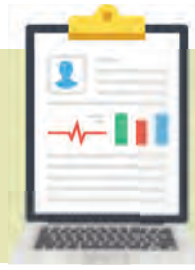
BRIAN HARTE, MD, SFHM

Evolution of a movement

PAGE 45



INNOVATIONS

- Hospitalist-patient partnerships
- Tools for more efficient admissions
- Enlisting social networks

PAGE 21

STEVEN M. HARRIS, ESQ.

Practice setting transitions

PAGE 46

The Hospitalist

VOLUME 21 No. 4 | APRIL 2017

AN OFFICIAL PUBLICATION OF THE SOCIETY OF HOSPITAL MEDICINE

PREVIEW HM17 LAS VEGAS

SHM's Annual Meeting Preview

Articles by Richard Quinn

HM17 is the Super Bowl of hospital medicine. It's the only meeting dedicated to hospitalists, designed by hospitalists, and focused purely on issues important to hospitalists. This year, the Society of Hospital Medicine returns to Las Vegas, May 1-4, at Mandalay Bay Resort and Casino, with expectations of record-setting crowds and a comprehensive array of educational and networking opportunities. Inside, 7 pages of insights into what's new this year, keynote speakers, and must-see sessions.

2017 HOSPITAL MEDICINE

MAY 1-4, 2017

MANDALAY BAY RESORT AND CASINO

LAS VEGAS, NEVADA

Q&A

SHM MEMBER SPOTLIGHT

FHM designation symbolizes physician commitment to hospital medicine

Umesh Sharma, MD, MBA, FHM, utilizes SHM leadership resources in practice at Mayo Clinic

SEE PAGE 8

THE HOSPITALIST
151 Fairchild Ave.,
Suite 2,
Plainview, NY 11803-1709

CHANGE SERVICE REQUESTED

Presorted Standard
U.S. Postage
PAID
Permit No. 384
Lebanon Jct. KY

shm Society of Hospital Medicine

the-hospitalist.org

2016 APEX AWARDS FOR PUBLICATION EXCELLENCE

Disappointment in article on NP, PA roles in HM groups

Editor's note: *The following "Letter to the Editor" was first emailed to the Society of Hospital Medicine, its board president, and John Nelson, MD, MHM, the author of the article, "Hospitalist Roles for NPs and PAs," which was published in the January 2017 issue. All parties agreed to publish the email exchange in* The Hospitalist.

From: Harris, Marci [mailto:Marci.Harris@bannerhealth.com]
Sent: Sunday, February 12, 2017 9:59 AM
To: Publications@hospitalmedicine.org; Communications@hospitalmedicine.org; John Nelson <john.nelson@nelsonflores.com>
Cc: bharte@hospitalmedicine.org
Subject: Offensive article on hospitalist roles for NPs, PAs

All,

I have been a hospitalist NP (nurse practitioner) for a decade and found the article in the January issue of The Hospitalist, Volume 21, Number 1, on the Hospitalist Roles for NPs and PAs, offensive and uninformed, with an intolerable amount of personal opinion not backed by research.

I am disappointed that The Hospitalist would publish such a low-class article. Your [magazine] promotes membership to all APPs (advanced practice providers), yet you publish articles that show a study with a positive finding yet allow and highlight an incredibly negative and offensive snippet. The highlighted box states that "Any group that thinks this study is evidence that adding more APPs and having them manage a high number of patients relatively independently will go well in any setting is MISTAKEN ... But it does offer a STORY of one place where, with careful planning and execution, it went OK."

I can only say that the physicians, APPs, and hospital group who did this study would likely also be offended for taking their study and turning it into a "story."

EDUCATE yourselves. There are numerous studies out there showing care by APP's is cost effective, efficient, and with excellent care outcomes. There is a national group, APPex (Advanced Practice Provider Executives), that can give you all the studies you would want showing this information. Or contact the national NP or PA groups.

I am a working hospitalist NP and appreciate my physician colleagues and have their respect. This "John" person obviously doesn't respect APPs and to publish him is just disheartening.

This publication could have and should have done better. You have one APP on your editorial advisory board – it appears you need more.

Marci Harris, MSN, FNP, ACNP
Acute Care Nurse Practitioner
Hospitalist/Internal Medicine
McKee Medical Center, Loveland, Colo.

Dr. Nelson responds:

Thanks for your message, Marci. It seems clear you've thought a lot about NPs and PAs in hospitalist practices and have arrived at conclusions that differ from what I wrote. Your voice and views are welcome.

I certainly didn't intend to offend anyone, including those who might see all of this very differently from me.

As I mention in the first paragraph, I'm very supportive of NPs and PAs in hospitalist practices. And I wanted to write about this particular study precisely because it provides data that is very supportive of their contributions.

The point I was trying to make in the column is that there is value in careful planning around roles and who does what. A sports team could recruit the most talented players but still won't perform well if they don't develop and execute a good plan around who does what and how they work together. Simply having talented people on the team isn't enough. I think the same is true of hospitalist teams.

