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The Hospitalist

shm
the-hospitalist.org

Photo by Heather Nan: Courtesy of University of Utah Health

Dr. Kencee K. Graves and Dr. Devin J. Horton

Charting a new course in sepsis management

'Motivated and multidisciplinary' team critical to improving sepsis care

By Bryn Nelson, PhD

A drug overdose victim is admitted to a hospital. Providers focus on treating the overdose and blame it for some of the patient's troubling vital signs, including low blood pressure and increased heart rate. Prior to admission, however, the patient had vomited and aspirated, leading to an infection. In fact, the patient is developing sepsis.

This real-world incident is but one of many ways that sepsis can fool hospitalists and other providers, often with rapidly deteriorating and deadly consequences. A range of quality improvement (QI) projects, however, are demonstrating how earlier identification and treatment may help to set a new course for addressing a condition that has remained stubbornly difficult to manage.

Every year, more than 1.5 million Americans develop sepsis – arising from the body's overwhelming and self-destructive response to infection – and roughly 250,000 die from it. According to the Centers for Disease Control and Prevention, about one in three hospital

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MEMBER SPOTLIGHT

Amith Skandhan, MD, FHM

Young hospitalists don't realize the potential influence they hold within their own institutions.

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ON HOSPITALIST BURNOUT

John Nelson, MD, MHM

Ensuring that you have some work-related interest outside of direct patient care can be really valuable.

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Hospitalist Movers and Shakers

By Matt Pesyna

Michael Rader, MD, has been named the chief medical officer of the Department of Veterans Affairs New York/New Jersey Health Care Network. The network serves upward of a half-million veterans in 76 counties in New York, New Jersey, and Pennsylvania. Dr. Rader's appointment began on Oct. 15, 2017.

Previously, Dr. Rader was chief medical officer at Prospect East Orange (N.J.) General. In his new position, the 35-year veteran will be charged with overseeing care at VA facilities in Albany Stratton, Bath, Canandaigua, and Syracuse in New York, as well as the VA Western New York Health System, the New York Harbor Health System, the New Jersey Health Care System, Hudson Valley Healthcare System, the James J. Peters and Northport VA Medical Centers, as well as 66 community-based outpatient clinics.

The Rhode Island Medical Society has elected **Bradley Collins, MD,** as its new president. An internist and hospitalist, Dr. Collins practices at Miriam Hospital in Providence, R.I., where he started in 2006 as a staff hospitalist. He's now the medical director of appeals for Lifespan at Miriam.

Dr. Collins is an assistant professor of clinical medicine at Brown University's Alpert Medical School, while also serving as a fellow for the Society of Hospital Medicine.

Tracy Cardin, ACNP, SFHM, has been named associate director of clinical integration at Adfinitas Health, a private hospitalist company based in Maryland that serves more than 50 hospitals and post–acute care centers across the Mid-Atlantic region. Cardin is responsible for advancing the company's training and onboarding infrastructure to support the full integration of physicians, nurse practitioners, and physician assistants into the Adfinitas care delivery model.

Jeffrey Millard, MD, has been named Patient Experience Provider of the Year by the employees and staff at Hardin Memorial Health (Elizabethtown, Ky.). Dr. Millard has been a hospitalist at Hardin Memorial Hospital since 2012.


Dr. Millard

The Patient Experience Provider of the Year award recognizes a provider who exceeds the company's mission and vision with patients and their families, as well as with the hospital's staff. Dr. Millard was chosen from a list of more than 800 nominations.

Benjamin Keidan, MD, has been appointed as chief medical officer for Boulder (Colo.) Community Health. Dr. Keidan advances from his previous role as medical director of quality and population health for outpatient primary care and specialty clinics.

Dr. Keidan is a former internist and hospitalist for BCH and has worked in Boulder County for the past 12 years. He is only the second CMO in BCH's history.

Dinesh Bande, MD, has been selected as the new chair of the department of internal medicine at the University of North Dakota, Grand Forks. Dr. Bande is a clinical associate professor at the school and a hospitalist with Sanford Health.


Dr. Bande

Dr. Bande has been the clerkship director for third-year medical students at UND for the past 2 years. As chair of internal medicine, he will oversee education, research, clinical care, training, and service programs within the department.

Business Moves

Management Service Organization **Continuum Health** (Marlton, N.J.) has signed an agreement with the Mid-Atlantic region's largest private hospitalist group, **Adfinitas Health** (Hanover, Md.), to be its revenue management cycle partner. Founded in 1999, Continuum Health now serves more than 1,500 providers in more than 400 locations.

Colquitt Regional Medical Center in Moultrie, Ga., has expanded its hospitalist program, adding 5 physicians to increase its total to 10 on-staff hospitalists. Colquitt Regional's program began in 2012.

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Is it time for health policy M&Ms?

Preparing hospitalists to effectively advocate for specific policy changes

By Kelly April Tyrrell

What would happen if hospitalists began to incorporate health policy into morbidity and mortality (M&M) conferences? That was a question Christopher Moriates, MD, explored in an entry for SHM's The Hospital Leader blog[1] and an idea that caused a minor stir on Twitter when he proposed it last summer.

In late July 2017, the U.S. Senate was debating a bill to repeal the Affordable Care Act, without a clear vision for replacing it. In response, physicians around the country took to Twitter to share their sentiments about repeal under the hashtag #DoctorsSpeakOut. In one such tweet, Dr. Moriates, assistant dean for health care value and an associate professor of internal medicine at Dell Medical School at the University of Texas, Austin, said this, in 140 characters: "We recently had an idea: health policy M&Ms for residents to discuss adverse outcomes we see as a result of lack of access."

Would this lead to more informed physicians? Improved patient advocacy? Increased understanding of the socioeconomic determinants of health? Better hospital performance? So far, the idea remains untested, but Dr. Moriates and some of his colleagues seem optimistic it could work.

The idea began with a conversation Dr. Moriates had with Beth Miller, MD, program director for the Dell Medical School Internal Medicine Residency Program. "We were meeting and talking about revamping the [resident] M&M conference to have more learning objectives and put in place best practices," Dr. Moriates said. "Dr. Miller suggested it could be a good forum [for health policy] because it's an area where we all come together and there's a natural hook to it. We can use it to recognize the drivers within the system that lead to bad outcomes."

In his SHM blog post, Dr. Moriates said he has increasingly observed adverse events that result from issues related to health policy. He provided an example: "A patient I admitted for 'expedited work-up' for rectal bleeding after he told me he had been trying to get a recommended colonoscopy for many months but could not get it scheduled due to his lack of insurance. He had colon cancer that had spread."

In another example, he conjured a hypothetical case where a patient prescribed blood thinners upon hospital discharge returns to the hospital soon after with a blood clot. Unable to afford the medication, or seek primary care follow-up, the patient is readmitted through no direct fault of his physicians. Yet, the patient is worse off and the hospital receives readmissions penalties.

Dr. Moriates believes that viewing a case like this through a health policy lens is critical to better understanding health care delivery, particularly in an environment where physician performance is measured, in part, by outcomes. He now believes health policy M&Ms would be valuable to all hospital-based physicians, not just residents.

"Hospitalists are being asked to hit these value-based performance metrics, like readmissions and length of stay, and while we deal with the consequences, we are not always the best informed" with respect to policy, he said. "We could use this forum to teach health policy topics and contribute to different discussions and understand how things are changing and impact our patients."

> *"We recently had an idea: health policy M&Ms for residents to discuss adverse outcomes we see as a result of lack of access."*

Keeping up with rapidly changing health policy is a full-time job and few physicians have time to do it, said Nadereh Pourat, PhD, director of research at the University of California, Los Angeles Center for Health Policy Research. "Doctors get almost all of their training on clinical practice with little on policy and its impact of their practice," she said. Health policy M&Ms could provide a way for more policy-engaged physicians to educate and inform their less-engaged colleagues.

"It's important for physicians to know the policies that are aligned with, and the policies that may undermine, what they're doing in their practice to improve their patients' health," Pourat said.


Dr. Christopher Moriates


Dr. Nadereh Pourat

This knowledge can benefit physicians, too, Pourat added, because health policy M&Ms could help providers understand policy goals and in turn adjust their own behaviors and expectations.

"Physicians could discuss, what are the underlying issues or root causes, like the decision not to expand Medicaid here in Texas," Dr. Moriates said. "Not all of these things you can fix, but you're exposing those stories and perhaps we can come up with some actionable steps. How do we ensure in the future that our patients are able to fulfill their prescription so we're not just sending someone out assuming they will but not knowing they're unable to afford it?"

Similar to other domains in which physician leaders become champions, such as antibiotic stewardship, Dr. Pourat suggested that hospitalists could champion policy awareness through the kind of M&Ms Dr. Moriates proposed.

While journal clubs and lectures are great ways for hospitalists to learn more about health policy, the emotionally gripping nature of M&Ms could inspire more physicians to act in favor of policies that benefit their patients and themselves, Dr. Moriates said.

For example, physicians may write to or visit legislative offices, or author op-eds in their local newspapers. This collective action carries the potential to effect change. And it need not be partisan.

"I believe that if health policy issues were more explicitly integrated into M&Ms then clinicians would be more inclined and prepared to effectively advocate for specific policy changes," he wrote in his blog post."

On Twitter, even before Dr. Moriates' first tweet about health policy M&Ms, New Jersey–based Jennifer Chuang, MD, an adolescent medicine physician, wrote: "M&M is heart-wrenching in academic hospitals. I dare @SenateGOP to present their role in M&M's to come if ACA is repealed."

While Dr. Moriates believes the chances are quite small that legislators and policymakers would attend health policy M&Ms, he called the notion "provocative and intriguing."

In his blog post, Dr. Moriates invites state legislators and local members of Congress to join him in reviewing M&M cases where patients have been negatively affected by policy. He also emphasized that, like most modern M&Ms, the point should not be finger-pointing, but an opportunity to learn how policy translates into practice.

Physicians may learn from legislators, too, he said in his blog post. "Just as policymakers could see legislation through the eyes of practitioners and their patients, this is where we as physicians could possibly learn from our legislators," he wrote. "We may recognize the potential trade-offs, downsides, and barriers to proposals that to us may have seemed like no-brainers."

Reference

1. Moriates C. Is it time for health policy M&Ms? The Hospital Leader. Aug 16, 2017. http://thehospitalleader.org/is-it-time-for-health-policy-mms/. Accessed 2017 Sep 14.

Q&A

Making hospital medicine a lifelong, enjoyable, and engaging career

Amith Skandhan, MD, FHM, wants young hospitalists to realize the potential influence they hold

By Felicia Steele

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

This month, THE HOSPITALIST spotlights Amith Skandhan, MD, FHM, a hospitalist, a director/physician liaison for clinical documentation improvement, and core faculty member in the Internal Medicine Residency Program at Southeast Alabama Medical Center in Dothan, Ala., and clinical faculty member at the Alabama College of Osteopathic Medicine also in Dothan. Dr. Skandhan is the cofounder and current president of the SHM Wiregrass Chapter and is an active member of SHM's Annual Conference and Performance Measurement Reporting Committees.

"If you're looking to advance your career as a hospitalist, take advantage of the conferences that SHM offers."

When did you join SHM, and what prompted you to apply for your current committee roles?

When I did my residency and chief residency at University of Pittsburgh Medical Center Mercy, I was fascinated by my faculty hospitalists – they seemed to have mastered a balance of managing acute, high intensity care with a lifestyle that encouraged exploring personal hobbies. But as I started my new role as a hospitalist at Southeast Alabama Medical Center, I discovered nuances to the profession that I had not seen during my graduate medical education.

There were many things that were not sufficiently taught during clinical training that were required in my day-to-day practice, like clinical documentation improvement, practice management, billing, coding, and so forth. I also quickly understood how vast and dynamic hospital medicine really was. While looking for an outlet to voice my questions, concerns, and curiosity, I decided to join SHM, which has helped me find and apply the techniques I'd been looking for to further my career as a hospitalist.

I'm now fortunate to be a part of SHM's national committees, which involve hospitalists of various backgrounds and experiences, who work together to improve the overall quality of inpatient medicine. I currently serve on the Performance Reporting Measurement Committee and the Annual Conference Committee. My interests in reviewing the ever-evolving policies of health care made me apply to be a part of the Performance Reporting Measurement Committee. We work very closely with the Public Policy Committee, analyzing written policies and subsequently offering our recommendations. It's been fulfilling to be a part of a committee that works toward developing policies that support a good quality of care on such a large scale.

My penchant for organizing events and bringing people together based on common ground led me to apply for the Annual Conference Committee. We meet every week to discuss various topics, choose and invite speakers, and help organize the entire event, which will host close to 5,000 hospitalists later this year. It has made me appreciate being a member of an organization that provides hospitalists with opportunities for education and growth. I'm hopeful that the attendees next year will find the conference to be a worthwhile experience!

As the president of SHM's Wiregrass Chapter, how has the chapter grown since its establishment in May 2015?

Our chapter is based in Dothan, a small, rural Alabama town where Southeast Alabama Medical Center is located. The chapter covers the counties of lower Alabama and the panhandle of Florida. We named the chapter after a special species of grass that grows in this region.

When we started the chapter, our goal was to bring the best and brightest of hospital medicine to our region to give talks on hot topics in the field and also to use their expertise to guide inpatient care in our hospital system. We aggressively marketed the events to bring in large crowds of medical professionals, and we consistently average around 70-80 attendees in our meetings. Bringing in leaders from the field helped create an atmosphere of learning and inspired us to grow and develop our hospitalist program. We now closely work with hospital medicine groups in surrounding rural areas toward improving inpatient hospital care.

During these past years, we also realized that, for the further growth of our chapter, we would need to nurture an interest in hospital medicine among future generations of doctors, and this realization led to the creation of our medical student and resident wing. So far, the students have been very enthusiastic about participating in SHM-related events, and I hope that continues. We also developed a mentor-mentee program, in which we paired selected medical students with hospitalists to help guide future careers in acute care medicine. This year, we have also been helping the hospital medicine division at Southeast Alabama Medical Center create a clinical research track for medical students. To that end, we have just completed our second annual poster competition where we presented around 50 posters in the areas of clinical vignettes, quality improvement, and original research.

