risks/benefits of anticoagulation resumption and better define its optimal timing in relation to ICH.



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Continued from page 12

all-cause stroke recurrence (HR 0.47; 95% CI, 0.36-0.64; P less than .0001). There was no significant difference in the rate of recurrent ICH when anticoagulation was resumed. Despite the notion that patients with cerebral amyloid angiopathy are at high risk of rebleeding, this positive association still held irrespective of lobar vs. nonlobar location of ICH.

Collectively, these studies suggest that resumption of anticoagulation may be effective in decreasing the rates of thromboembolism, as well as provide a functional and mortality benefit without increasing the risk of rebleeding, irrespective of the location of the bleed.

Less is known about the optimal timing of resumption of therapeutic anticoagulation, with data ranging from 72 hours to 30 weeks.¹⁰ The American Heart Association/American Stroke Association has a class IIB (very weak) recommendation to avoid anticoagulation for at least 4 weeks in patients without mechanical heart valves.⁴ The median time to resumption of therapeutic anticoagulation in aforementioned meta-analyses ranged from 10 to 44 days.^{8,9}

A recent observational study of

Which of the following is false regarding ICH?

- A.** Lobar ICHs are usually associated with cerebral amyloid angiopathy which are prone to bleeding.
- B.** Randomized, controlled studies have helped guide the decision as to when to resume anticoagulation in patients with ICH.
- C.** Current guidelines suggest deferring therapeutic anticoagulation for at least 4 weeks following ICH.
- D.** Resumption of anticoagulation after 4-8 weeks does not lead to increased risk of rebleeding in patients with prior ICH.

The false answer is B: Current recommendations regarding resumption of anticoagulation in patients with ICH are based solely on retrospective observational studies; there are no randomized, control trials to date.

A is true: In contrast to hypertensive vessel disease associated with deep ICH, lobar hemorrhages are usually associated with cerebral amyloid angiopathy, which are more prone to bleeding.

C is true: The AHA/ASA has a class IIB recommendation to avoid anticoagulation for at least 4 weeks after ICH in patients without mechanical heart valves.

D is true: Several studies have shown that resumption of anticoagulation 4-8 weeks after ICH does not increase the risk of rebleeding.

2,619 ICH survivors explored the relationship between the timing of reinstitution of anticoagulation and the incidence of thrombotic events (defined as ischemic stroke or death because of MI or systemic arterial thromboembolism) and hemorrhagic events (defined as recurrent ICH or bleeding event leading to death)

occurring at least 28 days after initial ICH in patients with atrial fibrillation.¹¹

A decrease in thrombotic events was demonstrated if anticoagulation was started 4-16 weeks after ICH. However, when anticoagulation was started more than 16 weeks after ICH, no benefit was seen. Additionally, there was no significant difference in hemorrhagic events between men and women who resumed anticoagulation. In patients with high venous thromboembolism risk based on CHA₂DS₂-VASc score, resumption of anticoagulation was associated with a decreased predicted incidence of vascular death and nonfatal stroke, with the greatest benefit observed when anticoagulation was started at 7-8 weeks after ICH.

Unfortunately, published literature to date on anticoagulation after ICH is based entirely on retrospective studies – not randomized, controlled studies – making it more likely that anticoagulation would have been resumed in healthier patients, not those left debilitated by the ICH.

Furthermore, information on the location and size of the hemorrhages – which may serve as another confounding factor – often has not been reported. This is important since patients with smaller hemorrhages in less precarious areas also may be more likely to have resumption of anticoagulation. Another limitation of the current literature is that warfarin is the most common anticoagulant studied, with few studies involving the increasingly prescribed newer direct oral anticoagulants. It is also important to

stress that a causal relationship between use of anticoagulants and certain outcomes or adverse effects following ICH may be more difficult to invoke in the absence of randomized controlled study designs.

Application of the data to our patient

Resumption of anticoagulation in our patient with ICH requires balancing the risk of hemorrhage expansion and recurrent ICH with the risk of thromboembolic disease.

Our patient is at higher risk of bleeding because of her advanced age, but adequate control of her blood pressure and nonlobar location of her ICH in the basal ganglia also may decrease her risk of recurrent ICH. Her high CHA₂DS₂-VASc score places her at high risk of thromboembolic event and stroke, making it more likely for reinstitution of anticoagulation to confer a mortality benefit.

Based on AHA guidelines,⁴ we should wait at least 4 weeks, or possibly wait until weeks 7-8 after ICH when the greatest benefit may be expected based on prediction models.¹¹

Bottom line

It would likely be safe to resume anticoagulation 4-8 weeks after ICH in our patient.

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Acute stroke thrombolysis worked safely despite GI bleed or malignancy

By **Mitchel L. Zoler**

MDedge News

FROM THE AHA SCIENTIFIC SESSIONS / CHICAGO / A recent history of GI bleeding or malignancy may not be a valid contraindication to thrombolytic therapy in patients with an acute ischemic stroke, based on a review of outcomes from more than 40,000 U.S. stroke patients.



Dr. Inohara

The analysis showed that, among 40,396 U.S. patients who had an acute ischemic stroke during 2009-2015 and received timely treatment with alteplase, “we did not find statistically

significant increased rates of in-hospital mortality or bleeding” in the small number of patients who received alteplase (Activase) despite a recent GI bleed or diagnosed GI malignancy, Taku Inohara, MD, said at the American Heart Association scientific sessions. The 2018 Guidelines for the Early Management of Patients With Acute Ischemic Stroke deemed thrombolytic therapy with alteplase in these types of patients contraindicated, based on consensus expert opinion (Stroke. 2018 Mar;49[3]:e66-110).

“Further study is needed to evaluate the safety of recombinant tissue-type plasminogen activator [alteplase] in this specific population,” said Dr. Inohara, a cardiologist and research fellow at Duke University, Durham, N.C.

His analysis used data collected by the Get With the Guidelines–Stroke program, a voluntary quality promotion and improvement program that during 2009-2015 included records for more than 633,000 U.S. stroke patients that could be linked with records kept by the Centers for Medicare & Medicaid Services. From this database, 40,396 patients (6%) treated with alteplase within 4.5 hours of stroke onset were identified. The alteplase-treated patients included 93 with a diagnosis code during the

prior year for a GI malignancy and 43 with a diagnostic code within the prior 21 days for a GI bleed.

Dr. Inohara and his associates determined patients’ mortality during their stroke hospitalization, as well as several measures of functional recovery at hospital discharge and thrombolysis-related complications. For each of these endpoints, the rate among patients with a GI malignancy, a GI bleed, or the rate among a combined group of both patients showed no statistically significant differences, compared with the more than 40,000 other patients without a GI complication after adjustment for several demographic and clinical between-group differences. However, Dr. Inohara cautioned that residual or unmeasured confounding may exist that distorts these findings. The rate of in-hospital mortality, the prespecified primary endpoint for the analysis, was 10% among patients with either type of GI complication and 9% in those without. The rate of serious thrombolysis-related complications was 7% in the patients with GI disease and 9% in those without.