The hospitalist group in the study has an impressively detailed plan for new provider (APC and MD alike) orientation and has a lot of operating processes that help ensure the PAs and MDs work effectively together. My experience is that many hospitalists groups have never developed such a plan.

—John Nelson, MD, MHM
Partner, Nelson Flores Hospital Medicine Consultants, Bellevue, Wash.

Correction

In the article "Hot-button issue: physician burnout," published in the February 2017 issue, a quotation was errantly attributed to the wrong source. Dr. Jon Yoon was the hospitalist who said: "In the contemporary medical literature, we have been encouraged to adopt the concepts and practices of industrial engineering and quality improvement. In other words, it seems that to the extent physicians' aspirations to practice good medicine are confined to the narrow and unimaginative constraints of mere scientific technique (more data, higher 'quality,' better outcomes) physicians will struggle to recognize and respond to their practice as meaningful. There is no intrinsic meaning to simply being a 'cog' in a medical-industrial process or an 'independent variable' in an economic equation."

The Hospitalist
Volume 21 Number 4 April 2017

THE HOSPITALIST is the official newspaper of the Society of Hospital Medicine, reporting on issues and trends in hospital medicine. THE HOSPITALIST reaches more than 35,000 hospitalists, physician assistants, nurse practitioners, medical residents, and healthcare administrators interested in the practice and business of hospital medicine. Content for THE HOSPITALIST is provided by Frontline Medical Communications. Content for the Society Pages is provided by the Society of Hospital Medicine.

POSTMASTER: Send changes of address (with old mailing label) to THE HOSPITALIST, Subscription Service, 151 Fairchild Ave., Suite 2, Plainview, NY 11803-1709.

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

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

THE HOSPITALIST (ISSN 1553-085X) is published monthly for the Society of Hospital Medicine by Frontline Medical Communications Inc., 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609. Print subscriptions are free for Society of Hospital Medicine members. Annual paid subscriptions are available to all others for the following rates:

Individual: *Domestic* – $175 (One Year), $327 (Two Years), $471 (Three Years) *Canada/Mexico* – $258 (One Year), $475 (Two Years), $717 (Three Years) *Other Nations-Surface* – $319 (One Year), $615 (Two Years), $901 (Three Years) *Other Nations-Air* – $410 (One Year), $795 (Two Years), $1,204 (Three Years)
Institution: *United States* – $364; *Canada/Mexico* – $441 *All Other Nations* – $511
Student/Resident: $51

Single Issue: *Current* – $35 (US), $47 (Canada/Mexico), $59 (All Other Nations) *Back Issue* – $47 (US), $59 (Canada/Mexico), $71 (All Other Nations)
To initiate a paid subscription, contact Subscription Services at 1-800-480-4851or frontline@emscirc.com

Letters to the Editor: jcarris@frontlinemedcom.com

Society of Hospital Medicine
FRONTLINE MEDICAL COMMUNICATIONS
BPA Worldwide is a global industry resource for verified audience data and *The Hospitalist* is a member.
2016 APEX AWARDS FOR PUBLICATION EXCELLENCE

To learn more about SHM's relationship with industry partners, visit www.hospitalmedicine.com/industry.

CMS recognizes Society of Hospital Medicine's Center for Quality Improvement

A shared hospital patient safety network reduces patient harm, saves lives, and reduces costs.

From staff reports

PHILADELPHIA – The Society of Hospital Medicine (SHM)'s Center for Quality Improvement (QI) has been distinguished by the Centers for Medicare & Medicaid Services for maintaining an ongoing collaborative partnership with CMS to enhance patient safety.

The letter of recognition from Paul McGann, MD, Jean Moody-Williams, RN, MPP, and Dennis Wagner, MPA, of the CMS, to Jenna Goldstein, MA, director of SHM's Center for QI, and Kevin Vuernick, MPA, senior project manager, noted: "Over the last several years, our team has been privileged to partner with you and the Society of Hospital Medicine on the work of quality improvement and patient safety. Without relationships like these, the results in the reduction of patient harm we have seen at a national scale, saving 87,000 lives and nearly $20 billion in cost savings, would never have been possible."

"This recognition by CMS demonstrates the tangible impact that SHM has not only on its members, but also on their patients and their institutions," said Beth Hawley, MBA, SFHM, FACHE, chief operating officer of SHM. "We look forward to even more partnerships that can ultimately lead to improved patient care."

In August 2016, CMS' Hospital Improvement Innovation Networks contacted SHM to participate in their weekly Partnership for Patients (PfP) Pacing Event webinar to present strategies for reducing opioid use and preventing adverse drug events, including SHM's Mentored Implementation pilot program on Reducing Adverse Drug Events Related to Opioids (RADEO). SHM's contribution to this webinar was twofold: Thomas W. Frederickson, MD, the lead author of the RADEO guide and one of two program mentors, spoke about the development of the RADEO program and its importance in the acute care setting. Matthew Jared, MD, a hospitalist at St. Anthony Hospital in Oklahoma City, one of the five pilot RADEO sites, discussed his experience implementing specific RADEO interventions as well as the mentoring provided by Dr. Frederickson of the department of hospital medicine at CHI Health in Omaha, Neb.