In addition, the chapter is very active with community activities. We took notice of the fact that many of our patients and community members were unaware of what hospitalists did because they could not understand how our work was different from that of primary care physicians. Our members have therefore participated in TV, radio, and newspaper interviews to help elucidate the role of hospitalists in patient care. We have also periodically visited primary care physician offices, nursing homes, senior citizen groups, and cancer support groups to educate these patients on various facets of health care and how hospitalists influence these areas.

In 2014, we organized a "walk with a hospitalist" event, for which

"When we started the chapter, our goal was to bring the best and brightest of hospital medicine to our region to give talks on hot topics in the field and also to use their expertise to guide inpatient care in our hospital system."

—Dr. Skandhan

we set up a half-mile "admission to discharge" scenario explaining the role of hospitalists and other departments involved in patient care. This year, in hopes of improving patient literacy in our region, we held a "shop with a doc" event, where the Southeast Alabama Medical Center hospitalists teamed up with dietitians and taught patients how food and lifestyle influenced their chronic medical illnesses. This was followed by physicians and dietitians shopping with patients in the grocery store, educating them on healthy choices and label reading.

We're incredibly grateful for the support that we've received from our medical and patient communities; they've been critical in helping our chapter grow as much as it has, and they motivate us to work harder and do more with the chapter. We were honored to receive the SHM's Rising Star Award at the Hospital Medicine 2017 conference in Las Vegas. We never thought that our little chapter in the American countryside would be chosen, but we're very thankful to have our efforts recognized on the national stage!

Which SHM conferences have you attended? Tell TH about your most memorable highlights or takeaways.

When I started out as a hospitalist in 2014, I decided to attend the annual conference in Las Vegas, and I can honestly say that conference changed the course of my career. I can still remember listening to the opening speech and realizing that I was surrounded by more than 3,000 hospitalists who understood the power we had to influence inpatient care. I've attended all the national conferences since then and am grateful that I now get to help organize the Hospital Medicine 2018 annual conference, also known as HM18.

I had been working to find a way to improve documentation within my group, as well as change the culture and perception toward billing and coding practices, which prompted me to attend the Quality and Safety Educators Academy. During one of the problem-solving sessions, I explained the challenges that I faced to my conference group. The exercise required me to explain the problem at hand, and the players of my group then discussed their thoughts while I took notes. It was a fantastic experience, as the participants at my table offered strong solutions to my problems within a matter of minutes. Their advice led to meaningful changes in our group's hospital documentation practices, and in turn, I've been promoted to physician adviser in Southeast Alabama Medical Center.

After such a great experience at Quality and Safety Educators Academy, I went on to attend SHM's Leadership Academy, where I had the opportunity to meet some of the top leaders and pioneers in the field of hospital medicine. It's empowering to be mentored by the very people you look up to and aspire to be like. Not only was I able to bring ideas home to my institution, but I was able to reflect and improve my own professional and personal growth. I'm happy to say that I've completed all three levels of Leadership Academy.

As I've become involved with the medical student and residency programs at my medical center, I recently attended the Academic Hospitalist Academy to help my transition into academic hospital medicine. Meeting and spending time with the faculty at Academic Hospitalist Academy made me further realize the roles that academic hospitalists play in the education of future physicians, emphasizing the idea that we can all be champions in quality and patient safety.

If you're looking to advance your career as a hospitalist, take advantage of the conferences that SHM offers. I've gained so much from each experience, and I'm looking forward to returning to these conferences as a potential facilitator, in hopes of offering what I've learned to hospitalists looking to bring about change in their fields and careers.

What can attendees at HM18 expect to see in the area of career development, and how is this different than previous years?

Hospital medicine is only about 2 decades old, making it one of the youngest branches in medicine today. Given this fact, the Annual Conference Committee feels that it is paramount to focus on career development for both new and midcareer hospitalists alike.

One question that we wish to explore and answer this year is: "How do you make hospital medicine a life-long, enjoyable, and engaging career?" In turn, our committee has created several new additions to HM18. This includes a "Seasoning Your Career" track, which will provide ideas on how to advance in leadership, use emotional intelligence to achieve success, change your roles midcareer, and change hospitalist schedules. Another unique addition this year are career development workshops, which will aim to develop various aspects of a hospitalist's career, such as working on leadership skills, refining presentation and communication skills, providing constructive feedback, promoting women in hospital medicine, preventing burnout, and turning ideas into clinical research. We also plan to incorporate an education track, which will focus on how hospitalists can expand their careers toward educational leadership.

Given your involvement in SHM at both the local and national levels, do you have any advice for young hospital medicine professionals looking to build their professional profiles?

I've frequently noticed that young hospitalists don't realize the potential influence they hold within their own institutions or the power they have to elicit change in health care at the national level.

Though we don't often admit it, some hospitalists feel like they are glorified residents, which definitely is not the case. As a provider on the front lines, you have the unique opportunity to implement changes pertaining to issues of cost, utilization of resources, process management, quality and patient safety, and bottlenecks in care, to name a few. These are issues that keep the administrators of your organization and leaders of hospital medicine up at night. Don't sit around and complain about how things could be or should be; look toward creating change. Bring up possible solutions to these problems with your leaders. They will appreciate the effort, and hopefully together you can find ways to tackle these problems.

I will conclude by saying this: Hospital medicine is such a unique specialty in that it's constantly evolving, and the pioneers of this field are still alive and practicing medicine. You can meet and interact with them during the SHM conferences and look to them as sources of inspiration or guidance. Meeting people you look up to and having them as your mentors can take you places.

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

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Leadership

Are you burned out? Are you resilient?

Demonstrate care about the professional and personal well-being of your team

By Leonard J. Marcus, PhD

I had the privilege of teaching two seminars at the recent Society of Hospital Medicine Leadership Academy in Scottsdale, Ariz. The theme of my second seminar was "Swarm Leadership," the topic of my September column. Participants were intrigued at the notion of leveraging instinctual responses to encourage team spirit and collective outcomes.

The key principles of these swarm-like behaviors are: 1) unity of mission, 2) generosity of spirit, 3) staying in lanes and helping others succeed in theirs, 4) no ego/no blame, and 5) a foundation of trust among those working together. Leaders create the conditions in which these behaviors are more likely to emerge. The resulting team spirit and productivity raise morale and increase the sense of work-related purpose and mission.

Despite the interest in the topic, an underlying objection arose in questions and comments. These remarks countered the intentions and opportunities for swarm-like connectivity.

People expressed their sense of being burned out and overworked, even to the extent of being exploited. Not everyone spoke though many people identified with the theme.

What I heard was enough to raise the question here: For hospitalist leaders, to what extent is burnout significant enough to give it serious attention? (I report observations as anecdotal. There is no implied critique of hospitalists on the whole nor any individual or groups.)

Burnout includes sensations of being exhausted, overburdened, underappreciated, undercompensated, cynical, and depressed. These phenomena together can affect your productivity, the quality of your work, and your endurance when the workload gets tough.

By contrast, the opposite of burnout is balance, including sensations of being engaged, enthusiastic, energetic, absorbed, challenged, and dedicated. Work is part of the equilibrium you establish in your life.

Ideal balance would have all the different parts of your life – from family to hobbies to work – in perfect synergy with one another. Complete burnout would have all parts of your life imploding on one another, with little room for joy, personal contentment, and professional satisfaction.

How do you assess the differences between burnout and balance? First, this is a very individual metric. What one person might consider challenging and engaging another would experience as overwhelming and alienating. When you assess a group of people, these differences are important and could inform how work assignments and heavy lifting are assigned.

During the SHM session and in private comments, people described this rise in burnout not as a personal phenomena. Rather, it results from the health system expecting more of hospitalists than they can reasonably and reliably produce. People described hospitalists getting to the breaking point with no relief in sight. What can be done about this phenomenon?

First, hold a mirror up to yourself. You cannot help others as a leader if you are not clear with your own state of burnout and balance. The questions for you – a leader of other hospitalists – include: To what extent are you burned out? If so, why? If not, why not? If you were to draw a continuum between burned out and balanced, where on that range would you place yourself? Where would others in your group pinpoint themselves, relative to one another, on this continuum?

How might burnout develop for hospitalist leaders? Like a car, even a high performance vehicle, you can go only so fast and so far. If your system is expecting the pace and productivity to outstrip what you consider reasonable, your performance, job satisfaction, and morale drops. Impose those demands upon a group of people and the unhappiness can become infectious.

With a decline in performance comes a decline in confidence. You and your colleagues strive for top-rate outcomes. Fatigue, pressure, and unreasonable expectations challenge your ability to feel good about what you are doing. That satisfaction is part of why you chose hospital medicine and without it, you wonder about what you are doing and why you are doing it.

When you and your colleagues sense that you are unappreciated, it can spark a profound sense of disappointment. That realization could express itself in many forms, including unhappiness about pay and workload to dissatisfaction with professional support or acknowledgment.

When I first began teaching at SHM conferences and had hospitalists in my classes at the Harvard School of Public Health, the field was novel, revolutionary, and striving to establish a newly effective and efficient way to provide patient services. It is useful to keep these roots in perspective – hospital medicine over the arc of time – from what WAS, to what IS and eventually what WILL BE. The cleverness of hospitalist leaders has been their capacity to understand this evolution and work with it. Hospital medicine built opportunities in response to high costs, the lack of continuity of care, and problems of communication. It was a solution.

How might you diagnose your burnout – and that of others – in order to build solutions? Is it a phenomenon that involves just several individuals or is it characteristic of your group as a whole? What are the causes? What are the symptoms, and what are the core issues? Some are system problems in which expectations for performance – and the resources to meet those objectives – are not reasonably aligned. There is a cost for trying to reduce costs on the backs of overworked clinicians.

If this is more than an individual problem, systematically ask the question and seek systematic answers. The better you document root causes and implications, the better are you able to make a data-driven case for change.

Showing that you care about the professional and personal well-being and balance of your workforce, in and of itself, is the beginning of an intervention. Be honest with yourself about your own experience. And then be open to the experiences of others. As a leader, your colleagues may suggest changes you make in your own leadership that could ameliorate some of that burnout. Better communication? Improved organization? Enhanced flexibility as appropriate? These are problems you can fix.

Other solutions must be negotiated with others on the systems level. With documentation in hand, build your case for the necessary changes, whatever that might entail. Hospitalist leaders negotiated their way into respected and productive positions in the health care system. Similarly, they must negotiate the right balance now to ensure the quality, morale, and reasonable productivity of their departments and workforce.

As a hospitalist leader, you know that each day will bring its complexities, its challenges, and its burdens. Your objective is to encourage – for yourself, your colleagues, and your system – both personal and organizational resilience. That resilience – the ability to take a hit and bounce back – is an encouraging signal of hope and recovery, for your workforce as well as the people for whom you care.

Dr. Marcus is coauthor of "Renegotiating Health Care: Resolving Conflict to Build Collaboration," Second Edition (San Francisco: Jossey-Bass Publishers, 2011) and is director of the Program for Health Care Negotiation and Conflict Resolution at the Harvard T.H. Chan School of Public Health. Dr. Marcus teaches regularly in the SHM Leadership Academy. He can be reached at ljmarcus@hsph.harvard.edu.

Special interest groups drive SHM engagement

New governance model encourages volunteer group interaction

By Ethan Gray

As a professional society supporting an increasingly diverse membership base, SHM is perpetually challenged to create an environment that offers relevance and community to all. While the broad hospital medicine population and SHM are focused on the same goals, there are nuances within membership that require specific networks and platforms to build this environment of community.

SHM relies on both staff and volunteers to be an engine for leadership, innovation, and labor. Over the last year, SHM has attempted to expand the infrastructure and opportunity for volunteer leadership by examining new approaches to allow pockets of membership to have their own voice. In 2018, members will continue to help staff forge a new landscape for constituency engagement.

If you are a current volunteer leader, or are interested in pursuing volunteer opportunities, you may be aware that the Committee structure has changed. There is also new publicity for things called "Special Interest Groups." Many of our constituency-based Committees are in the process of transforming into SIGs, which will be officially launched during HM18 in Orlando in April. They are adopting a more visible charge to create the most accessible and influence-able environment for the SHM community.

Committee-to-SIG transition is about both philosophy and mechanics. It aims to ensure that each constituency group can be shaped by the entire population it represents, and will work to create the infrastructure to facilitate that. SHM envisions SIGs being primary influencers over future content-development and policy objectives; their online communities serving as the principal means for socialization and dialogue around proposed ideas and initiatives. To that end, SHM invested in an entirely new platform for Hospital Medicine Exchange. To explore the new HMX and opportunities for niche networking, visit www.hmxchange.org.

We have also developed a new governance model to encourage interactions between volunteer groups. While there is overlap within Committee and SIG constructs and likely many volunteers serving in both spheres, it is important to create parallel environments with discrete charges around function and membership engagement.

During this transformation, existing volunteers are working with staff to determine the future. There will be some differences in the way Committees and SIGs function. There will also be consistent communication between SIGs and strategic and functional Committees with ongoing charges and oversight of existing SHM programs.

SIGs will have dedicated staff liaisons and volunteer leadership councils. Transforming Committees' current volunteers will serve as inaugural council leaders with the process for future election being developed over the next several months. SIG membership is open and free to all active SHM members. All current SIGs will facilitate live Special Interest Forums during SHM's Annual Conference.

Summaries of the live forums will be posted on corresponding HMX communities after the conference. There will be an open application period during summer 2018 for SIGs not yet defined. The SHM Board will review applications in September 2018, and new groups will be convened in October to begin building HMX communities, confirming leader councils, and charting their course with a dedicated staff liaison.