In a separate analysis of the complete database of more than 633,000 patients, Dr. Inohara and his associates found 148 patients who had either a GI bleed or malignancy and otherwise qualified for thrombolytic therapy but did not receive this treatment. This meant that, overall in this large U.S. experience, 136 of 284 (48%) acute ischemic stroke patients who qualified for thrombolysis but had a GI complication nonetheless received thrombolysis. Further analysis showed that the patients not treated with thrombolysis had at admission an average National Institutes of Health Stroke Scale score of 11, compared with an average score of 14 among patients who received thrombolysis.

This apparent selection for thrombolytic treatment of patients with more severe strokes “may have overestimated risk in the patients with GI disease,” Dr. Inohara said.

Dr. Inohara reported receiving research funding from Boston Scientific.



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ITL: Clinician reviews of HM-centric research

By Erin Gabriel, MD; Horatio (Teddy) Holzer, MD; Anne Linker, MD;
Aveena Kochar, MD; and Imuetinyan Asuen, MD

Division of Hospital Medicine at Mount Sinai Hospital, New York

IN THIS ISSUE

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By Erin Gabriel, MD

1 Physician burnout may be jeopardizing patient care

CLINICAL QUESTION: Is physician burnout associated with more patient safety issues, low professionalism, or poor patient satisfaction?

BACKGROUND: Burnout is common among physicians and has a negative effect on their personal lives. It is unclear whether physician burnout is associated with poor outcomes for patients.

STUDY DESIGN: Meta-analysis.

SETTING: Forty-seven published studies from 19 countries assessing inpatient and outpatient physicians and the relationship between physician burnout and patient care.

SYNOPSIS: After a systematic review of the published literature, 47 studies were included to pool data from 42,473 physicians. Study subjects included residents, early-career and late-career physicians, and both hospital and outpatient physicians. All studies used validated measures of physician burnout.

Burnout was associated with a twofold increased risk of physician-reported safety incidents (odds ratio, 1.96; 95% confidence interval, 1.59-2.40), low professionalism (OR, 2.31; 95% CI, 1.87-2.85), and likelihood of low patient-reported satisfaction (OR, 2.28; 95% CI, 1.42-3.68). There were no significant differences in these results based on country of origin of the study. Early-career physicians were more likely to have burnout associated with low pro-

fessionalism than were late-career physicians.

Of the components of burnout, depersonalization was most strongly associated with these negative



Dr. Gabriel

outcomes. Interestingly, the increased risk of patient safety incidents was associated with physician-reported, but not health care system-reported, patient safety outcomes.

This raises concerns that the health care systems may not be capturing “near misses” in their metrics.

BOTTOM LINE: Physician burnout doubles the risk of being involved in a patient safety incident, low professionalism, and poor patient satisfaction.

CITATION: Panagioti M et al. Association between physician burnout and patient safety, professionalism, and patient satisfaction. *JAMA Intern Med.* 2018;178(10):1317-30.

2 No Pip/Tazo for patients with ESBL blood stream infections

CLINICAL QUESTION: Can piperacillin/tazobactam be used as a “carbapenem sparing” alternative in patients with extended-spectrum beta-lactamase (ESBL) *Escherichia coli* or *Klebsiella pneumoniae* blood stream infections?

BACKGROUND: ESBL-producing

gram-negative bacilli are becoming increasingly common. Carbapenems are considered the treatment of choice for these infections, but they may in turn select for carbapenem-resistant gram-negative bacilli.

STUDY DESIGN: Open-label, noninferiority, randomized clinical trial.

SETTING: Adult inpatients from nine countries (not including the United States).

SYNOPSIS: Patients with at least one positive blood culture for ESBL *E. coli* or *K. pneumoniae* were screened. Of the initial 1,646 patients assessed, only 391 were enrolled (866 met exclusion criteria, 218 patients declined, and 123 treating physicians declined). Patients were randomized within 72 hours of the positive blood culture collection to either piperacillin/tazobactam 4.5 g every 6 hours or meropenem 1 g every 8 hours. Patients were treated from 4 to 14 days, with the total duration of antibiotics left up to the treating physician.

The primary outcome was all-cause mortality at 30 days after randomization. The study was stopped early because of a significant mortality difference between the two groups (12.3% in the piperacillin/tazobactam group versus 3.7% in the meropenem group).

The overall mortality rate was lower than expected. The sickest patients may have been excluded because the treating physician needed to approve enrollment. Because of the necessity for empiric antibiotic therapy, there was substantial crossover in antibiotics between the groups, although this would have biased the study toward noninferiority.

BOTTOM LINE: For patients with ESBL *E. coli* or *K. pneumoniae* blood stream infections, treatment with piperacillin/tazobactam was inferior to meropenem for 30-day mortality.

CITATION: Harris PNA et al. Effect of piperacillin-tazobactam vs meropenem on 30-day mortality for patients with *E coli* or *Klebsiella pneumoniae* bloodstream infection and ceftriaxone resistance: A randomized clinical trial. *JAMA.* 2018;320(10):984-94.

Dr. Gabriel is assistant professor of medicine and director of Preoperative Medicine and Medicine Consult Service in the division of hospital medicine at Mount Sinai Hospital, New York.

By Horatio (Teddy) Holzer, MD

3 New single-dose influenza therapy effective among outpatients

CLINICAL QUESTION: Is baloxavir marboxil, a selective inhibitor of influenza cap-dependent endonuclease, a safe and effective treatment for acute uncomplicated influenza?

BACKGROUND: The emergence of oseltamivir-resistant influenza A(H1N1) infection in 2007 highlights the risk of future neuraminidase-resistant global pandemics. Baloxavir represents a new class of antiviral agent that may help treat such outbreaks.

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

SETTING: Outpatients in the United States and Japan.

SYNOPSIS: The trial recruited 1,436 otherwise healthy patients aged 12-64 years of age (median age, 33 years) with a clinical diagnosis of acute uncomplicated influenza pneumonia. The patients were randomly assigned to receive either a single dose of oral baloxavir, oseltamivir 75 mg twice daily for 5 days, or matching placebo within 48 hours of symptom onset. The primary outcome was patient self-assessment of symptomatology.

Among the 1,064 adult patients (age 20-64) with influenza diagnosis confirmed by reverse transcription polymerase chain reaction (RT-PCR), the median time to alleviation of symptoms was lower in the baloxavir group than it was in the placebo group (53.7 hours vs. 80.2 hours; *P* less than .001). There was no significant difference in time to alleviation of symptoms in the baloxavir group when compared with the oseltamivir group. Adverse events were reported in 21% of baloxavir patients, 25% of placebo patients, and 25% of oseltamivir patients.