Jenna Goldstein, MA, director of SHM's Center for QI, and Kevin Vuernick, MPA, senior project manager, show off the letter of recognition for "maintaining an ongoing collaborative partnership with CMS to enhance patient safety."

As a result of this successful partnership, SHM was contacted in January to provide its perspective on best practices in managing inpatients receiving opioids and adverse drug event data collection. At that time, Mr. Vuernick discussed the lessons learned between RADEO's pilot program and the second iteration of RADEO, which launched in November 2016.

"[SHM's] Center for QI is extremely proud to be at the forefront of addressing opioid use and monitoring of patients receiving opioids and is honored to be recognized for the work that it has done," Mr. Vuernick said, "We are looking forward to new opportunities to partner with the CMS on their PfP events, as well as continuing to work to ensure patient safety in the hospital."

For more information about SHM's Center for QI, please visit www.hospitalmedicine.org/QI. For more information about SHM and hospital medicine, visit www.hospitalmedicine.org and follow SHM on Twitter at @SHMLive. TH

Q&A

FHM designation symbolizes physician commitment to hospital medicine

Umesh Sharma, MD, MBA, FHM, utilizes SHM leadership resources in practice at Mayo Clinic

By Felicia Steele

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

This month, The Hospitalist spotlights Umesh Sharma, MD, MBA, FHM, chair of the division of community hospital medicine at Mayo Clinic. Umesh became a Fellow in Hospital Medicine in 2016 and has found great value in attending the annual meeting each year.

Question: What inspired you to join SHM, and what prompted you to apply for the Fellow in Hospital Medicine designation?

Answer: I initially heard about SHM through colleagues when discussing their educational experience at SHM's annual meetings. SHM promotes the interests of hospitalists and hospital medicine as a growing specialty, and becoming a member provided me with opportunities to connect and network with my peers both virtually and in person. For me, becoming a Fellow in Hospital Medicine was a natural progression of my membership; it is an embodiment of dedication and commitment to the hospital medicine movement that also helps distinguish me as a leader in the field.

Q: How did you use SHM resources to help you in your pathway to Fellowship in Hospital Medicine?

A: There are specific eligibility requirements for the Fellow in Hospital Medicine designation, including a minimum of 5 years as a practicing hospitalist and 3 years as an SHM member, endorsements from two active members, regular meeting attendance and more. SHM provides a checklist for Fellow applicants online and an FAQ page to make the application process as user-friendly as possible. A friend of mine, Dr. Deepak Pahuja, is a Fellow, and he mentored me throughout the process.

Q: How else has SHM contributed to your professional growth and provided you with tools you need to lead hospitalists at Mayo Clinic?

A: There are many resources that SHM provides to help with professional growth both online and at in-person meetings. I referenced the *Key Principles and Characteristics of an Effective Hospital Medicine Group*, an online assessment guide, in my role as department chair in La Crosse, Wisc., to resurrect a hospital medicine group, secure resources, hire career hospitalists, and create a well-functioning, well-managed, efficient, effective group with zero turnover during a span of 4 years.

By focusing on the leadership track at annual meetings, I have been able to gain knowledge on proven leadership strategies and enhance my skills, which I have applied on many occasions in my practice.

—*Umesh Sharma, MD, MBA, FHM*

By focusing on the leadership track at annual meetings, I have been able to gain knowledge on proven leadership strategies and enhance my skills, which I have applied on many occasions in my practice. Being able to talk to multisite hospital medicine group colleagues in person helped me to learn best practices in how to successfully manage the integration of 14 hospital medicine community hospital sites across Mayo Midwest. I was able to get ideas on effectively understanding and managing challenges, like recruitment retention, staffing to workloads, and scope of practice, among others. SHM promotes peer-to-peer learning and has helped me share and learn best practices as it relates to the clinical and nonclinical aspect of the practice of hospital medicine.

Q: What one piece of advice would you give fellow hospitalists during this transformational time in health care?

A: This is an exciting time in health care, especially for hospital medicine professionals, who are at the forefront of providing value-based care. Every change is an opportunity to improve and innovate; the best way to handle change is to embrace and lead it. TH

Ms. Steele is SHM's communications coordinator.

NEWS & NOTES

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

By Brett Radler

Hospitalist specialty code becomes official designation

➤On April 3, 2017, "hospitalist" becomes an official specialty designation under Medicare – the code itself is C6. Starting on that date, hospitalists can change their specialty designation on the Medicare enrollment application. Specialty codes are self-designated and describe the kind of medicine that health care providers practice. Appropriate use of specialty codes helps distinguish differences among providers and improves the quality of utilization data. SHM applied for a specialty code for hospitalists nearly 3 years ago, and the Centers for Medicare & Medicaid Services approved the application in February 2016.

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

Assess your knowledge in hospital medicine with SPARK ONE

➤SHM recently launched SPARK ONE, a comprehensive online self-assessment tool created specifically for hospital medicine professionals. The activity contains 450-plus vignette-style multiple-choice questions covering 100% of the American Board of Internal Medicine's Focused Practice in Hospital Medicine (FPHM) exam blueprint. This online tool is your complete resource for successfully preparing for the FPHM exam, or assessing your general knowledge in hospital medicine.