To offer your thoughts and ideas about SIGs or anything else related to membership, please email membership@hospitalmedicine.org.

Mr. Gray is vice president of membership at the Society of Hospital Medicine.

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In the Literature

Physician reviews of HM-centric research

By Zahir Kanjee, MD, MPH; Jorge Rodriguez, MD; Pooja Gala, MD; Celeste Pizza, MD; Jessica Berwick, MD, MPH; Joshua Allen-Dicker, MD, MPH, FHM

Beth Israel Deaconess Medical Center, Harvard Medical School, Boston

In This Issue

By Zahir Kanjee, MD, MPH

1 Hospitalist empathy associated with reduced patient anxiety

CLINICAL QUESTION: What effect does hospitalist empathy have on patient anxiety, ratings of physician communication, and duration of encounter?

BACKGROUND: Physician empathy is associated with better patient-reported and medical outcomes in a number of settings. The effects of hospitalist empathy have been less well studied.

Dr. Kanjee

STUDY DESIGN: Observational study of audio recordings of hospitalist admission encounters.

SETTING: General medical service at two urban hospitals within an academic medical center from August 2008 to March 2009.

SYNOPSIS: Admission encounters (76 patients, 27 hospitalists) were recorded. Researchers detected negative emotional expressions from patients and characterized resultant physician replies as either empathic ("focuses toward further expression of emotion"), neutral ("focuses neither toward nor away from emotion"), or nonempathic ("focuses away from emotion"). Through use of regression models, response frequency was compared with change in pre/post-encounter patient anxiety, patient ratings of physician communication, and duration of encounter. Every additional empathic response was associated with a small decrease in anxiety, better ratings of physician communication, and no change in encounter duration. Nonempathic responses were associated with worse communication ratings. Limitations of the study include its observational nature, small sample size, exclusion of non–English-speaking patients, absence of data on nonverbal communication, and exclusively urban academic setting.

BOTTOM LINE: Empathic hospitalist responses during admission encounters are associated with reductions in patient anxiety and better ratings of physician communication without increases in encounter duration.

CITATION: Weiss R et al. Associations of physician empathy with patient anxiety and ratings of communication in hospital admission encounters. J Hosp Med. 2017;12(10):805-10.

2 Rivaroxaban versus warfarin in mild acute ischemic stroke secondary to atrial fibrillation

CLINICAL QUESTION: Is rivaroxaban as effective and safe as warfarin immediately following minor acute ischemic stroke from atrial fibrillation?

BACKGROUND: There is uncertainty regarding the best approach to anticoagulation acutely after ischemic stroke secondary to atrial fibrillation. To reduce the risk of intracranial hemorrhage, many physicians start aspirin immediately and delay initiating warfarin until days to weeks later. With their more predictable and rapid anticoagulant effect with potentially lower risk of intracranial hemorrhage, direct oral anticoagulants such as rivaroxaban are an attractive possible alternative to warfarin in the acute setting.

STUDY DESIGN: Multicenter, randomized, open-label superiority trial with blinded outcome assessment.

SETTING: Fourteen academic hospitals in South Korea.

SYNOPSIS: One hundred eighty-three patients with mild acute (within 5 days) ischemic stroke secondary to nonvalvular atrial fibrillation were randomized to immediately initiate either rivaroxaban or warfarin. The primary outcome (composite of new ischemic lesion or new intracranial hemorrhage on MRI at 4 weeks) occurred at similar frequency between groups (49.5% versus 54.5%, $P = .49$). Rates of adverse events were comparable in each group. Median hospitalization length was shorter in those randomized to rivaroxaban (4.0 versus 6.0 days,

Short Takes

Fluoroquinolone use tied to higher risk of aortic dissection and aneurysm

A meta-analysis of two observational studies found that current fluoroquinolone use was associated with modestly higher risk of aortic dissection (odds ratio, 2.79, 95% confidence interval, 2.31-3.37) and aortic aneurysm (OR, 2.25, 95% CI, 2.03-2.49).
CITATION: Singh S et al. Aortic dissection and aortic aneurysms associated with fluoroquinolones: A systematic review and meta-analysis. Am J Med. [online ahead of print, Jul 21, 2017].

Optimal lengths of postoperative opioid prescription range from 4 to 15 days

A multicenter review of opioid prescriptions after common surgical procedures found that the median prescription lengths were between 4 and 6 days for general surgery procedures, women's health procedures, and musculoskeletal procedures. The prescription lengths associated with lowest requirement for refill were 9 days for general surgery, 13 days for women's health, and 15 days for musculoskeletal procedures. Study authors recommend considering this information when determining the optimal opioid prescription duration for postoperative discharges.
CITATION: Scully RE et al. Defining optimal length of opioid pain medication prescription after common surgical procedures. JAMA Surg. Sep 2017.

P less than .001). Limitations include a radiographic primary outcome that captured many asymptomatic lesions, homogenous study population, and lack of a delayed anticoagulation group.
BOTTOM LINE: In patients with mild acute stroke from nonvalvular atrial fibrillation, rivaroxaban and warfarin demonstrated comparable efficacy and safety. More study is needed to determine the optimal anticoagulation strategy in acute stroke.
CITATION: Hong K-S et al. Rivaroxaban vs. warfarin sodium in the ultra-early period after atrial fibrillation-related mild ischemic stroke: A randomized clinical trial. JAMA Neurol. 2017; 74(10):1206-15.

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

By Jorge Rodriguez, MD

3 Evidence-based care processes decrease mortality in *Staphylococcus aureus* bacteremia

CLINICAL QUESTIONS: What are the trends in patient outcome for *Staphylococcus aureus* bacteremia (SAB)? Does the use of evidence-based care processes decrease mortality in SAB?
BACKGROUND: SAB is associated with poor clinical outcomes. Prior research has demonstrated that several evidence-based interventions, namely appropriate antibiotics, echocardiography, and infectious disease consults, have been associated with improved outcomes. The use of these interventions in clinical practice and their large-scale impact on SAB mortality is not known.


Dr. Rodriguez

STUDY DESIGN: Retrospective observational cohort study.
SETTING: Veterans Health Administration acute care hospitals in the continental United States from January 1, 2003, to Dec. 31, 2014.
SYNOPSIS: This study used the Veterans Affairs Informatics and Computing Infrastructure to identify 36,868 patients across 124 acute care hospitals with a first episode of SAB. Use of evidence-based care processes (specifically appropriate antibiotic use, echocardiography, and infectious disease consults) and patient mortality were recorded.

All-cause 30-day mortality decreased 25.7% in 2003 to 16.5% in 2014. Concurrently, the rate of evidence-based care processes increased from 2003 to 2014. There was lower risk-adjusted mortality when patients received all three evidence-based care processes compared to those who received none, with an odds ratio of 0.33 (95% confidence interval, 0.30-0.37); 57.3% of the decrease in mortality was attributable to use of all three evidence-based care processes.

Given the observational nature of the study, unmeasured confounders were not considered. Generalizability of the study is limited since the patients were primarily men.
BOTTOM LINE: The use of evidence-based care processes (appropriate antibiotic use, echocardiography, and infectious disease consultation) was associated with decreased SAB mortality.
CITATION: Goto M et al. Association of evidence-based care processes with mortality in *Staphylococcus aureus* bacteremia at Veterans Health Administration hospitals, 2003-2014. JAMA Intern Med. 2017;177(10):1489-97.

4 CPR decision support videos can serve as a supplement to CPR preference discussions for inpatients

CLINICAL QUESTION: Does the use of a CPR decision support video impact patients' code status preferences?
BACKGROUND: Discussions about cardiopulmonary resuscitation are an important aspect of inpatient care but may be difficult to complete for several reasons, including poor patient understanding of the CPR process and its expected outcomes. This study sought to evaluate the impact of a CPR decision support video on patient CPR preferences.
STUDY DESIGN: Nonblinded randomized controlled trial.
SETTING: General medicine wards at the Minneapolis Veterans Affairs from Sept. 28, 2015, to Oct. 23, 2015.
SYNOPSIS: One hundred and nineteen patients older than 65 were randomized to receive standard care plus viewing a CPR decision support video or standard care alone. The primary outcome was patient code status preference. Patients completed a survey assessing trust in their care team.

Among the patients who viewed the video, 37% chose full code, compared with 71% of patients in the usual care arm. Patients who viewed the video were more likely to choose DNR/DNI (56%, compared with 17% in the control group). There was no significant difference in patient trust of the care team.

Study conclusions are limited by a study population consisting predominantly of white males. Though the study was randomized, it was not blinded.
BOTTOM LINE: A CPR decision support video led to a decrease in full code preference and an increase in DNR/DNI preference among hospitalized patients.
CITATION: Merino AM et al. A randomized controlled trial of a CPR decision support video for patients admitted to the general medicine service. J Hosp Med. 2017;12(9):700-4.

Dr. Rodriguez is a hospitalist and a clinical informatics fellow, Beth Israel Deaconess Medical Center, Boston.

By Pooja Gala, MD

5 Anticoagulation use in new-onset secondary atrial fibrillation

CLINICAL QUESTION: Is anticoagulant use in patients with new-onset atrial fibrillation secondary to acute coronary syndrome, acute pulmonary disease, or sepsis associated with a reduction in ischemic stroke or an increase in bleeding risk?
BACKGROUND: Data on the efficacy of anticoagulation to reduce stroke risk in patients with new-onset atrial fibrillation due to acute coronary syndrome (ACS), acute pulmonary disease (APD), and sepsis are limited.


Dr. Gala

STUDY DESIGN: Retrospective cohort study.
SETTING: All hospitals in Quebec.
SYNOPSIS: Authors included 2,304 patients aged 65 and older with new atrial fibrillation secondary to ACS, APD, and sepsis. Anticoagulation was started for 38.4%, 34.1%, and 27.7% of these patients and the incidence of stroke was 5.4%, 3.9%, and 5.8% in the ACS, APD, and sepsis populations, respectively. After 3 years, anticoagulation use was not associated with a lower risk of ischemic stroke in any cohort. In a multivariate analysis adjusted for the HAS-BLED score, anticoagulation was associated with a higher risk of bleeding in patients with APD (odds ratio, 1.72; 95% confidence interval, 1.23-2.39) but not in ACS or sepsis.

The major limitation of this study was the reliance on administrative data alone, making it difficult to confirm and capture all patients with transient atrial fibrillation.
BOTTOM LINE: Anticoagulation use in patients with secondary atrial fibrillation may not be associated with a reduction in ischemic strokes, but may be associated with an increased bleeding risk in patients with atrial fibrillation secondary to acute pulmonary disease.
CITATION: Quon MJ et al. Anticoagulant use and risk of ischemic stroke and bleeding in patients with secondary atrial fibrillation associated

Continued on following page

Continued from previous page

with acute coronary syndromes, acute pulmonary disease, or sepsis. JACC: Clinical Electrophysiology. Article in Press.

6 Supplemental oxygen use for suspected myocardial infarction without hypoxemia

CLINICAL QUESTION: What is the effect of supplemental oxygen therapy on all-cause mortality for patients with a suspected myocardial infarction but no hypoxemia?
BACKGROUND: Clinical guidelines recommend supplemental oxygen in patients with suspected acute myocardial infarction but data to support its use in patients without hypoxemia are limited.
STUDY DESIGN: Open-label, registry-based randomized clinical trial.
SETTING: Thirty-five hospitals in Sweden with acute cardiac care facilities.
SYNOPSIS: Authors included 6,629 patients aged 30 and older who presented with symptoms suggestive of myocardial infarction. Patients with oxygen saturations 90% or greater were enrolled in the study and randomly assigned to either 6 liters per minute of face mask oxygen for 6-12 hours or ambient air. Median oxygen saturation was 99% in the treatment group and 97% in the ambient air group (*P* less than .0001). In an intention-to-treat model, 1 year after randomization there was no significant difference in all-cause mortality between the oxygen (5.0%) and ambient air (5.1%) groups (*P* = .80). There was no difference in the rate of rehospitalization with myocardial infarction or the composite endpoint of all-cause mortality and rehospitalizations for myocardial infarction at 30 days and 1 year. Limitations of this study include lower power than anticipated since calculations were based on a higher mortality rate than observed in this study, and the open-label protocol.
BOTTOM LINE: In patients who present with a suspected myocardial infarction without hypoxemia, oxygen therapy is not associated with improved all-cause mortality or decreased rehospitalizations for myocardial infarction.
CITATION: Hofmann R et al. Oxygen therapy in suspected acute myocardial infarction. N Engl J Med. 2017;377:1240-9.

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

By Celeste Pizza, MD

7 Diagnostic delays, morbidity, and epidural abscesses

CLINICAL QUESTION: What is the frequency of diagnostic delays in epidural abscesses, and what factors may contribute to these delays?
BACKGROUND: Diagnostic evaluation of back pain can be challenging. Missed diagnosis of serious conditions such as epidural abscesses can lead to significant morbidity.
STUDY DESIGN: Retrospective chart review.
SETTING: Veterans Affairs Electronic Medical Record database from more than 1,700 VA outpatient and inpatient facilities in the United States.
SYNOPSIS: Of the 119 patients with a new diagnosis of spinal epidural abscess, 55.5% were felt to have experienced a diagnostic error, defined by the study authors as a missed opportunity to evaluate a red flag (e.g., weight loss, neurologic deficit, fever) in a timely or appropriate manner. There was a significant difference in the time to diagnosis between patients with and without a diagnostic error (4 versus 12 days, *P* less than .01). Of those cases involving diagnostic error, 60.6% were felt to have resulted in serious patient harm and 12.1% in patient death. The most commonly missed red flags were fever, focal neurologic deficits, and signs of active infection.

Dr. Pizza

A delay in diagnosis resulting in patient harm or death may occur frequently in cases of epidural abscesses. Further work on targeted interventions to reduce error and prevent harm are needed.

Based on these findings, the authors suggest that future intervention focus on improving information gathering during patient-physician encounter and physician education about existing guidelines.