The enrolled patients were predominantly young, healthy, and

treated as an outpatient. Patients hospitalized with influenza pneumonia are often older, have significant comorbidities, and are at higher risk of poor outcomes. This trial does not directly support the safety or efficacy of baloxavir in this population.

BOTTOM LINE: A single dose of baloxavir provides similar clinical benefit as 5 days of oseltamivir therapy in the early treatment of healthy patients with acute influenza.

CITATION: Hayden FG et al. Baloxavir marboxil for uncomplicated influenza in adults and adolescents. *N Engl J Med.* 2018;379(10):914-23.

4 What drives intensification of antihypertensive therapy at discharge?

CLINICAL QUESTION: Are decisions to intensify antihypertensive medication regimens appropriate in older hospitalized adults?

BACKGROUND: Transient elevations in blood pressure are common among adult patients, yet there are no data or guidelines that support long-term medication changes based on these readings. Tight control of blood pressure is likely to improve outcomes among patients with heart failure, myocardial infarction, and

stroke. Patients with reduced life expectancy, dementia, or metastatic cancer are less likely to benefit from tight control.



Dr. Holzer

STUDY DESIGN: Retrospective cohort study.

SETTING: U.S. Veterans Administration (VA) Health System.

SYNOPSIS: The investigators reviewed data from 14,915 adults over

65 (median age, 76 years) admitted to the VA with a diagnosis of pneumonia, urinary tract infection, or venous thromboembolism. Most patients (65%) had well-controlled blood pressure prior to admission.

A total of 2,074 (14%) patients were discharged with an intensified hypertension regimen (additional medication or higher dose). While both elevated inpatient and outpatient blood pressures were predictive of intensification, the association with elevated inpatient blood pressure was much stronger (odds ratio, 3.66; 95% confidence interval, 3.29-4.08) than it was with elevated outpatient blood pressure (OR, 1.75; 95% CI, 1.58-1.93).

In a multivariate regression analysis, the investigators found no significant differences in intensification by life expectancy ($P = .07$), diagnosis of dementia ($P = .95$), or metastatic malignancy ($P = .13$). There was a small increased probability of intensification among patients with heart failure, but no such difference for patients with history of MI ($P = .53$), stroke ($P = .37$), or renal disease ($P = .73$).

The generalizability of this trial may be limited given the cohort was predominantly male (97%), white (77%), and 53% had at least four major comorbidities.

BOTTOM LINE: Intensification of antihypertensive therapy at discharge is often driven by inpatient blood pressure readings rather than the broader context of their disease, such as prior long-term outpatient blood pressure control or major comorbidities.

CITATION: Anderson TS et al. Intensification of older adults' outpatient blood pressure treatment at hospital discharge: A national retrospective cohort study. *BMJ.* 2018;362:k3503.

Dr. Holzer is an assistant professor of medicine in the division of hospital medicine at Mount Sinai Hospital, New York.

By Anne Linker, MD

5 Repeated qSOFA measurements better predict in-hospital mortality from sepsis

CLINICAL QUESTION: Do repeated quick Sepsis-Related Organ Failure Assessment (qSOFA) measurements improve predictive validity for sepsis using in-hospital mortality, compared with a single qSOFA measurement at the time a clinician first suspects infection?

BACKGROUND: Sepsis in hospitalized patients is associated with poor outcomes, but it is not clear how to best identify patients at risk. For non-ICU patients, the qSOFA score (made up of three simple clinical variables: respiratory rate greater than or equal to 22 breaths/minute, systolic blood pressure less than or equal to 100 mm Hg, and Glasgow Coma Scale score less than 15) has predictive validity for important outcomes including in-hospital mortality. qSOFA is relatively new in clinical practice, and the optimal utilization of the score has not yet been defined.

STUDY DESIGN: Retrospective Cohort Study.

Continued on following page

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Continued from previous page

SETTING: All adult medical and surgical encounters in the ED, hospital ward, postanesthesia care unit (PACU), and ICU at 12 hospitals in Pennsylvania in 2012.

SYNOPSIS: Kievlan et al. studied whether repeated qSOFA scores improved prediction of in-hospital mortality and allowed



Dr. Linker

identification of specific clinical trajectories. The study included approximately 37,600 encounters. Authors abstracted demographic data, vital signs,

laboratory results, and antibiotic/culture orders. An infection cohort was identified by a combination of orders for body fluid culture and antibiotics. The qSOFA scores were gathered at 6-hour intervals from the culture/antibiotic event (suspected sepsis). Scores were low (0), moderate (1), or high (greater than or equal to 2). Mean initial qSOFA scores were greater for patients who died, and remained higher during the 48 hours after suspected infection. Mortality was less than 2% in patients with an initial low qSOFA; 25% of patients with an initial moderate qSOFA had subsequent higher qSOFAs, and they had higher mortality, compared with patients with subsequent low qSOFA scores (16% vs. 4%).

Only those patients with initial qSOFA scores at the time of suspected infection were included, and missing data were common. The results may not be applicable to hospi-

tals with a different sepsis case mix from the those of study institutions.

BOTTOM LINE: Repeated qSOFA measurements improve predictive validity for in-hospital mortality for patients with sepsis. Patients with low initial qSOFA scores have a low chance (less than 2%) of in-hospital mortality. Further studies are needed to determine how repeat qSOFA measurements can be used to improve management of patients with sepsis. **CITATION:** Kievlan DR et al. Evaluation of repeated quick sepsis-related organ failure assessment measurements among patients with suspected infection. *Crit Care Med.* 2018. doi: 10.1097/CCM.0000000000003360.

6 Daily aspirin use may not improve CV outcomes in healthy elderly

CLINICAL QUESTION: What are the benefits and risks of daily aspirin use for primary prevention in healthy elderly adults?

BACKGROUND: Prior studies have shown the efficacy of aspirin for secondary prevention of cardiovascular disease and stroke, but the evidence supporting the use of aspirin for primary prevention is less certain.

STUDY DESIGN: Randomized, double-blind, placebo-controlled prospective study with a 5-year study period.

SETTING: Australia and the United States.

SYNOPSIS: The Aspirin in Reducing Events in the Elderly (ASPREE) trial included 19,114 community-dwelling healthy people (aged 70 years and older overall and aged 65 years and older if black or Hispanic), without cardiovascular disease, dementia, or disability. The goal was to investigate the effect of daily low-dose aspirin (100 mg, enteric coated) on healthy life span (without dementia or disability), with prespecified secondary outcomes (cardiovascular events and major hemorrhage).