Used as a self-paced study guide, it engages learners through an open-book format, allowing users to review detailed learning objectives and discussion points, and define individual areas of strengths and weaknesses. Identify knowledge gaps, see how you compare to your peers, create mini quizzes, and more. Visit hospitalmedicine.org/sparkone to learn more.

White paper now available: Hospitalist Attitudes Toward Electronic Medical Records

➤SHM's Health Information Technology Committee diligently analyzed survey results that captured hospitalists' attitudes towards electronic medical records, resulting in a white paper now available. The purpose of this paper is to effect change on EHR systems by informing conversations with decision makers and to provide hospital medicine a definitive voice in the landscape of the tumultuous world of electronic medical record systems.

SHM believes hospitalists are especially qualified to evaluate these systems, and the survey results paint a grim picture of the effectiveness and usability of the systems that hospitalists spend the majority of their time interacting with. These results should serve as a call to action to accelerate the pace of advancement and innovation in health care technology.

CONTINUED ON PAGE 10

The Hospitalist

NEWS & NOTES

CONTINUED FROM PAGE 8

By sharing these results, SHM hopes to raise awareness of the unacceptable performance of existing systems that contributes to slower-than-desired improvement in quality and safety as well as increasing provider frustration. SHM strongly believes that health care needs a renewed focus on initial goals of technology adoption. View the white paper at hospitalmedicine.org/EHR.

Join the Early-Career Academic Hospitalist Speed Mentoring Session at Hospital Medicine 2017

➤The SHM "speed mentoring" session, held on Tuesday, May 2 from noon to 1:00 p.m. at Hospital Medicine 2017, is designed to assist early-career hospitalists in specific areas of career development by providing a fresh perspective and rapid advice.

Early-career hospitalists will be matched with three senior advisors by area of interest. The "mentee" will spend 10-15 minutes with each advisor and will then rotate to the next advisor. After the session, there will be time for additional informal discussion and networking among advisors and peers.

Pre-registration by March 31, 2017 is required; it will not be possible to register for this activity on-site at HM17. There is no additional fee to register. Registration will be limited to the first 20 participants. Visit hospitalmedicine2017.org/academic today.

Now available: 4 new antimicrobial stewardship modules

➤SHM has developed four new antimicrobial stewardship modules to help you demonstrate an understanding of best practices to optimize and improve antimicrobial prescribing within your hospital:

1. Optimizing Antibiotic Use for Hospitalized Patients
2. Best Practices in Treatment of UTIs: "Low-Hanging Fruit"
3. Best Practices in Acute Bacterial Skin Infection
4. Antibiotic Use for Inpatient Respiratory Infections

View these resources at hospitalmedicine.org/abx.

Network with the largest gathering of pediatric hospital medicine professionals

➤Pediatric Hospital Medicine 2017 (PHM 2017) will be held July 20-23 at the Omni Nashville located in Nashville, Tenn. PHM 2017 offers an all-inclusive arrangement of educational and networking opportunities planned specifically for the pediatric hospital medicine professional. More than 100 concurrent sessions to choose from over the 4 days of the conference allow participants to get the best out of their PHM 2017 experience.

PHM 2017 will be comprised of concurrent sessions featuring lectures and larger sessions, oral presentations of abstracts and clinical conundrums, and smaller, interactive workshops. Acquire skills and knowledge from PHM experts, including peer-selected and nationally renowned leaders in the field of pediatric hospital medicine. To view the full meeting schedule and learn more, visit peds2017.org.

Earn free CME in the enhanced SHM Learning Portal

➤You asked, and we listened: Introducing the enhanced SHM Learning Portal! The SHM Learning Portal, the online learning home for hospitalists with all eLearning initiatives in one place, just launched a brand-new responsive design in March 2016.

Launching this summer, SHM's new Learning Portal will offer a better way to access and track online CME, with member discounts to a growing library of content. For more information, visit www.shmlearningportal.org.

Bringing SHM to you with local chapter meetings

➤Attend a chapter meeting and experience SHM locally. Chapters provide focused educational topics through key speakers and presentations and the opportunity to network with other hospitalists in your area. Find a chapter meeting close to you at hospitalmedicine.org/chapters.

A new look for SHM's Center for Hospital Innovation & Improvement

➤Just as hospital medicine is evolving, so is SHM's group dedicated to developing quality improvement safety tools and programs to meet health care's changing needs. SHM is proud to unveil a new look for its Center for Hospital Innovation & Improvement this month. Stay tuned for more, and visit hospitalmedicine.org/QI for the latest offerings in a variety of quality improvement topics and clinical areas.

Stand out as a leader with the Fellow in Hospital Medicine designation

➤Applications for SHM's Fellow in Hospital Medicine designation open on April 17, 2017. You may be eligible if you have been a member of SHM for at least 3 years and have been involved in key quality improvement programs and leadership roles in hospital medicine. Learn more and apply at hospitalmedicine.org/fellows. TH

Mr. Radler is Communications Specialist at the Society of Hospital Medicine.