The limitations of this study include its use of data from a single health system, and the employment of chart reviews instead of a root cause analysis based on provider and patient interviews.
BOTTOM LINE: A delay in diagnosis resulting in patient harm or death may occur frequently in cases of epidural abscesses. Further work on targeted interventions to reduce error and prevent harm are needed.
CITATION: Bhise V et al. Diagnosis of spinal epidural abscesses in the era of electronic health records. Am J Med. 2017;130(8):975-81.

8 A simplified risk prediction model for patients presenting with acute pulmonary embolism

CLINICAL QUESTION: Is there a simplified risk prediction model to identify those with low risk pulmonary embolism (PE) who can be treated as outpatients?
BACKGROUND: Existing prognostic models for patients with acute PE are dependent on comorbidities, which can be challenging to use in a scoring system. Models that make use of acute clinical variables to predict morbidity or mortality may be of greater clinical utility.
STUDY DESIGN: Retrospective chart review with derivation and validation analysis.
SETTING: Tertiary care hospital in Chennai, India.
SYNOPSIS: The authors identified 400 patients with acute PE who met inclusion criteria. Using logistic regression and readily accessible clinical variables previously shown to be associated with acute PE mortality, the authors created the HOPPE prediction score: heart rate, PaO_2, systolic blood pressure, diastolic blood pressure, and ECG score. Each variable was classified into three groups and assigned a point value that could be summed to a cumulative 30-day mortality risk score. In the derivation and validation cohorts, the low, intermediate, and high HOPPE scores were associated with a 30-day mortality of 0%, 7.5-8.5%, and 18.2-18.8%, respectively, with similar trends for secondary outcomes including right ventricular dysfunction, nonfatal cardiogenic shock, and cardiorespiratory arrest.

In comparison with the previously validated PESI score, the HOPPE score had significantly higher sensitivity, specificity, and discriminative power. The conclusions from this study were limited by its single institutional design.
BOTTOM LINE: The HOPPE score provides a risk assessment tool to identify those patients with acute PE who are at lowest and highest risk for morbidity and mortality.
CITATION: Subramanian M et al.

Short Takes

Increased mortality in weekend and holiday hospital admissions

A meta-analysis of 97 studies showed a greater relative risk of mortality for patients admitted during the weekend or holidays compared to those admitted during the week. Subgroup analyses did not reveal significant effect modification by staffing level and other hospital factors. Further research to identify contributing factors and potential interventions is needed.
CITATION: Pauls LA et al. The weekend effect in hospitalized patients: a meta-analysis. J Hosp Med. 2017;12(9):760-6.

Kayexalate should not be taken at the same time as other medications

The Food and Drug Administration has released a drug safety communication on kayexalate (sodium polystyrene sulfonate). Given recent research showing that kayexalate may decrease the absorption and effectiveness of many oral medications, the FDA recommended that, when kayexalate is prescribed, it should be given at least 3 hours before or after administration of other oral medications. This time should be increased to 6 hours for those with conditions that result in delayed gastric emptying.
CITATION: Food and Drug Administration. Kayexalate (sodium polystyrene sulfonate): Drug Safety Communication. 2017 Sep 6.

Most thrombophilia testing done in the hospital does not add value

A retrospective cohort study among emergency department and hospitalized patients at an academic medical center examined 163 patients and 1,451 thrombophilia tests; 63% of tests were of "minimal clinical utility."
CITATION: Cox N et al. Patterns and appropriateness of thrombophilia testing in an academic medical center. J Hosp Med. 2017;12(9):705-09.

Derivation and validation of a novel prediction model to identify low-risk patients with acute pulmonary embolism. Am J Cardiol. 2017;120(4):676-81.

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

By Jessica Berwick, MD, MPH

9 Transfusion threshold and bleeding risk in malignancy-related thrombocytopenia

CLINICAL QUESTION: What are laboratory predictors of bleeding in patients with thrombocytopenia, and what is the effect of platelet or RBC transfusion on actively bleeding patients?

BACKGROUND: The association between platelet counts, risk of bleeding, and transfusions in patients with thrombocytopenia related to stem cell transplant (SCT) or chemotherapy is not clear, except at very low platelet counts.

STUDY DESIGN: Secondary analysis of a multicenter, randomized controlled trial, stratified by cause of thrombocytopenia: autologous or syngeneic SCT (AUTO), allogeneic SCT (ALLO), or chemotherapy for hematologic malignancy without SCT (CHEMO).

SETTING: Twenty-six hospitals from 2004 to 2007.

SYNOPSIS: The PLADO trial enrolled more than 1,200 patients aged 18 years and older expected to experience a period of hypoproliferative thrombocytopenia as a result of chemotherapy or SCT, and randomized them to low, medium, or high doses of prophylactic platelets. This secondary analysis assessed laboratory predictors of bleeding, and the effect of transfusion.

Of 1,077 patients who received platelet transfusions, there were no differences between dose groups for any bleeding outcomes. Over a wide range of platelet counts, the ALLO stratum had a higher risk of bleeding than other strata, with clinically significant bleeding on 21% of patient-days in the ALLO stratum, compared with 19% in the AUTO stratum and 11% in the CHEMO stratum (*P* less than .001). Risk for bleeding was significantly higher at platelet counts of equal to or less than $5x10^9$/L, compared with platelet counts greater than or equal to $81x10^9$/L. Higher aPTT and INR were also associated with higher risk of clinically significant bleeding. In a multipredictor model, only hematocrit was significantly associated with more severe bleeding. Neither platelet transfusion nor RBC transfusion reduced the risk of bleeding on the following day, although the authors note some possibility of confounding by indication.

Dr. Berwick

BOTTOM LINE: Predictors of overall increased risk for bleeding in patients with secondary hypoproliferative thrombocytopenia were treatment stratum, platelet counts less than or equal to $5x10^9$/L, hematocrit less than 25%, INR greater than 1.2, and aPTT greater than 30 seconds. This study challenges the conventional wisdom that transfusions reduce bleeding risk in patients with secondary hypoproliferative thrombocytopenia.

CITATION: Uhl L et al. Laboratory predictors of bleeding and the effect of platelet and RBC transfusions on bleeding outcomes in the PLADO trial. Blood. 2017;130(10):1247-58.

10 PFO closure reduces the risk of recurrent stroke compared to antiplatelet therapy alone

CLINICAL QUESTION: Does closure of a patent foramen ovale (PFO) reduce the risk of recurrent ischemic stroke?

BACKGROUND: Previous research on the use of PFO closure to prevent recurrent stroke has yielded mixed results.

STUDY DESIGN: Gore REDUCE, CLOSE, and RESPECT were all multicenter, randomized, open-label superiority trials, with blinded adjudication of endpoint events. RESPECT data reflected an exploratory analysis of an extended follow-up period.

SETTING: Gore REDUCE was a multinational study conducted at 63 sites in Europe and North America, from 2008-2015. CLOSE was conducted at 34 sites in France and Germany, from 2007 to 2016. RESPECT was conducted at 69 sites in the United States and Canada, from 2003 to 2011.

SYNOPSIS: Three trials reexamined the impact of PFO closure with standard antiplatelet treatment, with a total of 2,307 patients between the ages of 16 and 60 years. CLOSE included only patients with a PFO and an associated atrial septal aneurysm or a large interatrial shunt. Gore REDUCE and RESPECT were both industry funded. All three trials found a statistically significant reduction in risk of recurrent ischemic stroke associated with PFO closure and antiplatelet therapy compared to antiplatelet therapy alone (CLOSE: hazard ratio, 0.03; 95% confidence interval, 0-0.26; *P* less than .001), (RESPECT: HR, 0.55; 95% CI, 0.31-0.999; *P* = .046), (Gore REDUCE: HR, 0.23; 95% CI, 0.09-0.62; *P* = .002). Gore REDUCE and CLOSE identified increased rates of post-procedural atrial fibrillation or flutter (Gore REDUCE: 6.6% vs. 0.4%; *P* less than .001; CLOSE: 4.6% vs. 0.9%; *P* = .02). Serious adverse events related to the procedure or device ranged from 3.9% to 5.9%.

PFO closure combined with antiplatelet therapy in patients aged 60 years or younger, particularly in those with significant right-to-left shunts and atrial septal aneurysms, reduced the risk of recurrent ischemic stroke, compared with antiplatelet therapy alone.

BOTTOM LINE: PFO closure combined with antiplatelet therapy in patients aged 60 years or younger, particularly in those with significant right-to-left shunts and atrial septal aneurysms, reduced the risk of recurrent ischemic stroke, compared witho antiplatelet therapy alone.

CITATIONS: Mas JL et al. Patent foramen ovale closure or anticoagulation vs. antiplatelets after stroke. N Engl J Med. 2017;377(11):1011-21.

Saver JL et al. Long-term outcomes of patent foramen ovale closure or medical therapy after stroke. N Engl J Med. 2017;377(11):1022-32.

Søndergaard L et al. Patent foramen ovale closure or antiplatelet therapy for cryptogenic stroke. N Engl J Med. 2017;377(11):1033-42.

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Charting a new course

Continued from page 1

deaths can be at least partially linked to sepsis.

Devin J. Horton, MD, an academic hospitalist at University Hospital in Salt Lake City, sometimes compares sepsis to acute MI to illustrate the difficulty of early detection. A patient complaining of chest pain immediately sets in motion a well-rehearsed chain of events. "But the patient doesn't look at you and say, 'You know, I think I'm having SIRS [systemic inflammatory response syndrome] criteria in the setting of infection,'" he said. "And yet, the mortality of severe septic shock is at least as bad as acute myocardial infarction." The trick is generating the same sense of urgency without a clear warning.

The location in a hospital also can present a major obstacle for early identification. Hospitalist Andy Odden, MD, SFHM, patient safety officer in the department of medicine at Washington University in St. Louis, calls hospital wards the "third space" of sepsis care, after the ICU and ED. "A lot of the historical improvement efforts and research has really focused on streamlining care in the ICU and streamlining care in the emergency department," he said. Often, however, sepsis or septic shock isn't recognized until a patient is admitted to a medical or surgical ward.

Patients on the wards, though, usually begin with a nonsepsis diagnosis, which can produce an anchoring bias. Furthermore, Dr. Odden said, the data needed to identify sepsis may arrive asynchronously, increasingly the difficulty of pulling it all together for a timely diagnosis. As Dr. Horton points out, the trigger for transferring a decompensating sepsis patient from the wards to the ICU is murkier as well. "We don't know what is too sick for the floor," he said. "A lot of it is kind of a gestalt."

Observational studies by the Surviving Sepsis Campaign suggested that patients diagnosed on the floor had mortality rates comparable to and substantially higher than theoretically sicker patients diagnosed in the ICU and ED, respectively.[1] "That was kind of a sea change for a lot of people and really articulated what a lot of us on the wards had been feeling," Dr. Odden said. "We can't simply apply the lessons that we've learned from the emergency department and the ICU to the wards if we're going to provide the right care for these patients," he said.

Dueling definitions

Better sepsis care in hospital wards will require a better understanding of shifting management guidelines. Confusing and contradictory definitions haven't helped. In October 2015, the Centers for Medicare & Medicaid Services instituted its Sepsis Core Measure (SEP-1) for Medicare, requiring every hospital to audit a percentage of patients treated with best-practice 3- and 6-hour bundles for severe sepsis and septic shock. The SEP-1 measure uses the traditional definition of severe sepsis as two or more SIRS criteria, a suspected or proven infection, and organ dysfunction.

Dr. Odden

A separate set of guidelines issued by the international Sepsis-3 task force in February 2016, by contrast, concluded that the term "severe sepsis" is redundant.[2] The update defines sepsis as "life-threatening organ dysfunction caused by a dysregulated host response to infection" and asserts that the condition can be represented by an increase in the SOFA (Sequential Organ Failure Assessment) score of 2 or more points.

For hospital wards, the task force recommended a bedside scoring system called qSOFA (quickSOFA) for adult patients with a suspected infection. The risk stratification tool may help rapidly identify those who are likely to have poorer outcomes typical of sepsis if they meet two of the following three clinical criteria: a "respiratory rate of 22 [breaths]/min or greater, altered mentation, or systolic blood pressure of 100 mm Hg or less."

CMS doesn't recognize the Sepsis-3 definition at all, and multiple providers have described widespread skepticism and uncertainty over how to reconcile it with the prior definition. Dr. Odden says the dueling definitions have "caused a tremendous amount of confusion" over diagnoses, the necessary sense of urgency, and whether severe sepsis is still a recognized entity. "When people aren't speaking the same language with the same terminology, there is enormous opportunity for miscommunication to occur," he said.

Hospitalist Lisa Shieh, MD, PhD, medical director of quality in the department of medicine at Stanford (Calif.) University Medical Center, said Sepsis-3 was never meant to be a screening tool. It can, however, help doctors identify patients at higher risk. Craig A. Umscheid, MD, MSCE, of the department of epidemiology and vice chair for quality and safety in the department of medicine at the University of Pennsylvania, Philadelphia, said many providers agree that, at least theoretically, changes in a patient's qSOFA score can predict bad outcomes better than SIRS criteria.

Obtaining reliable scores is another matter. The qSOFA blood pressure score generally is measured accurately, he said. On noncritical care units, though, nurses aren't always trained to consistently and accurately document a patient's mental status. Likewise, he said, documentation of respiratory rate often is subjective, and an abnormal rate can be easily missed. Changing that dynamic, he stressed, will require coordination with nursing leadership to ensure more consistent and accurate measurements.

Another big issue is that sepsis screening still is based on early recognition, Dr. Shieh said. "The problem with Sepsis-3 is that it is later in the continuum of sepsis." As such, she recommends sticking with the CMS definition for now. "It catches sepsis earlier, which is the whole strategy for improving sepsis mortality," she said.