Analysis was by intention to treat. Participants were predominantly white, approximately 10% of patients had diabetes, 74% had hypertension, and 65% had dyslipidemia. There was high adherence to the intervention. There was no significant difference in the primary outcome (disability-free survival) or in the secondary outcome of cardiovascular event (fatal or nonfatal MI or stroke, or hospitalization for heart failure.) The rate of major hemorrhage (hemorrhagic stroke, symptomatic intracranial bleeding,

clinically significant extracranial bleeding) was higher in the aspirin group (P less than .001). In contrast to prior studies, subgroup analysis showed higher mortality in the aspirin group (attributed to an increase in the risk of cancer-related death.) The authors warn that this finding should be interpreted with caution.

BOTTOM LINE: Aspirin use for primary prevention in healthy elderly persons over a 5-year period did not change disability-free survival, did not decrease cardiovascular risk, and increased the rate of major hemorrhage.

CITATIONS: McNeil JJ et al. Effect of aspirin on all-cause mortality in the healthy elderly. *N Engl J Med.* 2018;379:1519-28.

Dr. Linker is an assistant professor of medicine in the division of hospital medicine at Mount Sinai Hospital, New York.

By Aveena Kochar, MD

7 Mitral valve repair improves prognosis in heart failure patients with secondary MR

CLINICAL QUESTION: Does mitral valve repair (MVR) improve prognosis in heart failure patients with secondary mitral regurgitation (MR)?

BACKGROUND: In patients with primary degenerative MR, MVR is curative, with the transcatheter approach being safer than surgical repair. However, it is unknown whether patients with secondary MR from left ventricular dilatation would confer the same benefit of MVR.

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

SETTING: 78 sites in the United States and Canada.

SYNOPSIS: From December 2012 to June 2017, 614 patients from 78 centers in the United States and Canada with symptomatic MR were enrolled with 302 patients assigned to the device group (transcatheter MVR and medical treatment) and 312 to the control group (medical therapy). Over 2 years, the device group's annual rate for heart failure hospitalizations was significantly lower (35.8%/patient-year versus 67.9%/patient-year in the control group), as was all-cause mortality (29.1% for the device group versus 46.1%). The rate of freedom from device-related



Dr. Kochar

complications was 96.6%, better than the goal of 88%. There was improvement in quality of life, functional capacity, severity of MR, and left ventricular remodeling.

Limitations include that investigators were not blinded because the device was visible on imaging. Longer follow-up in the device group may have contributed to the observed decreased mortality. It is unknown whether less-symptomatic patients would attain the same benefit.

BOTTOM LINE: In patients with symptomatic, moderate to severe, and severe secondary MR, MVR lowers rates of hospitalization, decreases mortality, and improves quality of life.

CITATION: Stone GW et al. Transcatheter mitral-valve repair in patients with heart failure. *N Engl J Med.* 2018 Sep 23. doi: 10.1056/NEJ-Moa1806640.

8 Same-day discharge after elective PCI has increased value and patient satisfaction

CLINICAL QUESTION: What is the prevalence of same-day discharges (SDDs) for elective percutaneous coronary interventions (PCIs), and what is the effect on readmissions and hospital cost?

BACKGROUND: SDDs are as safe as non-SDDs (NSDDs) in patients after elective PCI, yet there has been only a modest increase in SDD.

STUDY DESIGN: Observational cross-sectional cohort study.

SETTING: 493 hospitals in the United States.

SYNOPSIS: With use of the national Premier Healthcare Database, 672,470 elective PCIs from January 2006 to December 2015 with 1-year follow-up showed a wide variation in SDD from 0% to 83% among hospitals with the overall corrected rate of 3.5%. Low-volume PCI hospitals did not increase the rate. Additionally, the cost of SDD patients was \$5,128 less than NSDD patients. There was cost saving even with higher-risk transfemoral approaches and patients needing periprocedural hemodynamic or ventilatory support. Complications (death, bleeding, acute kidney injury, or acute MI at 30, 90, and 365 days) were not higher for SDD than for NSDD patients.

Limitations include that 2015 data may not reflect current practices. ICD 9 codes used for obtaining complications data can be misclassified. Cost savings are variable. Patients with periprocedural complications were not candidates

Short Takes

Restrictive transfusion strategy for cardiac surgery patients remains noninferior at 6 months post op

The authors previously reported that, in moderate- to high-risk cardiac surgery patients, a restrictive transfusion strategy was noninferior to a liberal strategy based on the clinical outcomes of all-cause mortality, MI, stroke, or new renal failure with dialysis. The groups continued to show no significant difference in outcomes at 6 months post op.

CITATION: Mazer CD et al. Six-month outcomes after restrictive or liberal transfusion for cardiac surgery. *N Engl J Med.* 2018;379:1224-33.

for SDD but were included in the data. The study does not account for variation in technique, PCI characteristics, or SDD criteria of hospitals.

BOTTOM LINE: Prevalence of SDDs for elective PCI patients varies by institution and is an underutilized opportunity to significantly reduce hospital costs and increase patient satisfaction while maintaining the safety of patients.

CITATION: Amin AP et al. Association of same-day discharge after elective percutaneous coronary intervention in the United States with costs and outcomes. *JAMA Cardiol.* Published online 2018 Sep 26. doi: 10.1001/jamacardio.2018.3029.

Dr. Kochar is an assistant professor of medicine in the division of hospital medicine at Mount Sinai Hospital, New York.

By Imuetinyan Asuen, MD

9 Adjustment for characteristics not used by Medicare reduces hospital variations in readmission rates

CLINICAL QUESTION: Can differences in hospital readmission rates be explained by patient characteristics not accounted for by Medicare?

BACKGROUND: In its Pay for Performance program, Medicare ties payments to readmission rates but adjusts these rates only for limited patient characteristics. Hospitals serving higher-risk patients have received greater penalties. These programs may have the unintended consequence



Dr. Asuen

of penalizing hospitals that provide care to higher-risk patients.

STUDY DESIGN: Observational study.

SETTING: Medicare admissions claims from 2013 through 2014 in 2,215 hospitals.

SYNOPSIS: Using Medicare claims for admission and linked U.S. census data, the study assessed several clinical and social characteristics not currently used for risk adjustment. A sample of 1,169,014 index admissions among 1,003,664 unique beneficiaries was analyzed. The study compared rates with and without these additional adjustments.

Additional adjustments reduced overall variation in hospital re-

admission by 9.6%, changed rates upward or downward by 0.4%-0.7% for the 10% of hospitals most affected by the readjustments, and they would be expected to reduce penalties by 52%, 46%, and 41% for hospitals with the largest 1%, 5%, and 10% of penalty reductions, respectively.

BOTTOM LINE: Hospitals serving higher-risk patients may be penalized because of the patients they serve rather than the quality of care they provide.

CITATION: Roberts ET et al. Assessment of the effect of adjustment for patient characteristics on hospital readmission rates: Implications for Pay for Performance. *JAMA Intern Med.* 2018;178(11):1498-507.