Discussing advance care planning

Every healthcare encounter is an opportunity to better identify and document patients' wishes for care.

Dr. Rudolph is Vice President of physician development and patient experience for Sound Physicians, Tacoma, Wash. and chair of the SHM Patient Experience Committee.

By Mark A. Rudolph, MD, SFHM

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

What I Say and Do

I empower all of my patients by giving them the opportunity to consider advance care planning.

Why I Do It

Everyone deserves advance care planning, and every healthcare encounter, including a hospitalization, is an opportunity to better identify and document patients' wishes for care should they become unable to express them. If we wait for patients to develop serious advanced illness before having advance care planning conversations, we risk depriving them of the care they would want in these situations. Additionally, we place a huge burden on family members who may struggle with excruciatingly hard decisions in the absence of guidance about their loved one's wishes.

How I Do It

I start by identifying which components of advance care planning each patient needs, using a simple algorithm (see figure). All of my patients are queried about code status, and I give them the opportunity to better understand the value of having a healthcare proxy and advance directives, if they are not already in place.

For those patients with "serious advanced illness," I start with a goals-of-care conversation, if this has not been addressed previously. To determine who has "serious advanced illness," I ask myself the "surprise question": *"Would I be surprised if this patient died in the next year?"* This question has been shown, in studies of patients with tumors or who are undergoing dialysis, to identify patients who are at high risk for early mortality.[1]

For the remainder of this column, I'm going to focus on patients who have an acute and/or chronic treatable illness – those who require simpler advance-care-planning conversations.

To comfortably initiate the conversation about advance care planning, I always start by asking permission. I commonly say, "There are a couple of important items I discuss with all of my patients to make sure they get the care they want. Would it be okay for us to talk about those now?" This respectfully puts the patient in control. I then initiate a discussion of code status by saying, "It's important that all of us on your care team know what you would like us to do if you got so sick that we couldn't communicate with you. I'm not expecting this to happen, but I ask all my patients this question so that we have your instructions." From there, the conversation evolves depending on whether the patient has any familiarity with this question and its implications.

To introduce the concept of a healthcare proxy and advance directives, I ask, "Have you ever thought about who you might choose to make medical decisions on your behalf if you became too sick to make those decisions yourself?" Then, finally, I share the following information, usually referring to the blank advance directives document they received in their admission packet: "There is a valuable way to put your wishes about specific care options in writing so others will know your wishes if you're unable to communicate with them. Would you like to talk about that right now?" Again, this gives the patient control of the situation and an opportunity to decline the conversation if they are not interested or comfortable at that time.

It's important to document the nature and outcome of these conversations. Keep in mind, advance care planning discussions need not occur at the time of admission. In fact, admission may be the worst time for some patients, further underscoring the importance of documentation so that subsequent providers can see whether advance care planning has been addressed during the hospital stay.

Note: For useful educational resources that address goals-of-care conversations in patients toward the end of life, the Center to Advance Palliative Care (www.capc.org) has a number of educational courses that address these important communication skills. TH

Admission may be the worst time for some patients, further underscoring the importance of documentation so that subsequent providers can see whether advance care planning has been addressed during the hospital stay.

Reference

1. Moss, A.H., Ganjoo, J, Sharma S, et al. Utility of the "Surprise" Question to Identify Dialysis Patients with High Mortality. *Clinical Journal of the American Society of Nephrology: CJASN*. 2008;3(5):1379-84. doi:10.2215/CJN.00940208.

Key skills for optimal patient communications

Core principles: active listening, body language, empathy

Key communication	Purpose
The introduction: Establish rapport and trust through courtesy, diligence, and explanations	
Knock and acknowledge patient by name	Shows courtesy and verifies identity of patient
Introduce yourself to patient and others in room	Shows respect for friends/family
Solicit patient's preferred name	Shows commitment to patient-centered communication; engages patient
Sit down/be at eye level	Patient sees you are committed to listening carefully
Explain hospitalist role	Patient understands why you are caring for him or her
Explain connection to primary care physician	Assures patient that primary care physician will be kept informed
Inform patient you have reviewed chart/familiar with diagnosis	Shows that you are engaged in the patient's care
Solicit patient/family goals for the visit/day	Shows commitment to patient-centered care
The care: Solidify trust by being present, confirming understanding, and answering questions	
Ask permission to examine patient/share exam findings	Shows courtesy and respect/part of explanation
Clearly explain diagnoses and care plan in plain terms	Patient understands illness and your treatment
Confirm understanding using teach-back method	Allows you to address patient uncertainty and clarify plan
Confirm acceptance and agreement with care plan	Shows commitment to patient-centered care and patient autonomy
Set expectations for tests/results (timing/duration/delays)	Manages expectations regarding test timing and sharing of results
Set expectation for anticipated discharge/next site of care	Patient/family can begin to anticipate progress beyond hospital stay
Ask patient/family about other concerns	Opens door for patient/family to share questions, concerns, confusion
The goodbye: Maintain trust by confirming your availability and intent to return	
Set expectation for return visit	Patient knows when you will return
Use team brochure/business card (if patient is new to you)	Shows confidence in role and comfort with accountability
Accountability statement, such as, "It's important to me that you get great care while you're here"	Patient knows you are concerned about quality of care and are accountable for it
Encourage patient to have nurse call if questions	Patient knows that you are available if he or she needs help
Endorse care team members (team, nurses, consultants, other dept.)	Builds patient confidence in care team, facility
Ask patient/family/nurse what other concerns/needs	Allows patient to voice any other needs