Reshaping sepsis pathways

So how can hospitals identify sepsis sooner? Some hospitals have relied more on EMR-based screening methods; others have relied more on nurses to lead the charge. Either way, Dr. Shieh said, the field is trying to encourage the use of set pathways. Almost every medical center that performs well on sepsis measures, she says, has a good screening program, a pathway implemented through an order set or nursing staff, and a highly trained sepsis team that ensures patients get the treatment they need.

At Middlesex Hospital in Middletown, Conn., a major QI project led to significant improvements in sepsis

mortality, total mortality, sepsis-related serious safety events and sepsis length of stay. Terri Savino, MSN, RN, CPHQ, the hospital's manager of patient experience and service excellence, said the project sprang from concerns by the hospital's Rapid Response Review Committee about some serious safety events involving a delay in sepsis diagnosis and treatment.

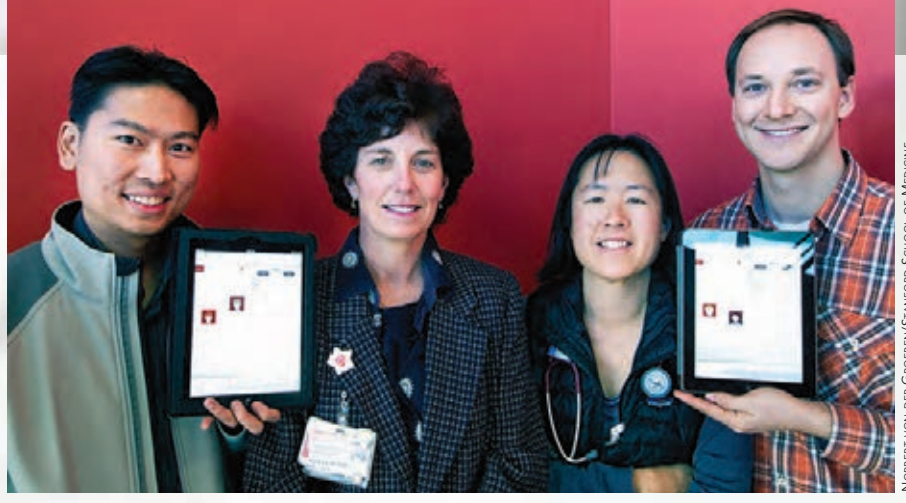
Ms. Savino

Dr. Umscheid

As part of a QI effort led by an interdepartmental task force, the hospital first updated its inpatient and ED sepsis pathways to incorporate the Surviving Sepsis Campaign's 2012 guidelines. "We continued to tweak our pathways, so they've now embedded other infection pathways into the sepsis pathway to make sure that we're not missing anybody," Ms. Savino said. The hospital also launched an early recognition and treatment educational effort targeting all health care staff and rolled out a new electronic early warning system in February 2014.

In 2013, the hospital documented three serious safety events related to a delay in diagnosis and treatment of sepsis. In 2014, it recorded only one event and has had none since then. From 2014 to 2015, sepsis-related mortality fell by more than 20%, saving an estimated 25 lives. Sepsis length of stay also declined. "We're identifying them sooner and treating them sooner so they're not getting as sick or requiring critical care and longer length of stays," Ms. Savino said.

Dr. Odden has participated in two multicenter QI initiatives on sepsis. One, a partnership led by the Institute for Healthcare Improvement in Cambridge, Mass., and New York's North Shore-LIJ Health System, focused on how to diagnose sepsis in hospital ward patients as quickly as possible and how to successfully deliver the 3-hour sepsis bundle.[3] Beyond getting everyone on the same page regarding definitions, he said, the collaborators discussed and shared strategies for identifying patients. "One hospital would often have a solution for a problem that other hospitals could either take directly or modify based on their own understanding of their own processes," he said.



Norbert von der Groeben/Stanford School of Medicine

Jamie Tsui, Eileen Pummer, Dr. Lisa Shieh, and Brian Tobin were part of the Stanford team that designed the Septris game for teaching doctors to treat sepsis.

Dr. Odden also participated in a national project sponsored by the Surviving Sepsis Campaign that focused on developing protocols for nurse-led screening processes in hospital wards. Within a pilot unit of each participating hospital, bedside nurses screened every patient for sepsis during every shift. For positive screens, the hospitals then developed protocols for order sets, like blood work and fluids.

The initiative suggested that a nurse-based, every-shift screening method might be one feasible way to identify sick patients as early as possible. "Going through the screening process really seemed to empower the nurses to take a much more active role in partnering with the physicians and in recognizing some of the early warning signs," Dr. Odden said. The project led to other benefits as well, including improved identification of strokes, delirium, and even a gastrointestinal bleed because the "barriers in communication had been broken down," he said.

To help medical providers recognize sepsis earlier, Dr. Shieh and her colleagues created a free game called Septris as an adjunctive teaching tool. Based on a player's diagnosis and treatment decisions, patient outcomes ei-

Continued on following page

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ther rise or fall – often rapidly. "I'm an educator and what I know is that the best way you learn is by doing," she said. The interactive and repetitive nature of Septris, she said, helps its take-home messages stick in a player's mind without the expense of patient simulations. Dr. Shieh said the game has been adapted for German and British medical institutions as well, and that she collects data from players around the world about their experiences and scores.

Winning interdisciplinary buy-in

To maximize the chances for success, several doctors emphasize the importance of forming an interdisciplinary task force that includes every department affected by a QI project. Ms. Savino said executive sponsorship of her hospital's QI project was key as well. So was meeting frequently with the carefully chosen team members representing key stakeholders throughout the hospital. "It was a lot of work," she said. "But I really think that was one reason why it was so successful. We had everybody's buy-in, and we kept our short-term goals on track."

Dr. Horton and collaborator Kencee K. Graves, MD, an academic hospitalist at the University of Utah, Salt Lake City, agreed that "face time" was the best way to get buy-in throughout their hospital during their own QI initiative. "We spent a lot of time sitting and listening to concerns and feedback from providers," Dr. Graves said. "We would then integrate some of their feedback into the process, so people knew they were heard." Securing the buy-in of nursing staff was another huge key to their success in improving the quality of sepsis care and reducing costs.[4] "Honestly, they were the secret sauce of the whole project," Dr. Horton said. Changing the culture in the hospital helped immensely but required considerable time and patience to build both trust and acceptance within different units.

Based on their success, the QI initiative has spread to two other hospitals in the University of Utah's network. "Once the culture changes have been made and the project's up and going, it's kind of self-sufficient," Dr. Horton said. "But it was so much work." He and Dr. Graves are careful to emphasize that there are other options for sepsis-related QI efforts. "I think it is better to start something small than to believe you can't do anything at all," Dr. Graves said.

No matter what the size, assembling a motivated and multidisciplinary team is critical, she said. So is empowering nurses to talk to physicians about decompensating patients and other aspects of sepsis care. Being available and willing to listen to other providers also can pay big dividends. "Knowing that we cared about the project's success was important to people working on it," Dr. Graves said.

Despite the remaining challenges, Dr. Shieh points out that sepsis mortality rates have improved significantly, thanks in large part to more awareness and ambitious QI projects. "I do want to say that we have come a long way," she said.

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Paring the risk of antibiotic resistance

By Bryn Nelson, PhD

One unintended consequence of the increased attention to early sepsis identification and intervention can be unnecessary or excessive antibiotic use. Overuse of broad-spectrum antibiotics, in turn, can fuel the emergence of life-threatening infections such as antibiotic-resistant *Clostridium difficile*, a scourge in many hospitals.

For a sepsis quality improvement (QI) initiative at the University of Utah, Salt Lake City, the hospitalist coleaders took several precautions to lessen the risk of antibiotic overuse. Kencee K. Graves, MD, said she and her colleague Devin J. Horton, MD, designed the hospital's order sets in collaboration with an infectious disease specialist and pharmacist so they could avoid overly broad antibiotics whenever possible. The project also included an educational effort to get pharmacists in the habit of prompting medical providers to initiate antibiotic de-escalation at 48 hours. The hospital had an antibiotic stewardship program that likely helped as well, she said. As a result of their precautions, the team found no significant difference in the amount of broad-spectrum antibiotics doled out before and after their QI pilot project.

Infection control and antimicrobial specialists also can help; they can monitor an area's resistance profile, create a antibiogram, and reevaluate sepsis pathways and order sets to adjust the recommended antibiotics as the resistance profile changes.

Preventing sepsis alert fatigue

By Bryn Nelson, PhD

If they're too infrequent, alerts can delay sepsis identification and treatment. If they're too abundant, the alerts can overwhelm providers. Finding the sweet spot for sepsis alerts, QI leaders say, can require time, technology, patience – and sometimes trial and error.

University Hospital in Salt Lake City wanted to broaden its sepsis recognition system to ensure that decompensating patients were seen and resuscitated quickly, regardless of the cause. Another hospital offered a lesson in what not to do when a staff member cautioned that a sepsis alert system based on SIRS alone had been a "total disaster" and left providers fuming. One report suggested that nearly half of all ward patients meet SIRS criteria at some point during their hospitalization, and that using the criteria for sepsis screening in hospital wards is both "time consuming and impractical."

Instead, University Hospital tweaked its MEWS or Modified Early Warning System, based on consultations with hospitalists, ICU physicians, and other providers about the appropriate thresholds for vital signs. "It's kind of like asking someone, 'Well, when are you really scared of the heart rate and when are you sort of scared and when are you not scared at all?'" said project co-leader Devin J. Horton, MD, an academic hospitalist.

The team also analyzed the number of alerts per week per unit and their sensitivity and specificity in detecting sepsis. As junior faculty members, Dr. Horton and his collaborator, academic hospitalist Kencee K. Graves, MD, were mindful to avoid angering other doctors over being alerted too often. For their MEWS scoring system, they sacrificed a bit of sensitivity to ensure that the number of alerts remained manageable.

Before going live with its own new alert system, Middlesex Hospital in Middletown, Conn., had a subgroup spend several weeks testing the system in silent mode and tweaking different parameters such as respiratory rate and heart rate to reduce the potential for too many alerts. "If you look at each and every alert, then you can identify how to make your adjustment so that it's not overly sensitive," said Terri Savino, MSN, RN, CPHQ, the hospital's manager of patient experience and service excellence.

A sepsis task force also shared data showing the hospital's significant reductions in sepsis mortality, total hospital mortality, and sepsis length of stay. "Medical staff were willing to accept the frequency and high sensitivity of the alert because the data demonstrated that it was making a difference in the lives of our patients," said David M. Cosentino, MD, the hospital's chief medical information officer.

Other alert systems' mixed performances have yielded important lessons. At the University of Pennsylvania, Philadelphia, one prototype detected clinically deteriorating patients and sent an alert to the nurse, physician, and a rapid response team. Alerted providers converged on the patient's bedside within 30 minutes and decided whether to elevate the level of care. Craig Umscheid, MD, MSCE, of the department of epidemiology and vice chair for quality and safety in the department of medicine, said the system was associated with a suggestion of reduced mortality. But it was noisy and less helpful than it could have been, he said, because it didn't separate out declining patients already known to the team from those who were still unrecognized.

Key Clinical Question

How to manage a patient presenting with syncope

Proper treatment of syncope will depend on its etiology

By Michael Roberts, MD; David Krason, MD; and Farrin A. Manian, MD, MPH

Massachusetts General Hospital in Boston

Brief overview

When evaluating a patient admitted for syncope or falls, the hospitalist must address a number of questions: a) Did the patient actually have syncope?; b) What factor(s) precipitated the syncope?; c) How might similar events be prevented or mitigated in the future?; and d) Is the patient at high risk for a serious adverse outcome (for example, ventricular dysrhythmia, cardiac arrest, intracranial bleed, or death) and, therefore, in need of more immediate or intensive work-up?

The American College of Cardiology, American Heart Association, and Heart Rhythm Society guidelines define syncope as "a symptom that presents with an abrupt, transient, complete loss of consciousness, associated with inability to maintain postural tone, with rapid and spontaneous recovery" with cerebral hypoperfusion as the presumed mechanism.[1] Furthermore, "there should not be clinical features of other nonsyncope causes of loss of consciousness, such as seizure, antecedent head trauma, or apparent loss of consciousness (that is, pseudosyncope)."[1]

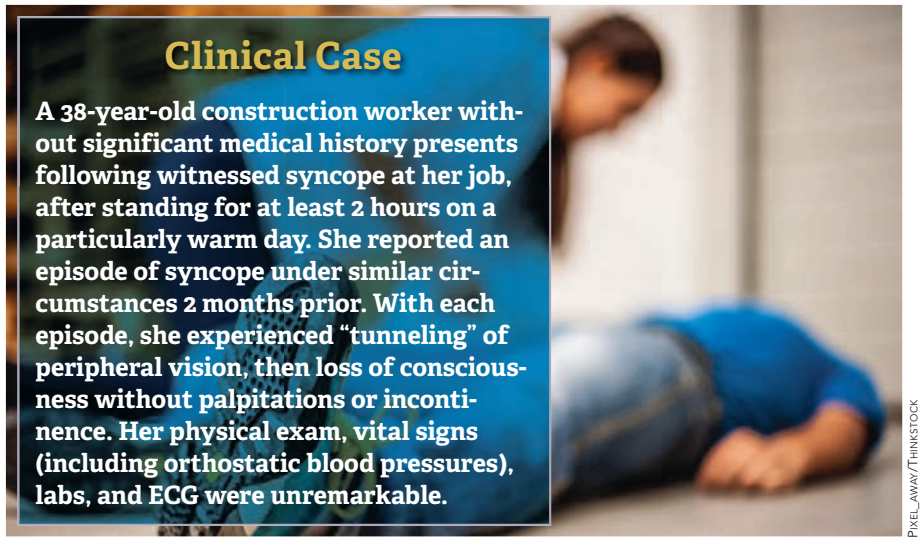
A careful history revolving around the patient's behavior prior to, during, and following the event, a thorough past medical history, and a review of current medications are essential. Potential obstacles in obtaining details of the event include lack of witnesses, patient's inability to recall the experience, and inaccurate description of convulsive syncope as a "seizure" by bystanders.[2]

Certain characteristics may help identify types of syncope based on clinical presentation. Major categories of syncope include neurally mediated syncope (that is, vasovagal, situational, and carotid sinus hypersensitivity), orthostatic hypotension, and cardiac syncope – which may occur in the setting of acute events such as myocardial infarction, cardiac tamponade, aortic dissection, or pulmonary embolism (PE).