10 Uncomplicated appendicitis can be treated successfully with antibiotics

CLINICAL QUESTION: What is the late recurrence rate for patients with uncomplicated appendicitis treated with antibiotics only?

BACKGROUND: Short-term results support antibiotic treatment as alternative to surgery for uncomplicated appendicitis. Long-term out-

comes have not been assessed.

STUDY DESIGN: Observational follow-up.

SETTING: Six hospitals in Finland.

SYNOPSIS: The APPAC trial looked at 530 patients, aged 18-60 years, with CT-confirmed acute uncomplicated appendicitis, who were randomized to receive either appendectomy or antibiotics. In this follow-up report, outcomes were assessed by telephone interviews conducted 3-5 years after the initial interventions. Overall, 100 of 256 (39.1%) of the antibiotic group ultimately underwent appendectomy within 5 years. Of those, 70/100 (70%) had their recurrence within 1 year of their initial presentation.

BOTTOM LINE: Patients with uncomplicated appendicitis treated with antibiotics have a 39% cumulative 5-year recurrence rate, with most recurrences occurring within the first year.

CITATION: Salminen P et al. Five-year follow-up of antibiotic therapy for uncomplicated acute appendicitis in the APPAC Randomized Clinical Trial. *JAMA.* 2018;320(12):1259-65.

Dr. Asuen is an assistant professor of medicine in the division of hospital medicine at Mount Sinai Hospital, New York.

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Pediatric ITL

Public insurance income limits and hospitalizations for low-income children

Vulnerable populations at greater risk

By Alissa Darden, MD

BACKGROUND: Medicaid and the Children's Health Insurance Program (CHIP) provide health care to over 30 million children in the United States.^{1,2} As a result, low-income children have had increased access to health care, of all forms, which has increased the utilization of primary care and decreased unnecessary ED visits and hospitalizations. However, this comes at a high cost, both at the state and national level. Medicaid currently subsidizes more than 50% of every state's public insurance program, spending about \$100 billion/year in health care payments for children.³ Given this hefty price tag, there have been myriad strategies proposed to help decrease these costs. One such strategy, includes decreasing enrollment in public insurance through

decreasing income eligibility thresholds. As a result, many children from low-income families would lose their public insurance and be eligible for commercial insurance only. Consequently, this would place an undue financial burden on these families and the health care systems that care for them. Furthermore, it is anticipated that poor health care outcomes would increase in these vulnerable populations.

STUDY DESIGN: Retrospective cohort study using 2014 State Inpatient Databases.

SETTING: Pediatric hospitalizations (aged less than 18 years) from 14 states during 2014 with public insurance listed as the primary payer. This encompassed about 30% of family households in the United States in 2014.

SYNOPSIS: Simulations were done at three different thresholds of the

federal poverty level (FPL), including less than 100%, less than 200%, and less than 300%. Of the families included, 43% lived below 300%, 27% below 200%, and 11% below 100% of the FPL. Of note, public insurance FPL eligibility limits tended to be lower in states with a greater percentage of the population being below 300% of the FPL. The results, of these reductions, were as follows:

- If reduced to less than 300% of the FPL, about 155,000 hospitalizations became ineligible for reimbursement. The median per-hospitalization estimated costs ranged from approximately \$6,000 to approximately \$10,000, accumulating \$1.2 billion in estimated costs.
 - If reduced to less than 200% of the FPL, about 440,000 hospitalizations became ineligible for reimbursement. The median per-hospitalization estimated costs ranged from approximately \$2,000 to approximately \$10,000, accumulating \$3.1 billion in estimated costs.
 - If reduced to less than 100% of the FPL, about 650,000 hospitalizations became ineligible for reimbursement. The median per-hospitalization estimated costs ranged from approximately \$2,000 to approximately \$10,000, accumulating \$4.4 billion in estimated costs.
- If these reductions occurred, healthy newborns would be disproportionately affected by them, which is important to note because newborn hospitalization is one of the fastest-rising costs in pediatric care. In fact, it can range from approximately \$700 to approximately \$2,000 per hospitalization, which may represent a huge financial strain for families that are unable to secure commercial insurance. Furthermore, with the average hospitalization of non-newborns ranging from \$3,000 to \$10,000, it is likely that this cost would constitute a fairly large percentage of a low-income family's annual income, which may represent an untenable financial burden.

Thus, if these families are unable to obtain commercial insurance and/or pay these debts, the financial



Dr. Darden is a pediatric hospitalist at Phoenix Children's Hospital and clinical assistant professor, University of Arizona, Phoenix.

burden will shift to the institutions that care for these vulnerable populations.

BOTTOM LINE: If public insurance eligibility thresholds were decreased, a large number of pediatric hospitalizations would become ineligible for coverage, which would shift the costs to families and institutions that are already financially strained and likely result in poor health care outcomes for some of our most vulnerable pediatric patients.

CITATION: Bettenhausen JL et al. The effect of lowering public insurance income limits on hospitalizations for low-income children. *Pediatrics*. 2018 Aug. doi: 10.1542/peds.2017-3486.

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ASH releases new VTE guidelines

By Mitchel L. Zoler
MDedge News

The American Society of Hematology has released a new set of guidelines for the prevention, diagnosis, and management of venous thromboembolism.

The guidelines contain more than 150 individual recommendations, including sections devoted to managing venous thromboembolism (VTE) during pregnancy and in pediatric patients. Guideline highlights cited by some of the writing-panel participants included a high reliance on low-molecular-weight heparin (LMWH) agents as the preferred treatment for many patients, reliance on the D-dimer test to rule out VTE in patients with a low pretest probability of disease, and reliance on the 4Ts score to identify patients with heparin-induced thrombocytopenia.

The guidelines took more than 3 years to develop, an effort that began in 2015.

An updated set of VTE guidelines were needed because clinicians now have a “greater understanding of risk factors” for VTE as well as having “more options available for treating VTE, including new medications,” Adam C. Cuker, MD, cochair of the guideline-writing group and a hematologist and thrombosis specialist at the University of Pennsylvania, Philadelphia, said during a webcast to unveil the new guidelines.

Prevention

For preventing VTE in hospitalized medical patients the guidelines recommended initial assessment of the patient’s risk for both VTE and bleeding. Patients with a high bleeding risk who need VTE prevention should preferentially receive mechanical prophylaxis, either compression stockings or pneumatic sleeves. But in patients with a high VTE risk and an “acceptable” bleeding risk, prophylaxis with an anticoagulant is preferred over mechanical measures, said Mary Cushman, MD, professor and medical director of the thrombosis and hemostasis program at the University of Vermont, Burlington.

For prevention of VTE in medical inpatients, LMWH is preferred over unfractionated heparin because of its once-daily dosing and fewer complications, said Dr. Cushman, a member of the writing group. The panel also endorsed LMWH over

a direct-acting oral anticoagulant, both during hospitalization and following discharge. The guidelines for prevention in medical patients explicitly “recommended against” using a direct-acting oral anticoagulant “over other treatments” both for hospitalized medical patients and after discharge, and the guidelines further recommend against extended prophylaxis after discharge with any other anticoagulant.