Source: SHM's Patient Experience Committee

Frontline Medical News

CHECK OUT KEY COMMUNICATION TACTICS HIGHLIGHTED IN "Everything We Say and Do" at the-hospitalist.org.

SURVEY INSIGHTS

What do you call a hospitalist focused on comanaging a single medical subspecialty?

For more than 2 decades, U.S. health systems have drawn on hospitalists' expertise to lower length of stay and enhance safety for general medical patients. Many hospital medicine groups have extended this successful practice model across a growing list of services, stretching the role of generalists as far as it can go. While a diverse scope of practice excites some hospitalists, others find career satisfaction with a specific patient population. Some even balk at rotating through all of the possible primary and comanagement services staffed by their group. A growing number of jobs have emerged for individuals who are drawn to a specialized patient population but either remain generalist at heart or don't want to complete a fellowship.


Dr. White

The latest *State of Hospital Medicine* (SoHM) report provides new insight into this trend, which brings our unique talents to subspecialty populations.

It is hard to know what we should even call these hospitalists. The term "specialty hospitalist" is ambiguous because it could reasonably describe board-certified subspecialists who only practice in the hospital or hospitalists who only comanage a unique patient population. Nonetheless, I'll call the latter group "specialty hospitalists" until a better term emerges.

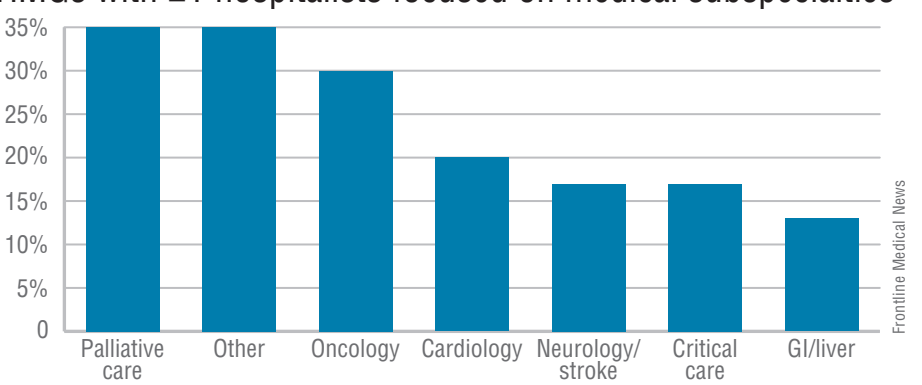
To understand the prevalence of this practice style, the following topic was added to the 2016 SoHM survey: "Some hospital medicine groups include hospitalists who focus their practice exclusively or predominantly in a single medical subspecialty area (e.g., a general internist who exclusively cares for patients on an oncology service in collaboration with oncologists)." Groups were asked to report whether one or more members of their group practiced this way and with which specialty. Although less than a quarter of groups responded to this question, we learned that a substantial portion of respondent groups employ such individuals (see Figure 1).

The prevalence and diversity of specialty hospitalist positions suggests they can be readily arranged in ways that benefit and engage all stakeholders. The report particularly indicates that hospital medicine groups have become a home for many palliative care specialists, allowing them to alternate between a primary and a consultative role. For the other specialties, common co-management pitfalls should be anticipated and addressed through clear descriptions of team expectations for decision making, communication, and workload.

We look forward to tracking this area with subsequent surveys. Already, national meetings are developing for specialty hospitalists (for example, in oncology), and we see opportunities for specialty hospitalists to network through the Society of Hospital Medicine annual meeting and HMX online. My prediction is for growth in the number of groups reporting the employment of specialty hospitalists, but only time will tell. Hospital medicine group leaders should consider both participating in the next SOHM survey and digging into the details of the current report as ways to advance the best practices for developing specialty hospitalist positions. TH

Dr. White is associate professor of medicine at the University of Washington, Seattle, and a member of SHM's Practice Analysis Committee.

HMGs with ≥1 hospitalists focused on medical subspecialties



Note: Less than a quarter of groups responded to the survey question on "specialty hospitalists."

Source: Society of Hospital Medicine's 2016 State of Hospital Medicine report

QI enthusiast turns QI leader

Quality improvement success starts with curiosity, builds with connection

By Claudia Stahl

Editor's note: *This new series highlights the professional pathways of quality improvement leaders. This month features the story of Kevin O'Leary, MD, MS, SFHM, chief of hospital medicine at Northwestern University Feinberg School of Medicine in Chicago.*

Kevin O'Leary, MD, MS, SFHM, chose a career path in hospital medicine for the reasons that attract many to the specialty – a love of "a little bit of everything, clinically" and the opportunity to problem-solve a diverse range of professional challenges on a daily basis.