Continued on following page

Clinical Case

A 38-year-old construction worker without significant medical history presents following witnessed syncope at her job, after standing for at least 2 hours on a particularly warm day. She reported an episode of syncope under similar circumstances 2 months prior. With each episode, she experienced "tunneling" of peripheral vision, then loss of consciousness without palpitations or incontinence. Her physical exam, vital signs (including orthostatic blood pressures), labs, and ECG were unremarkable.



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Overview of data

Obtaining a detailed history is crucial to understanding both the etiology of the syncopal event and determining which patients are at high risk for adverse outcomes. The etiology of syncope can be determined by history alone in 26% of patients younger than 65 years.[3] Data on the prevalence of syncope by cause vary widely. As a general rule, in younger patients, especially those under 40 years of age, neurally mediated syncope is most common. As patients age, orthostatic hypotension and cardiac causes (including arrhythmias and structural diseases) occur more frequently, though neurally mediated syncope is still the most common.


Dr. Manian

Hospitalists should bear in mind that clear categorization of syncope is often challenging in the elderly. Retrograde amnesia can be seen following syncope in the aged, and even patients who can provide a history may not necessarily provide an accurate account of the event. For example, up to one-half of patients who undergo tilt-table testing and have an observed episode of syncope deny that loss of consciousness ever occurred.[4] Repeated falls in an elderly patient may also require an evaluation for syncope. The typical prodromal symptoms and characteristics of cardiac and neurally mediated syncope also tend to overlap in elderly patients. In a study that examined 46 variables in various age groups, only myoclonic movements during syncope and syncope during physical activity or when supine helped differentiate cardiac from neurally mediated syncope in patients over 65 years of age. Polypharmacy may also increase the susceptibility of the elderly to both orthostatic hypotension and vasovagal syncope.[5] Though rare in younger patients, carotid sinus syncope should be considered in the older population, particularly under certain circumstances.

As an aid for the clinician in risk stratifying patients as relates to the likelihood of serious outcomes, a number of studies propose risk predictors for syncope (for example, the San Francisco Syncope Rule [SFSR], Evaluation of Guidelines in Syncope Study [EGSYS], Short-Term Prognosis of Syncope, Boston Syncope Rule, and the Risk Stratification of Syncope in the Emergency Department rule, to name a few). Unfortunately, the definition of and the timing of the adverse outcomes related to syncope often vary among studies, with reported risk factors ranging from anemia to hypotension on presentation to positive fecal occult blood testing, elevated brain natriuretic peptide, and various ECG findings. Nevertheless, several consistent predictors of serious adverse outcomes tend to emerge, such as hemodynamic instability, anemia, abnormal ECG, evidence of heart failure or structural heart disease, and acute coronary syndrome or its attendant symptoms.


Dr. Krason

Many of these predictors, however, would raise the clinical suspicion of most hospitalists for adverse outcomes in their hospitalized patients independent of the presence or absence of syncope. In fact, a meta-analysis has concluded that "None of the evaluated prediction tools (SFSR, EGSYS) performed better than clinical judgment in identifying serious outcomes during emergency department stay, and at 10 and 30 days after syncope."[6]

Once the patient is hospitalized, further evaluation should be based on a careful history and physical examination. Standard evaluation also includes careful review of medications, an ECG to exclude findings suggestive of arrhythmias as well as structural or coronary artery disease, and orthostatic blood pressure measurements.[1] Additional tests should be considered as deemed appropriate. For example, in patients over 40 years of age without history of carotid artery disease or stroke and in whom no carotid artery bruit is appreciated, a carotid sinus massage may be considered. The correct technique is to massage the sinus on the right then left, each for 5 seconds in both supine and standing positions with continuous heart rate and frequent blood pressure monitoring. Reproduction of syncope, especially concurrent with a cardiac pause of greater than 3 seconds and a systolic blood pressure drop of greater than 50 mm Hg, is considered a positive test. Tilt-table testing should be considered in those for whom neurally mediated syncope is suspected but not confirmed, or in patients who might benefit from further elucidation of their prodromal symptoms.

If the patient's history is concerning for arrhythmia but without supportive ECG findings, ECG monitoring should be considered. The type of monitoring will depend on the frequency of the patient's symptoms, with consideration given to Holter monitors for more frequent events and external patch or implantable loop recorders considered

Key Points

- The major categories of syncope are neurally mediated, orthostatic hypotension, and cardiac syncope. Neurally mediated is the most commonly identified cause of syncope.
- A detailed and accurate history is essential and physical exam should include orthostatic blood pressure measurements and a careful cardiac examination for signs of structural heart disease.
- Predictors of serious adverse outcome in a patient with syncope include hemodynamic instability, history suggestive of arrhythmic syncope, abnormal ECG, evidence of heart failure or structural heart disease, acute coronary syndrome, electrolyte abnormalities, and severe anemia.
- A recent study found pulmonary embolism to be an underappreciated cause of syncope.

Major categories of syncope and their common characteristics

Category & Characteristics

Neurally mediated: Vasovagal
- Occurs under warm or crowded conditions
- Associated with emotional distress, pain, fear
- Prodrome of lightheadedness, dizziness, blurred vision, pallor, abdominal unease, feeling hot or cold
- Occurs after exertion
- Brief disorientation following event, possibly accompanied by nausea, vomiting, fatigue
- History of recurrent syncope
- No history of heart disease

Neurally mediated: Situational
- Event occurs during or near coughing, urinating, defecating, laughing or following a meal or exercise

Neurally mediated: Carotid sinus hypersensitivity
- Patient older than 40 years
- Event occurs with head movement, during shaving, or while wearing a tight collar

Orthostatic hypotension
- Occurs with sudden change in posture or with standing up after prolonged sitting
- Pain in "coat-hanger distribution" of shoulders and neck following event
- History of diabetes, alcohol use disorder, Parkinson disease, Lewy body dementia, amyloidosis, uremia
- Newly initiated or adjusted medications that can affect blood pressure
- Recent history of vomiting or diarrhea

Cardiac syncope
- Occurs during exertion or when patient is supine
- Accompanied or followed by chest pain or dyspnea
- No prodrome or prodrome of palpitations only
- Immediate complete recovery
- History of heart disease
- Abnormal ECG findings
- Family history of sudden cardiac death

Additional Reading

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Quiz

Which of the following conditions was recently found to occur in about 1 in 6 patients presenting to the hospital with syncope?

A. Acute coronary syndrome
B. Aortic dissection
C. PE
D. Supraventricular tachycardia
E. None of the above

Answer: C, PE. In a study of patients presenting with a first episode of syncope, 17% were found to have PE. Acute coronary syndrome and aortic dissection are less frequent causes of syncope and supraventricular tachycardia is generally not associated with syncope.

in more sporadic events. An echocardiogram can be useful in those suspected of having structural heart disease. Although the overall yield of echocardiography is elucidating the cause of syncope is low,[7] it may help further risk stratify those patients with suspected cardiac syncope and, in some cases, help with consideration of implantable cardioverter defibrillator placement. Cardiac stress testing may be considered for exercise-related syncope or patients suspected of having cardiac ischemia. Head imaging, EEG, and carotid ultrasounds are generally considered very low-yield in patients whose history suggests true syncope.


Dr. Roberts

Of note, a study recently published in the New England Journal of Medicine suggests that the prevalence of PE in patients (median age, 80 years) presenting with a first episode of syncope was 17%, a rate that is substantially higher than historically presumed.[8] Although the prevalence of PE was highest among patients presenting with syncope of unclear origin (25%), nearly 13% of patients with other explanations for syncope also had PE.

Application of data

Treatment of syncope will depend on its etiology. Patients with neurally mediated syncope should be educated about avoiding or mitigating potential triggers (for example, orthostatic hypotension, emotional stress, severe cough, straining during urination) and recognizing prodromal symptoms. Such patients should also be counseled regarding physical counter-pressure maneuvers (for example, limb/abdominal contraction, leg crossing, hand grip) and increasing fluid and salt intake. Midodrine, an alpha-adrenergic vasoconstricting agent, may also be considered in patients with recurrent situational neutrally mediated syncope, to be taken an hour before situations that may induce syncope. Patients with carotid sinus syncope should be considered for pacemaker placement. For patients with orthostatic hypotension, potential exacerbating drugs should be held if possible and the patients counseled on liberalizing fluid and salt intake, along with rapid cool water ingestion and physical counter-pressure maneuvers. Abdominal binders, compression stockings, and midodrine, fludrocortisone, or pyridostigmine can also be considered. Treatment of syncope due to cardiac causes depends on the specific cause and should be based on established guidelines. Finally, PE should be treated with anticoagulation and, if needed, more aggressive measures (for example, thrombolysis).

Bottom Line

Our patient likely suffered from neurally mediated vasovagal syncope due to warm conditions, supported by a previous syncopal event under similar conditions. She should be counseled regarding potential physical counter-pressure maneuvers and increased fluid and salt intake when working under warm conditions.

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Features of syncope that should prompt admission or early intensive evaluation

Canadian Cardiac Society guidelines[9]

- Abnormal ECG: Tachyarrhythmia, bradyarrhythmia, conduction disease, new ischemia, or old myocardial infarct.
- History of cardiac disease: Ischemia; arrhythmia; and structural, obstructive, or valvular disease.
- Hypotension: Systolic BP less than 90 mm Hg.
- Heart failure: Current or past history.
- Minor risk factors: Age more than 60 years, dyspnea, anemia (hematocrit less than 30%), hypertension, cerebrovascular disease, family history of sudden cardiac death (SCD) (age less than 50 years), and specific situations (for example, syncope during exertion, while supine, or without prodrome).

European Society of Cardiology guidelines[10]

- Severe structural or coronary artery disease: Heart failure, previous myocardial infarction, low left ventricular ejection fraction.
- ECG features of arrhythmic syncope: Bifascicular block (complete left bundle branch block, right bundle branch block with left hemifascicular block) or other interventricular conduction delay with QRS duration 120 ms or greater, nonsustained ventricular tachycardia, inadequate sinus bradycardia (less than 50 bpm) or sinoatrial block in absence of negative chronotropic medications or physical training, pre-excited QRS complex, prolonged or short QT interval, Brugada pattern, negative T waves in right precordial leads, epsilon waves and ventricular late potentials suggestive of arrhythmogenic right ventricular cardiomyopathy.
- Clinical features of arrhythmic syncope: Syncope during exertion, palpitations at the time of syncope, or family history of SCD.
- Important comorbidities: Severe anemia or electrolyte disturbance.

ACC/AHA/HRS guidelines[1]

- Cardiac arrhythmic conditions: Sustained or symptomatic ventricular tachycardia, symptomatic conduction system disease or Mobitz II or third-degree heart block, symptomatic bradycardia or sinus pauses not related to neurally mediated syncope, symptomatic supraventricular tachycardia, pacemaker/implantable cardiac defibrillator malfunction, inheritable cardiovascular conditions predisposing to arrhythmias.
- Cardiac or vascular nonarrhythmic conditions: Cardiac ischemia, severe aortic stenosis, cardiac tamponade, hypertrophic cardiomyopathy, severe prosthetic valve dysfunction, pulmonary embolism, aortic dissection, acute HF, moderate to severe LV dysfunction.
- Noncardiac conditions: Severe anemia or gastrointestinal bleeding, major traumatic injury due to syncope, persistent vital sign abnormalities.

Convulsive syncope vs. seizure

Distinguishing characteristics

Convulsive syncope

- Prodrome of diaphoresis, warmth, abdominal discomfort
- Pallor
- Fixed or upward eye deviation
- Myoclonic jerks
- Postdromal nausea, fatigue, brief disorientation

Seizure

- Prodromal cry
- Tongue biting
- Lateral eye deviation
- Rhythmic, generalized movements
- Prolonged postictal confusion

Source: Adapted from reference[2]

Diagnostic work-up for syncope

Standard work-up

- Detailed history
- Physical examination
- ECG
- Orthostatic blood pressure measurement
- Review of medications

Additional work-up if needed

- Targeted blood testing (for example, D-dimer, CBC, BMP, troponin, NT-proBNP, based on history.)
- Carotid sinus massage
- ECG monitoring
- Echocardiography
- Tilt-table testing
- Electrophysiologic testing
- Exercise stress testing
- Fecal occult blood testing
- Radiographic evaluation for pulmonary embolism

Academic Nocturnist Hospitalist

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

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

Competitive salary and benefits among highly qualified, friendly colleagues foster networking opportunities. Excellent schools, affordable cost of living, great family-oriented lifestyle with a multitude of outdoor activities year-round. Relocation assistance, CME funds, Penn State University tuition discount for employees and dependents, LTD and Life insurance, and so much more!

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

For additional information, please contact:
Brian Mc Gillen, MD — Director, Hospitalist Medicine
Penn State Milton S. Hershey Medical Center
c/o Heather Peffley, PHR FASPR — Physician Recruiter
hpeffley@hmc.psu.edu

PennState Health
Milton S. Hershey Medical Center

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

Employment Opportunity in the Beautiful Adirondack Mountains of Northern New York

Current Opening for a full-time, Hospital Employed Hospitalist. This opportunity provides a comfortable 7 on/7 off schedule, allowing ample time to enjoy all that the Adirondacks have to offer!

Come live where others vacation!