Another important takeaway from the prevention section was a statement that combining both mechanical and medical prophylaxis was not needed for medical inpatients. And once patients are discharged, if they take a long air trip they have no need for compression stockings or aspirin if their risk for thrombosis is not elevated. People with a “substantially increased” thrombosis risk “may benefit” from compression stockings or treatment with LMWH, Dr. Cushman said.

Diagnosis

For diagnosis, Wendy Lim, MD, highlighted the need for first categorizing patients as having a low or high probability for VTE, a judgment that can aid the accuracy of the diagnosis and helps avoid unnecessary testing.

For patients with low pretest probability, the guidelines recommended the D-dimer test as the best first step. Further testing isn’t needed when the D-dimer is negative, noted Dr. Lim, a hematologist and professor at McMaster University, Hamilton, Ont.

The guidelines also recommended using ventilation-perfusion scintigraphy (V/Q scan) for imaging a pulmonary embolism over a CT scan, which uses more radiation. But V/Q scans are not ideal for assessing older patients or patients with lung disease, Dr. Lim cautioned.

Management

Management of VTE should occur, when feasible, through a specialized anticoagulation management service center, which can provide care that is best suited to the complexities of anticoagulation therapy. But it’s a level of care that many U.S. patients don’t currently receive and hence is an area ripe for growth, said Daniel M. Witt, PharmD, professor and vice-chair of pharmacotherapy at the University of Utah, Salt Lake City.

The guidelines recommended

against bridging therapy with LMWH for most patients who need to stop warfarin when undergoing an invasive procedure. The guidelines also called for “thoughtful” use of anticoagulant reversal agents and advised that patients who survive a major bleed while on anticoagulation should often resume the anticoagulant once they are stabilized.

For patients who develop heparin-induced thrombocytopenia, the 4Ts score is the best way to make a more accurate diagnosis and boost the prospects for recovery, said Dr. Cuker (Blood. 2012 Nov 15;120[20]:4160-7). The guidelines cite several agents now available to treat this common complication, which affects about 1% of the 12 million Americans treated with heparin annually: argatroban, bivalirudin, danaparoid, fondaparinux, apixaban, dabigatran, edoxaban, and rivaroxaban.

ASH has a VTE website with links to detailed information for each of the guideline subcategories: prophylaxis in medical patients, diagnosis, therapy, heparin-induced thrombocytopenia, VTE in pregnancy, and VTE in children. The website indi-

cates that additional guidelines will soon be released on management of VTE in patients with cancer and in patients with thrombophilia, and for prophylaxis in surgical patients, as well as further information on treatment. A spokesperson for ASH said that these additional documents will post sometime in 2019.

At the time of the release, the guidelines panel published six articles in the journal Blood Advances that detailed the guidelines and their documentation.

The articles include prophylaxis of medical patients (Blood Advances. 2018 Nov 27;2[22]:3198-225), diagnosis (Blood Advances. 2018 Nov 27;2[22]:3226-56), anticoagulation therapy (Blood Advances. 2018 Nov 27;2[22]:3257-91), pediatrics (Blood Advances. 2018 Nov 27;2[22]:3292-316), pregnancy (Blood Advances. 2018 Nov 27;2[22]:3317-59), and heparin-induced thrombocytopenia (Blood Advances. 2018 Nov 27;2[22]:3360-92).

Dr. Cushman, Dr. Lim, and Dr. Witt reported having no relevant disclosures. Dr. Cuker reported receiving research support from T2 Biosystems.

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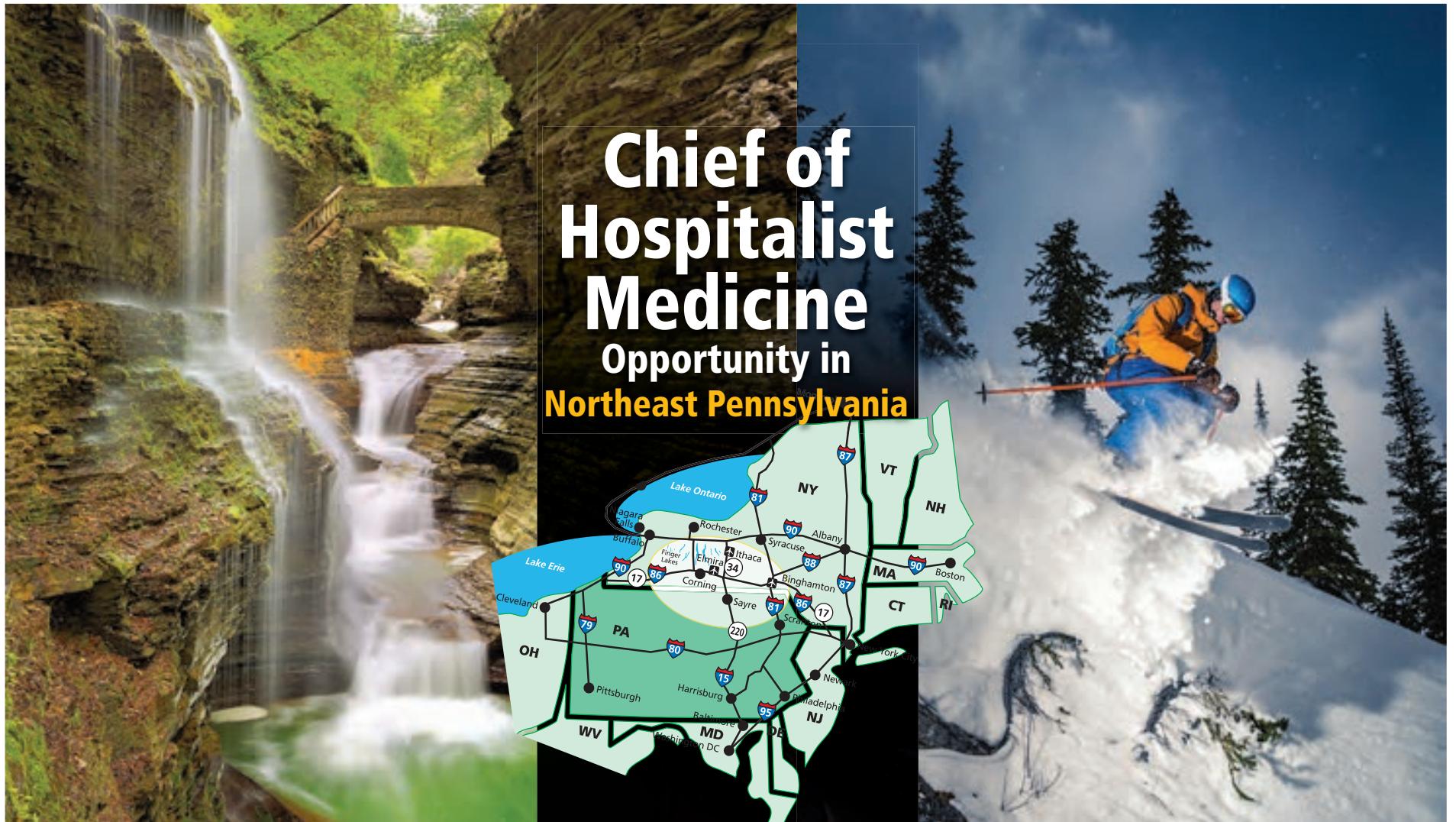
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For more information about this leadership opportunity, please contact **Krisi VanTassel** at krisi.vantassel@guthrie.org or (570) 887-5203, www.ichoseguthrie.org.