Fresh out of residency on the new hospitalist service at Northwestern University Feinberg School of Medicine in Chicago, it wasn't long before Dr. O'Leary began to connect many of the obstacles he encountered at bedside to larger, systemic issues.

"I was frustrated with our internal inefficiencies, and motivated by wanting to provide optimal care to patients," Dr. O'Leary said, recalling his entry into the world of quality improvement. "It was the first time as a physician that I felt like quality was a problem that I owned – and if anyone was going to address it, it would have to be a hospitalist."

That epiphany 16 years ago led Dr. O'Leary, now chief of hospital medicine at the same institution, on a path of enacting change. He began volunteering on small improvement projects around the hospital, which led to an invitation to chair the Quality Management Committee in the hospital medicine department. He continued to build his skills by enrolling in Six Sigma training and in Northwestern University's Master in Healthcare Quality and Patient Safety program.

Dr. O'Leary

"That was transformative," Dr. O'Leary said. "The master's program, coupled with performance training, changed the trajectory of my career in quality improvement."

While he encourages anyone with an interest in QI to seek additional training opportunities, he says personal qualities – tenacity, curiosity, and a willingness to collaborate—are better predictors of success. For those wondering how to get started, "look for a niche, an unmet need that is valuable to your organization, and fill it," he advised. "You don't have to be an expert in that area, but you can become one."

Making strong connections within the hospital system is essential. Reach out to the contacts you know, he said, and if they are not the ones to help you solve the problem, they often know who can.

"That's key to quality improvement success, as well as career success," he said. "Find a mentor. It might be someone who is more senior within the hospitalist group, in medicine, or even outside the hospital. Meet with them regularly and ask them for feedback on your ideas."

Newcomers to QI should embrace opportunities to change care and not get discouraged when a project has unintended outcomes.

"Failure is when a team never gets to the point of implementing the intervention or when a team doesn't know whether the intervention has actually changed results," he said. "Learning why an intervention isn't effective can be as valuable as implementing one that is. If every project is successful, it just means that you're not taking enough risks."

Dr. O'Leary spends about 25% of his professional time providing clinical care, and another 15% meeting his responsibilities as division chief. He uses the other protected time in his schedule to lead QI and teach QI skills in programs like Northwestern Medicine's Academy for Quality and Safety Improvement (AQSI).

As a former faculty member in SHM's Quality and Safety Educator's Academy (QSEA), he has trained medical educators to develop curricula in quality improvement and patient safety. He says both AQSI and QSEA are especially effective because they encourage interaction, which is valuable to professionals at all levels looking to advance their skill in QI.

"Even in a teaching capacity," he noted, "what I learned from other faculty and participants in QSEA was critical."

Residents and junior hospitalists often have the impression that they lack the skills to lead quality initiatives, but Dr. O'Leary says medical school provides the nuts and bolts – analytical skills, statistical knowledge, critical thinking. He encouraged hospitalists to move ahead, even without formal QI training.

"If you have strong interpersonal skills – the willingness to make friends and build connections – you will be successful," he said.

It's also an excellent way to learn about the ins and outs of the hospital system and the work of other departments and specialties. Dr. O'Leary especially enjoys that aspect of his work, as well as the ability to address systemic issues that he values.

"I get the greatest fulfillment from the opportunity to be creative … and to implement projects that are important to me and help patients," he said. "As long as the projects align with organizational goals, I can usually find the support we need to be successful." TH

Ms. Stahl is a content manager for the Society of Hospital Medicine.

SNEAK PEEK

The Hospital Leader Blog

A renewed call to overhaul hospital observation care

By Ann M. Sheehy, MD, MS, FHM

FEATURED POST: "A Renewed Call to Overhaul Hospital Observation Care"

In response to concerns about Medicare beneficiary out-of-pocket financial risk, Congress unanimously passed the NOTICE Act, which President Obama signed into law August 5, 2015. This law states that all Medicare beneficiaries hospitalized for 24 hours or more as outpatients under observation must to be notified in writing that they are outpatients "not later than 36 hours after the time such individual begins receiving such services" as well as the associated "implications for cost-sharing." Last month, the Centers for Medicare & Medicaid Services (CMS) released the final Medicare Outpatient Observation Notice (MOON) that hospitals will start delivering to patients no later than March 8, 2017 to comply with the law. Patients or their representatives must sign the form to acknowledge receipt.

There is no doubt transparency is important, and patients should be informed when hospitalized as outpatients instead of as inpatients. But the wisdom of the NOTICE Act essentially stops there.

First, Medicare beneficiaries are notified after they have been hospitalized, certainly after they could make an informed decision about accepting observation care. Second, patients or their representative must sign the form, yet it is unclear if this signature holds the patient financially liable, particularly if signed by a representative with no legal authority over the patient's financial affairs. Third, the form does nothing for a patient's right to appeal their status. And because observation is a billing distinction, the field at the top of the form requiring hospitals to specify why the patient is not an inpatient is circular reasoning, as patients are outpatients only when they fail to meet Medicare inpatient billing criteria.