- Convenient schedules
- Competitive salary & benefits
- Unparalleled quality of life
- Family friendly community
- Excellent schools
- Nearby Whiteface Mountain ski resort
- Home of the 1932 & 1980 Winter Olympics and current Olympic Training Center
- Annual Ironman Competition
- World Cup Bobsled and Ski Events
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Hike, fish, ski, golf, boat or simply relax and take in the beauty and serenity of the Adirondack Mountains

Contact: Joanne Johnson
518-897-2706
jjohnson@adirondackhealth.org
www.adirondackhealth.org

ADIRONDACK HEALTH

UNIVERSITY OF MICHIGAN
DIVISION OF HOSPITAL MEDICINE

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

The University of Michigan, Division of Hospital Medicine seeks BC/BE 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. An educational loan forgiveness program provides up to $50,000 in loan forgiveness for qualifying educational loans.

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

Mail or email cover letter and CV to:
Mail Vineet Chopra, MD, MSc, Chief, Division of Hospital Medicine,
UH South Unit 4, 1500 East Medical Center Drive, Ann Arbor, MI 48109-5226
Email **kcreed@umich.edu**

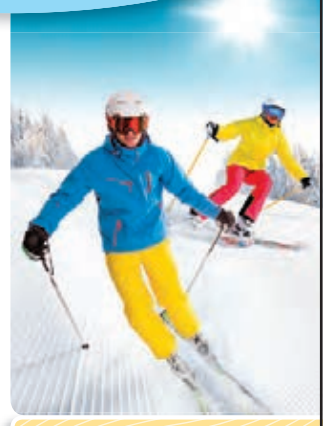
WWW.MEDICINE.UMICH.EDU/HOSPITAL-MEDICINE

Physician-Led Medicine in Montana
Hospitalist

Billings Clinic

BE/BC Hospitalist (Internal Medicine/ Family Medicine) for Montana's premier tertiary referral center and accredited Chest Pain Center.

- Flexible scheduling, day/night openings
- Work-life balance
- Generous compensation package
- Integrated 50+ specialty group practice
- "America's Best Town of 2016" Outside Magazine



Billings Clinic is nationally recognized for clinical excellence and is a proud member of the **Mayo Clinic Care Network.** Located in Billings, Montana – this friendly college community is a great place to raise a family near the majestic Rocky Mountains. Exciting outdoor recreation close to home. 300 days of sunshine!

#1 Hospital in Montana
U.S.News & World Report usnews.com

Contact: Rochelle Woods
1-888-554-5922
physicianrecruiter@ billingsclinic.org
billingsclinic.com

Chair, Division of Hospital Medicine

at Lahey Hospital & Medical Center

The Division of Hospital Medicine at Lahey Health, headquartered in Burlington Massachusetts, is actively seeking an experienced physician leader to manage and operate Hospital Medicine Services within our geographically distributed system of hospitals located North of Boston. The Hospital Medicine group is comprised of approximately 63 physician FTEs, and 24 FTE advanced care providers responsible for approximately 11,000 discharges annually, and all committed to providing high quality patient-centered care. Our hospitalists enjoy a high level of collegiality and a supportive environment in which individual contributions are recognized and true team spirit is fostered and expected. The Chair of Hospital Medicine at Lahey Health reports to the Chair of the Department of Medicine.

Lahey Health is a progressive and highly regarded integrated healthcare system offering a continuum of care that includes three Truven Health Analytics top 100 hospital organizations in the country: Lahey Hospital & Medical Center, a renowned 317-bed, Tufts-affiliated Teaching Hospital; Winchester Hospital, perennially voted the top hospital to work for in Massachusetts; and Beverly Hospital, recognized by Blue Cross and Blue Shield for two years running as the top quality hospital in all of Massachusetts. Lahey Health also includes outpatient centers, primary care providers and specialists, behavioral health services, post-acute programs such as home health services, skilled nursing and rehabilitation facilities, and senior care resources located throughout northeastern Massachusetts and southern New Hampshire.

Lahey is dedicated to the goal of building a culturally diverse and pluralistic organization committed to caring for patients and ourselves in a multicultural environment. We strongly encourage applications from minorities and women.

It is expected that the Chair of Hospital Medicine will:

- Work and collaborate with physician, nursing and administrative leadership as a triad in achieving high quality, patient centric, and cost effective care.
- Collaborate effectively with the other Divisions within the Department of Medicine, and with the Departments of Emergency Medicine and Surgery, as well as community practitioners.
- Develop and implement quality improvement goals and objectives that are aligned with Lahey's organizational strategy.
- Provide high quality clinical care.
- Serve as a supportive role model and mentor to other members of the Division.
- Develop and conduct annual performance evaluations for all clinicians.
- Lead the recruitment and retention of physicians and advanced practitioners.
- In collaboration with administrative and finance staff, develop and manage to the annual budget for the Division.
- Actively support the educational mission of the Division in the teaching of medical students and residents, and in Lahey's CME programs.
- Develop a program of research which is inclusive and aligned with the clinical and quality improvement mission of the Division.

Candidates for this position:

- Must be Board Certified in Internal Medicine and eligible for licensure in Massachusetts.
- Should have a minimum of 5 years' experience working as a hospitalist, and at least 2 years' experience in a leadership role.
- Should have attained fellowship in the Society of Hospital Medicine and/or fellowship of the American College of Physicians.
- Should possess strong clinical, managerial and leadership skills, and demonstrate a high level of emotional and social intelligence.

For consideration and/or additional details, please contact:

David T Martin, MD, FRCP, MACP
Chair, Department of Medicine Lahey Hospital & Medical Center
41 Mall Road, Burlington, MA 01805
Email: david.t.martin@lahey.org

Lahey Health

LaheyHealth.org/Careers

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HOSPITALIST

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

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

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

Successful candidates require the following:

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

For further consideration, please send your CV to:

Brian McGillen, MD – Director, Hospital Medicine
Penn State Milton S. Hershey Medical Center
c/o Heather Peffley, PHR FASPR – Physician Recruiter
hpeffley@hmc.psu.edu

PennState Health
Milton S. Hershey Medical Center

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

Hospitalists & Nocturnists

Greater St. Louis Area

Mercy Clinic is seeking Hospitalists and Nocturnists to join established Hospitalist teams at various hospital locations throughout the Greater St. Louis area.

Positions Offer:

- Competitive base salary, quarterly bonus and incentives
- Attractive block schedule
- System-wide EPIC EMR
- Comprehensive benefits including health, dental, vacation and CME
- Relocation assistance and professional liability coverage
- Closed ICU
- No procedures
- No restrictive covenant

For more information, please contact:

Joan Humphries
Director, Physician Recruitment
p 314.364.3821 | f 314.364.2597
Joan.Humphries@mercy.net

AA/EEO/Minorities/Females/Disabled/Veterans

Mercy

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2017

The Ohio State University Wexner Medical Center

BEST HOSPITALS USNews NATIONAL 2016-17

Join a Leader in Hospital Medicine

As one of the nation's largest academic hospitalist programs, we offer a variety of teaching and non-teaching inpatient and consultative services.

OSUWMC Division of Hospital Medicine is dedicated to the health and well-being of our patients, team members, and the OSUWMC community. We are currently seeking exceptional individuals to join our highly regarded team. We focus on improving the lives of our patients and faculty by providing personalized, patient-centered, evidence-based medical care of the highest quality. Our clinical practice meets rigorous standards of scholarship, and we are devoted to serving as expert educators and mentors to the next generation of physicians.

Preferred candidates are BC/BE in Internal Medicine or Internal Medicine-Pediatrics, have work experience or residency training at an academic medical center, and possess excellent inpatient, teamwork, and clinical skills.

We are an Equal Opportunity/Affirmative Action Employer, Qualified women, minorities, Vietnam-era and disabled Veterans, and individuals with disabilities are encouraged to apply. This is not a J-1 opportunity.

Our faculty enjoy:

- Manageable clinical workload
- Flexible scheduling options
- Competitive salary & bonus
- Comprehensive benefit package
- Faculty appointment commensurate with experience
- Research & teaching opportunities
- Ongoing education and development programs
- Occurrence-based malpractice
- Relocation allowance

Practice Locations:

- University Hospital • University Hospital East
- James Cancer Hospital & Solove Research Institute
- Richard M. Ross Heart Hospital
- Dodd Rehabilitation Hospital
- OSU Harding Hospital
- Nationwide Children's Hospital (Med-Peds)

We are interviewing competitive applicants!

Forward your letter of interest and CV:

Natasha Durham, DASPR
http://go.osu.edu/hospitalmedicine
hospitalmedicine@osumc.edu
614/366-2360

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Hospitalists

Philadelphia, PA

Einstein Healthcare Network is seeking Hospitalists in both Philadelphia and Elkins Park, PA (Einstein Practice Plan, Inc., Elkins Park, PA).

In this role, you will diagnose and treat inpatient patients, providing continuous care; prescribe medications and treatment regimens; admit patients for hospital stays; write patient discharge summaries; conduct discharge planning and discharge patients; order and interpret results of tests, such as laboratory and x-rays; communicate with primary care physicians; refer patients to medical specialists, social services or other professionals as needed; attend inpatient consultations in areas of specialty; apply leadership and teaching skills; utilize medical simulation; and supervise up to 3 physician assistants.

Qualifications include MD or DO (or foreign equivalent); Pennsylvania medical license; 36 months of ACGME-approved residency in internal medicine; 12 months as a Hospitalist or similar; and experience in an acute care setting, including ICU patient care, ventilation management, cardiac stress tests, EKG interpretation and emergency department management that included ACS and acute stroke patients.

EHN offers a compensation package, including CME allowance, a pension plan, excellent health insurance, coverage for relocation expenses, and other benefits.

Reply to Kim Hannan at HannanKi@einstein.edu.

Einstein HEALTHCARE NETWORK

EOE

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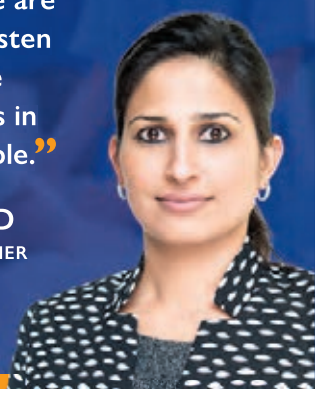
THIS IS YOUR PRACTICE

"At CEP America, we are truly valued. They listen to our input and are willing to support us in whatever way possible."

Gurvinder Kaur, MD
HOSPITAL MEDICINE PARTNER



CEP America currently has hospitalist, intensivist, and skilled nursing practices in California, Illinois, New Jersey, and Oregon, some with sign-on bonuses up to $100,000.

And we sponsor visa candidates!

CALIFORNIA
- Fresno
- Modesto
- Redding
- Sacramento
- San Diego
- San Jose
- San Mateo
- San Francisco
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ILLINOIS
- Alton

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- Passaic

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- Roseburg

INTERESTED IN TRAVEL?
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LOOKING TOWARD MANAGEMENT?
Apply for our Administrative Fellowship.

Visit go.cep.com/myteam2017
to see a full list of our hospitalist and leadership opportunities.

CEP America

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and thousands of communities nationwide

JOIN OUR HOSPITAL MEDICINE TEAM

Medical Director Opportunities at:
Kendall Regional Medical Center, Miami
Mercy Hospital, Miami
St. Lucie Medical Center, Port St. Lucie

Regional Medical Director Opportunity for South Florida area

Benefits
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- Malpractice Insurance
- Leadership Development Opportunities
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- Exceptional Quality of Practice

Apply by sending your resume to
inpatientjobs@evhc.net

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Atlantis, FL

To learn more, visit www.the-hospitalist.org and click "Advertise"or contact Heather Gonroski • 973-290-8259 • hgonroski@frontlinemedcom.com or Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

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MASSACHUSETTS – HOSPITALIST POSITIONS AVAILABLE

Location, Location, Location

Come join our well established hospitalist team of dedicated hospitalist at Emerson Hospital located in historic Concord, Massachusetts. Enjoy living in the suburbs with convenient access to metropolitan areas such as Boston, New York and Providence as well as the mountains, lakes and coastal areas. Opportunities available for hospitalist and nocturnists; full time, part time, per diem and moonlighting positions, just 25 minutes from Boston. A great opportunity to join a well established program.

- Manageable daily census
- Flexible scheduling to ensure work life balance
- Dedicated nocturnist program
- Intensivists coverage of critical care unit
- Competitive compensation and bonus structure
- Comprehensive benefit package including CME allowance
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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

Emerson Hospital
Premium Care. Personal Touch.
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The Practice You've Always Wanted in the Hometown You've Always Dreamed About

- Physician owned and managed
- Enjoy an outstanding employment package
- Bask in the beauty of a mild climate, stunning lakes and pristine national forests

Hospitalist positions are now available. Learn more at NAzHospitalists.com

Sandy: SBetter@yrmc.org
(928) 771-5487

NOW RECRUITING new team members who share our passion for hospital medicine. Talk to us about becoming part of the NAzH team.

NAzH NORTHERN ARIZONA HOSPITALISTS
NazHospitalists.com ▪ Prescott, Arizona

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shm The Hospitalist

Berkshire Health Systems is currently seeking BC/BE Internal Medicine & Med/Peds physicians to join our comprehensive Hospitalist Department

- Day, Evening and Nocturnist positions
- 7 on/7 off 10 hour shift schedule
- 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
- A major teaching affiliate of the University of Massachusetts Medical School
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We understand the importance of balancing work with a healthy personal lifestyle

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- 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 at
Emahan@bhs1.org or apply online at
www.berkshirehealthsystems.org

Berkshire Health Systems

To advertise in *The Hospitalist* or *The Journal of Hospitalist Medicine*

Contact:

Heather Gonroski • 973.290.8259
hgonroski@frontlinemedcom.com

or

Linda Wilson • 973.290.8243
lwilson@frontlinemedcom.com

shm Society of Hospital Medicine The Hospitalist

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A Service of Dignity Health Medical Foundation

INSPIRE greatness

At Mercy Medical Group, a service of Dignity Health Medical Foundation, we lead by example. By always striving to give our personal best—and encouraging our patients and colleagues to do the same—we're able to achieve and do more than we ever imagined. If you're ready to inspire greatness in yourself and others, join us today.