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Ballad Health, located in Southwest Virginia and Northeast Tennessee, is currently seeking Full Time, BE/BC, Day Shift Hospitalists and Nocturnist Hospitalists to join its team.

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Facilities:

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Ballad Health Northeast Tennessee

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Please Contact:

Ballad Health Physician Recruitment

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docjobs@balladhealth.org



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

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

- Position requires PM shifts (7p-7a) plus weekend day shifts
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Applicants should be trained and Board Certified in Internal Medicine or Family Medicine and possess excellent clinical and communication skills plus a demonstrated commitment to CHA's multicultural, underserved patient population.

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

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



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Emerson Hospital provides advanced medical services to more than 300,000 people in over 25 towns. We are a 179 bed hospital with more than 300 primary care doctors and specialists. Our core mission has always been to make high-quality health care accessible to those that live and work in our community. While we provide most of the services that patients will ever need, the hospitals strong clinical collaborations with Boston's academic medical centers ensures our patients have access to world-class resources for more advanced care. For more information please contact: Diane M Forte, Director of Physician Recruitment and Relations 978-287-3002, dforte@emersonhosp.org

Not a J-1 of H1B opportunity



Hospitalist Opportunities with Penn State Health

Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. We are seeking IM/FM trained physicians interested in joining the Penn State Health family in various settings within our system.

What We're Offering:

- Community Setting Hospitalist opportunities (Lancaster and Berks County positions)
- We'll foster your passion for patient care and cultivate a collaborative environment rich with diversity
- Commitment to patient safety in a team approach model
- Experienced hospitalist colleagues and collaborative leadership
- Salary commensurate with qualifications
- Relocation Assistance

What We're Seeking:

- Internal Medicine or Family Medicine trained
- Ability to acquire license in the State of Pennsylvania
- Must be able to obtain valid federal and state narcotics certificates
- Current American Heart Association BLS and ACLS certification required
- BE/BC in Family Medicine or Internal Medicine (position dependent)

No J1 visa waiver sponsorships available

What the Area Offers:

Penn State Health is located in Central Pennsylvania. Our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Our surrounding communities are rich in history and offer an abundant range of outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

For more information please contact: Heather J. Peffley, PHR FASPR, Penn State Health Physician Recruiter
hpeffley@pennstatehealth.psu.edu



Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce.
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Berkshire Health Systems is currently seeking BC/BE Internal Medicine physicians to join our comprehensive Hospitalist Department

- Day, Evening and Nocturnist positions
- Previous Hospitalist experience is preferred

Located in Western Massachusetts Berkshire Medical Center is the region's leading provider of comprehensive health care services


- 302-bed community teaching hospital with residency programs
- A major teaching affiliate of the University of Massachusetts Medical School and UNCOM
- Geographic rounding model
- A closed ICU/CCU
- A full spectrum of Specialties to support the team
- 7 on/7 off 10 hour shift schedule

We understand the importance of balancing work with a healthy personal lifestyle

- Located just 2½ hours from Boston and New York City
- Small town New England charm
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Berkshire Health Systems offers a competitive salary and benefits package, including relocation.

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Liz Mahan, Physician Recruitment Specialist, Berkshire Health Systems
725 North St. • Pittsfield, MA 01201 • (413) 395-7866.
Applications accepted online at www.berkshirehealthsystems.org



HOSPITALISTS/ NOCTURNISTS NEEDED IN SOUTHEAST LOUISIANA



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

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

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

Reference # SHM2017.



Sorry, no opportunities for J1 applications.

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

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UNIVERSITY OF MICHIGAN DIVISION OF HOSPITAL MEDICINE



The University of Michigan, Division of Hospital Medicine seeks board certified/board eligible internists to join our growing and dynamic division. Hospitalist duties include teaching of medical residents and students, direct patient care in our non-resident and short-stay units and involvement in quality improvement and patient safety initiatives. Novel clinical platforms that feature specialty concentrations (hematology/oncology service, renal transplant service and bone marrow transplant teams) as well as full-time nocturnist positions are also available. Our medical short stay unit provides care for both observation and inpatient status patients and incorporates advanced practice providers as part of the medical team.

The ideal candidate will have trained at, or have clinical experience at a major US academic medical center. Sponsorship of H1B and green cards is considered on a case-by-case basis for outstanding individuals. Research opportunities and hospitalist investigator positions are also available for qualified candidates.

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

HOW TO APPLY

Interested parties may apply online at www.medicine.umich.edu/hospital-medicine or email cover letter and CV to Vineet Chopra, MD, MSc, Chief, Division of Hospital Medicine at kcreed@umich.edu.

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The Division of Hospital Medicine at the Emory University School of Medicine and Emory Healthcare is currently seeking exceptional individuals to join our highly respected team of physicians and medical directors. Ideal candidates will be BC/BE internists who possess outstanding clinical and interpersonal skills and who envision a fulfilling career in academic hospital medicine. Emory hospitalists have opportunities to be involved in teaching, quality improvement, patient safety, health services research, and other professional activities. Our hospitalists have access to faculty development programs within the Division and work with leaders focused on mentoring, medical education, and fostering research.

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- Previous Med/Peds Hospitalist experience is preferred
- Leadership opportunities available

Located in Western Massachusetts Berkshire Medical Center is the region's leading provider of comprehensive health care services

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 - o Geographic rounding model
 - o A closed ICU/CCU
 - o A full spectrum of Specialties to support the team
 - o A major teaching affiliate of the University of Massachusetts Medical School and University of New England College of Osteopathic Medicine
- 7 on/7 off 12 hour shift schedule

We understand the importance of balancing work with a healthy personal lifestyle

- Located just 2½ hours from Boston and New York City
- Small town New England charm
- Excellent public and private schools
- World renowned music, art, theater, and museums
- Year round recreational activities from skiing to kayaking, this is an ideal family location.

Berkshire Health Systems offers a competitive salary and benefits package, including relocation.