HOSPITALISTS - Sacramento, CA

Full-time and part-time openings are available, as are opportunities for Nocturnists. At our large multi-specialty practice with approximately 450 providers, we strive to offer our patients a full scope of healthcare services throughout the Sacramento area. Our award-winning Hospitalist program has around 70 providers and currently serves 4 major hospitals in the area.

Sacramento offers a wide variety of activities to enjoy, including fine dining, shopping, biking, boating, river rafting, skiing and cultural events.

Our physicians utilize leading edge technology, including EMR, and enjoy a comprehensive, excellent compensation and benefits package in a collegial, supportive environment.

For more information, please contact:
Physician Recruitment
Phone: 888-599-7787 | Email: providers@dignityhealth.org
www.mymercymedgroup.org
www.dignityhealth.org/physician-careers

These are not J1 opportunities.

Make an impact
as part of our Hospitalist team.

Christiana Care Health System, one of the nation's largest health care providers and ranked No. 3 in the Philadelphia region by *U.S. News & World Report*, is recruiting for Internal Medicine physicians to join our progressive academic hospitalist program in our acute care hospitals located in Newark and Wilmington, Delaware. Christiana Care is a Level-I Trauma Center with more than 1,100 beds and is ranked 21st in the nation for hospital admissions.

Qualified candidates must possess excellent clinical, communication and interpersonal skills; work collaboratively; and enjoy teaching. Hospitalists are encouraged to be thought leaders through participation in team initiatives and projects.

We offer flexible schedules, competitive salary/benefits, relocation reimbursement and generous time off. Living in Delaware offers low taxes, excellent dining and cultural venues, and short drives to Philadelphia, New York City, and all Delaware and New Jersey beach resorts.

Take your hospitalist career further. Submit your CV to Amy Bird at **abird@christianacare.org**.

EEO/AA/Vet/Disability Institution

CHRISTIANA CARE HEALTH SYSTEM

HOSPITALISTS/ NOCTURNISTS
NEEDED IN SOUTHEAST LOUISIANA

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

- Hospital Medicine was established at Ochsner in 1992. We have a stable 50+ member group
- 7 on 7 off block schedule with flexibility
- Dedicated nocturnists cover nights
- Base plus up to 50 K in incentives
- Average census of 14-18 patients
- E-ICU intensivist support with open ICUs at the community hospitals
- EPIC medical record system with remote access capabilities
- Dedicated RN and Social Work Clinical Care Coordinators
- Community based academic appointment
- The only Louisiana Hospital recognized by US News and World Report Distinguished Hospital for Clinical Excellence award in 4 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

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

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

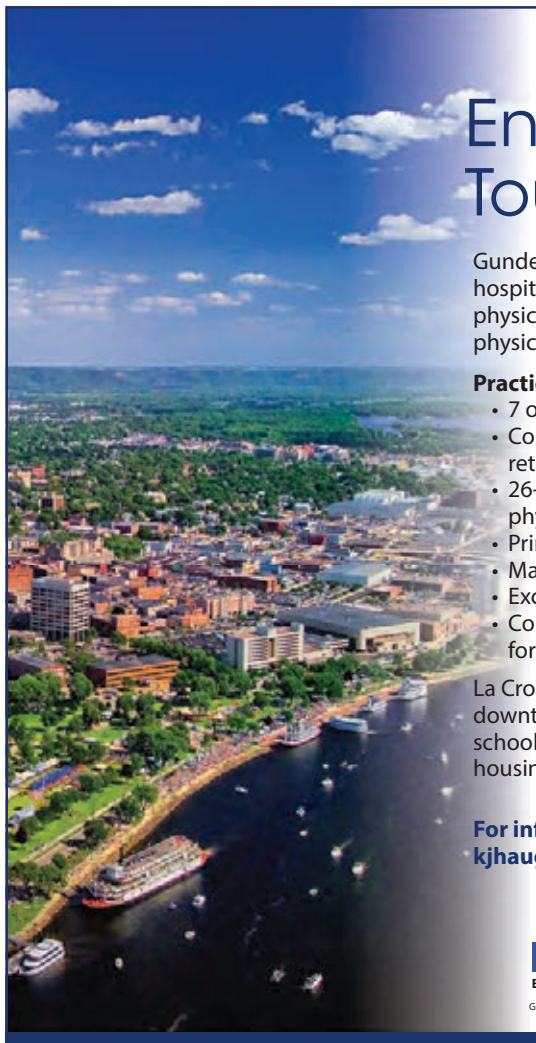
Reference # SHM2017.

Ochsner Health System

Sorry, no opportunities for J1 applications.

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

To learn more, visit www.the-hospitalist.org and click "Advertise"or contact
Heather Gonroski • 973-290-8259 • **hgonroski@frontlinemedcom.com** or
Linda Wilson • 973-290-8243 • **lwilson@frontlinemedcom.com**



Enriching Every Life We Touch…Including Yours!

Gundersen Health System in La Crosse, WI is seeking an IM trained hospitalist to join its established team. Gundersen is an award winning, physician-led, integrated health system, employing nearly 500 physicians.

Practice highlights:

- 7 on 7 off schedule (26 weeks per year) 3 shifts per 24 hour period
- Collaborative, cohesive hospitalist team established in 2002 with high retention rate and growth
- 26-member internal medicine hospitalist team comprised of 16 physicians and 10 associate staff
- Primary responsibility is adult inpatient care
- Manageable daily census
- Excellent support and collegiality with subspecialty services
- Competitive compensation and benefits package, including loan forgiveness

La Crosse is a vibrant city, nestled along the Mississippi River. The historic downtown and riverfront host many festivals and events. Excellent schools and universities, parks, sports venues, museums and affordable housing make this a great place to call home.

For information contact Kalah Haug, Medical Staff Recruitment, at kjhaug@gundersenhealth.org. or (608) 775-1005.

Equal Opportunity Employer

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GUNDERSEN HEALTH SYSTEM®
Where Caring Meets Excellence

St Luke's UNIVERSITY HEALTH NETWORK

Hospitalist/Nocturnist Opportunities in PA Starting Bonus and Loan Repayment

St Luke's University Health Network (SLUHN) has hospitalist and nocturnist opportunities in eastern Pennsylvania for BC/BE physicians. Nocturnist opportunities are available at our Bethlehem Campus with additional opportunities at our Anderson, Miners, Allentown and our newest hospital in Monroe County that opened in October of 2016.

We offer:

- Starting bonus and up to $100,000 in loan repayment
- 7 on/7 off schedules
- Additional stipend for nights
- Attractive base compensation with incentive
- Excellent benefits, including malpractice, moving expenses, CME

SLUHN is a non-profit network comprised of physicians and 7 hospitals, providing care in eastern Pennsylvania and western NJ. We employ more than 500 physician and 200 advanced practitioners. St. Luke's currently has more than 180 physicians enrolled in internship, residency and fellowship programs and is a regional campus for the Temple/St. Luke's School of Medicine. Visit **www.slhn.org**

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

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

Join the largest physician-led and governed medical group in Illinois!

IMMEDIATE OPENINGS-Advocate Medical Group (AMG), a part of **Advocate Health Care**, is actively recruiting **HOSPITALISTS** for growing teams across metro Chicago.

- Flexible 7 on7 off scheduling
- Manageable daily census
- Established, stable program with 90+ providers
- First-rate specialist support
- Comprehensive benefits, relocation & CME allowance

AMG is a part of Advocate Health Care, the largest health system in Illinois & one of the largest health care providers in the Midwest. Over 1600+ physicians representing 50+ medical/surgical specialties comprise AMG.

Submit CV & cover letter to Rebecca.bork@advocatehealth.com

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PITTSBURGH

The Department of Medicine at University of Pittsburgh and UPMC is seeking an experienced physician as an overall director of its Academic Hospitalist Programs within five teaching hospitals. The individual will be responsible for development of the strategic, operational, clinical and financial goals for Academic Hospital Medicine and will work closely with the Medical Directors of each the five Academic Hospitalist programs. We are seeking a candidate that combines academic and leadership experience. The faculty position is at the Associate or Professor level. Competitive compensation based on qualifications and experience.

Requirements: Board Certified in Internal Medicine, significant experience managing a Hospitalist Program, and highly experienced as a practicing Hospitalist.

Interested candidates should submit their curriculum vitae, a brief letter outlining their interests and the names of three references to:

Wishwa Kapoor, MD c/o Kathy Nosko
200 Lothrop Street
933 West MUH
Pittsburgh, PA 15213
Noskoka@upmc.edu • Fax 412 692-4825

EO/AA/M/F/Vets/Disabled

Johnston Memorial Hospital
Mountain States Health Alliance

HOSPITALISTS & NOCTURNISTS

Johnston Memorial Hospital, located in Historic Abingdon, Virginia, is currently seeking Full Time BE/BC, Day Shift Hospitalists and Nocturnists to join their team. These are Full Time positions with the following incentives:

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More thoughts about hospitalist burnout

Increasing attention, resources directed at wellness initiatives

By John Nelson, MD, MHM

I wrote about physician burnout and well-being in the July 2017 version of this column, and am still thinking a great deal about those issues. In the past 6 months, I can't identify anything that strikes me as a real breakthrough in addressing these issues. However, the ever-increasing attention and resources directed at physician burnout and wellness, on both a local and national level, strike me as reason for cautious optimism.

A chief wellness officer

In summer 2017, Stanford (Calif.) University created a new physician executive role called chief wellness officer (CWO). As far as I am aware, this is the first such position connected with a hospital or medical school. It will be interesting to see if other organizations create similar positions, although I suspect that, in places where it is explicitly recognized as a priority, responsibility for this work will be one of the many duties of a chief medical officer or other such executive, and not a position devoted solely to wellness. Interestingly, an Internet search revealed that some non–health care businesses have executive positions with that title, though the role seems focused more on physical health – as in exercise and smoking cessation – than emotional well-being and burnout.

According to a statement on the Stanford Medicine website, the new CWO will work with colleagues to continue "building on its innovative WellMD Center, which was established in 2016. The center has engaged more than 200 physicians through programs focusing on peer support, stress reduction, and ways to cultivate compassion and resilience, as well as a literature and a dinner series in which physicians explore the challenges and rewards of being a doctor. The center also aims to relieve some of the burden on physicians by improving efficiency and simplifying workplace systems, such as electronic medical records."

A national conference

Over the last 2 or 3 years many, if not most, physician conferences, including the SHM annual conference, have added some content around physician burnout and well-being. But for the first time I'm aware of, an entire conference, the American Conference on Physician Health, addressed these topics in San Francisco in October 2017, and attracted 425 attendees along with an all-star faculty. I couldn't attend myself, but found a reporter's summary informative and I recommend it.

While the summary didn't suggest the conference provided a cure or simple path to improvement, I'm encouraged that the topic has attracted the attention of some pretty smart people. If there is a second edition of this conference, I'll try hard to attend.

Worthwhile web resources

The home page of Stanford's WellMD Center provides a continuously updated list of recent research publications on physician health and links to many other resources, and is worth bookmarking.

Another great educational resource for physician wellness is the AMA's STEPS Forward, a site devoted to practice improvement that provides guidance on patient care, work flow and process, leading change, technology and finance, as well as professional well-being. Of the five separate education modules in the latter category, I found the one on "Preventing Physician Burnout" especially informative. The site is free, doesn't require an AMA membership, and can provide CME credit.

Making a difference locally: Individuals

Surveys, research, and the experience of experts available via the above resources and others are very valuable, but may be hard to translate into action for you and your fellow local caregivers. My sense is that many hospitalists address their own work-related distress by simply working less in total – reducing their full-time equivalents. That may be the most tangible and accessible intervention, and undeniably the right thing to do in some cases. But it isn't an ideal approach for our field, which faces chronic staffing shortages. And it doesn't do anything to change the average level of distress of a day of work. I worry that many people will find disappointment if working fewer shifts is their only burnout mitigation strategy.

Ensuring that you have some work-related interest outside of direct patient care, such as being the local electronic health record expert, or even the person leading formation of a support committee, can be really valuable. I first addressed this topic in the June 2011 issue of THE HOSPITALIST, and there is a long list of things to consider: mindfulness, practicing "self-compassion," cultivating deeper social connections in and out of the workplace, etc. Ultimately, each of us will have to choose our own path, and for some that should include professional help, e.g., from a mental health care provider.

But as a colleague once put it, a focus on changing ourselves is akin to just learning to take a punch better. A worthwhile endeavor, but it's also necessary to try to decrease the number of punches thrown our way.

Making a difference locally: Medical staff

I'm part of the Provider Support Committee at my hospital, and I have concluded that nearly every hospital should have a group like this. Our own committee was modeled after the support committee at a hospital 5 miles away, and both groups see value in collaborating in our efforts. In fact, a person from each hospital's committee serves on the committee at the other hospital.

These committees have popped up in other institutions, and many have been at it longer than at my hospital. But they all seem to share a mission of developing and implementing programs to position caregivers to thrive in their work, increase resilience, and reduce their risk of burnout. Some interventions are focused on making changes to an EHR, work schedules, work flows, or even staffing levels (i.e., reducing the "number of punches"). Other efforts are directed toward establishing groups that support personal reflection and/or social connections among providers.

A review of activities undertaken by seven different organizations is available at the AMA STEPS Forward Preventing Physician Burnout website (click on "STEPS in practice").

"While the summary didn't suggest the conference provided a cure or simple path to improvement, I'm encouraged that the topic has attracted the attention of some pretty smart people. If there is a second edition of this conference, I'll try hard to attend."

Dr. Nelson has had a career in clinical practice as a hospitalist starting in 1988. He is cofounder and past president of SHM, and principal in Nelson Flores Hospital Medicine Consultants. He is codirector for SHM's practice management courses. Contact him at john.nelson@nelsonflores.com

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