Interested candidates are invited to contact:

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

Applications accepted online at www.berkshirehealthsystems.org



Hospitalist—Charlottesville, VA

Sentara Martha Jefferson Hospital, is currently recruiting for a full time hospitalist and nocturnist to join our hospitalist team.

Our hospital offers a wide array of patient services, with excellent subspecialty and ancillary support. We strive to create an environment where safety and quality are the cornerstones to delivering exceptional healthcare. We offer competitive salary, benefits, and a cohesive work environment.

***Hospitalist:** varied shifts from 8-12 hours

***Nocturnist:** 6 nights on/8 off (7p-7a) with in-house APC cross cover support.

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Hospitalist Opportunities in Eastern PA – Starting Bonus and Loan Repayment –

We have day positions at our Miners Campus in beautiful Schuylkill County and at our newest hospital in Monroe County set in the Pocono Mountains. Both campuses offer you an opportunity to make a difference in a Rural Health Community yet live in your choice of family friendly, thriving suburban areas. In addition, you'll have access to our network's state of the art technology and Network Specialty Support Resources. We also have opportunities at our Quakertown campus, where a replacement hospital will open in 2019.

We offer:

- Starting bonus and up to \$100,000 in loan repayment
- 7 on/7 off schedules
- Additional stipend for nights
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SLUHN is a non-profit network comprised of physicians and 10 hospitals, providing care in eastern Pennsylvania and western NJ. We employ more than 800 physician and 200 advanced practitioners. St. Luke's currently has more than 220 physicians enrolled in internship, residency and fellowship programs and is a regional campus for the Temple/St. Luke's School of Medicine. Visit www.sluhn.org.

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Please email your CV to Drea Rosko at physicianrecruitment@sluhn.org



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Looking into the future and making history

Emergence of population health management

By Nasim Afsar, MD, MBA, SFHM

For the first time ever, on March 7, 2019, tens of thousands of hospitalists across the United States and around the world will celebrate their day, National Hospitalist Day.

On this day, we will honor the hard work and dedication of hospitalists in the care of millions of hospitalized patients. With more than 62,000 hospitalists across the United States, hospital medicine has been the fastest growing medical specialty and among the largest of all specialties in medicine. Hospitalists now lead clinical care in over 75% of U.S. hospitals, caring for patients in their communities. We educate the future providers of health care by serving as teachers and mentors. We push the boundaries of science in hospital care through innovative research that defines the evidence-based practices for our field. Hospitalists proudly celebrate all that we have accomplished together on March 7, and moving forward, every first Thursday in March annually.

The Society for Hospital Medicine's celebration of National Hospitalist Day will include spotlights on hospitalists, a social medical campaign, downloadable customizable posters, and much more. Stay tuned for details!

The only meeting designed just for you

Be among the thousands of hospitalists who will celebrate hospital medicine in person at Hospital Medicine 2019 (HM19), March 24-27 in National Harbor, Md.

While at HM19, check out more than 20 educational tracks, including clinical updates, diagnostic reasoning, and health policy. New this year are two mini tracks: "Between the Guidelines" and "Clinical Mastery." Between the Guidelines explores how we can address some of the most challenging cases we encounter in hospital medicine, where clear guidelines don't exist. Clinical Mastery is designed to enhance our bedside diagnostic skills, from ECGs to ultrasounds.

Get ready to vote in HM19's "The Great Debate" – pairing two talented clinicians who will debate opposing sides of challenging clinical decisions that we encounter on the

front lines of health care delivery. Attendees have the opportunity to hear the two sides and then vote on who they believe has the right approach. There are six precourses planned for HM19, with a new offering in Palliative Care and Pain Management. This year, the annual conference also features additional sessions for our NP/PA attendees. They include specific workshops as well as a track that includes four didactic sessions. Lastly, HM19 will offer CME, MOC, AOS, AAFP, and Pharmacology credits to address the needs of our attendees.

A look into the future

While hospitalists are a vital part of U.S. health care, our delivery systems are in transition with greater focus on value-based care. To ensure hospital medicine continues to thrive in today's dynamic scene, SHM's Board of Directors held a strategic meeting in October 2018 to focus on the role of hospitalists and hospital medicine in population health management.

There are many hospitalists across the nation who are currently involved in population health management. These range from medical directors to vice presidents of accountable care organizations, population health management, or value-based care. Hospitalists are seeking communities focused on population health management to share best practices and learn from each other. To address this, SHM's Advocacy and Public Policy HMX community has served as a meeting point to discuss issues related to value-based care. To join the discussion, visit the community by logging in at hospitalmedicine.org/hmx. Furthermore, at HM19, hospitalists will have the opportunity to meet face to face regarding these issues in the Advocacy Special Interest Forum.

Key points: Population health management

• Source of truth

SHM has served as the source of reliable and trusted information about hospital medicine. We will continue to develop content and resources specific to population health management on our website so hospitalists can easily access this information. To increase our awareness about population health management, presenters at HM19 will integrate a slide about the

implications of population health management on their clinical topic. These slides will illustrate the clinical and nonclinical services that are necessary to enhance the patient's quality of care and life. In addition to best practice care, these slides will highlight topics like the role of style modification and prevention, risk stratification, chronic disease management, and care coordination throughout the continuum of care.

• Advocating for us

In addition to providing a home for hospitalists to collaborate regarding population health management, SHM will advance this agenda from a regulatory perspective. The Public Policy and Performance Measurement & Reporting Committees are actively evaluating and leading the transition from volume to value. SHM is also working with potential key partners and organizations in the areas of primary care, skilled nursing facilities, and accountable care organizations that will help improve the effectiveness of delivering population health management.

• Creating expertise

SHM will lead best practice development for tools and skills that are necessary for hospitalists to lead population health management. Telemedicine is an increasingly critical tool as we help manage our patients in other facilities and in inpatient or skilled nursing facilities, as well as at home. SHM has developed a white paper about telemedicine in hospital medicine that highlights modalities, offerings, implementation of programs, and work flows necessary for success. You can find it under "Resources" at hospitalmedicine.org/telemedicine.

SHM will continue to actively develop tools that appropriately address the challenges we're facing. From National Hospitalist Day to population health management, this is an exciting time in hospital medicine – I hope to see you at HM19 to celebrate our specialty and our bright future.

Correction

In the December 2018 Board Room column, Dr. Christopher Frost's employer was identified incorrectly. Dr. Frost is currently national medical director, hospital-based services, at LifePoint Health in Brentwood, Tenn.



Dr. Afsar is president of the Society of Hospital Medicine, and chief ambulatory officer and chief medical officer for accountable care organizations at UC Irvine Health.

“Hospitalists now lead clinical care in over 75% of U.S. hospitals, caring for patients in their communities. We educate the future providers of health care by serving as teachers and mentors.”

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