Perhaps most importantly, the primary purpose of the NOTICE Act – to inform beneficiaries of the "implications for cost-sharing" when hospitalized under observation – cannot truly be accomplished.

On December 19, 2016, the Department of Health and Human Services Office of Inspector General (OIG) issued the best cost-sharing data available to date describing observation hospital care under the 2-midnight rule. In their report, the OIG used FY 2014 data to compare cost of short outpatient and inpatient stays with similar diagnoses. But because hospitalized outpatients under observation pay a copayment for each individual hospital service, financial risk is not directly correlated with a diagnosis but instead the result of the number, cost, and complexity of services rendered in the hospital, with no limit on the additive amount of per-service deductibles. In contrast, the inpatient deductible is finite per benefit period.

As the OIG report does not provide an accounting of services rendered nor comparison based on equivalent services, it isn't clear how these cost estimates will help inform discussions when my observation patients receive their MOON. TH

Dr. Sheehy is a physician and associate professor at the University of Wisconsin School of Medicine and Public Health.

Read the full text of this blog post at http://blogs.hospitalmedicine.org/Blog/a-renewed-call-to-overhaul-hospital-observation-care/

ALSO ON "THE HOSPITAL LEADER" BLOG

POST: New ABIM MOC Two-Year Plan for Internal Medicine Threatens the Focused Practice in Hospital Medicine
By Burke Kealey, MD, SFHM

POST: The Nursing Home Get Out of Jail Card ("We Don't Want Our Patient Back"). It's Now Adios.
By Brad Flansbaum, DO, MPH, MHM

Free Yourself.

Forget what you think you know about locum tenens.
Lucidity's powerful technology is redefining locum tenens
and putting **YOU** in charge.

Personalized Pay & Availability | Complete Job Details | Direct Medical Practice Engagement | Credential & Document Management | Loyalty Rewards

lucidity
Locums *Without* The Agency™

In today's on-demand economy, entrepreneurial physicians deserve a better choice—an easier, hassle-free way to find and manage locum tenens and part-time opportunities, without the agency middlemen.

Lucidity® is that choice.

We are a technology company built and managed by physicians who know and understand what other physicians need. Like you, we had enough of the aggressive recruiters, the constant emails for jobs we didn't want and the hassles of dealing with it all. We built Lucidity with your interests and needs at heart.

Lucidity puts you in control and eliminates your need for the agency middleman.

Lucidity is an intuitive, powerful online platform that makes it fast and easy for physicians to find and manage temporary and part-time opportunities. Just sign up and log in on any desktop or mobile device to get started.

Take control of your career. Whether you're new to freelance work or a locum veteran, Lucidity is a powerful tool that eliminates the need for an agency and gives you exactly what you're looking for, with complete transparency:

- **personalize** your pay rate and negotiate directly with medical practices;
- **vet opportunities** thoroughly (and anonymously) before you apply;
- **match your schedule** of availability to the opportunity; and much more!

It takes less than two minutes to set up your FREE account.
Visit luciditydirect.com and sign up today.

SNEAK PEEK

Journal of Hospital Medicine

Predicting 30-day pneumonia readmissions using electronic health record data

By Anil N. Makam, MD, MAS; Oanh Kieu Nguyen, MD, MAS; Christopher Clark, MPA; Song Zhang, PhD; Bin Xie, PhD; Mark Weinreich, MD; Eric M. Mortensen, MD, MSc; Ethan A. Halm, MD, MPH

BACKGROUND: Readmissions after hospitalization for pneumonia are common, but the few risk-prediction models have poor to modest predictive ability. Data routinely collected in the EHR may improve prediction.

OBJECTIVE: To develop pneumonia-specific readmission risk-prediction models using EHR data from the first day and from the entire hospital stay ("full stay").

DESIGN: Observational cohort study using backward-stepwise selection and cross validation.

SUBJECTS: Consecutive pneumonia hospitalizations from six diverse hospitals in north Texas from 2009 to 2010.

MEASURES: All-cause, nonelective, 30-day readmissions, ascertained from 75 regional hospitals.

RESULTS: Of 1,463 patients, 13.6% were readmitted. The first-day, pneumonia-specific model included sociodemographic factors, prior hospitalizations, thrombocytosis, and a modified pneumonia severity index. The full-stay model included disposition status, vital sign instabilities on discharge, and an updated pneumonia severity index calculated using values from the day of discharge as additional predictors. The full-stay, pneumonia-specific model outperformed the first-day model (C-statistic, 0.731 vs. 0.695; $P = .02$; net reclassification index = 0.08). Compared with a validated multicondition readmission model, the Centers for Medicare & Medicaid Services pneumonia model, and two commonly used pneumonia severity of illness scores, the full-stay pneumonia-specific model had better discrimination (C-statistic, 0.604-0.681; P less than 0.01 for all comparisons), predicted a broader range of risk, and better reclassified individuals by their true risk (net reclassification index range, 0.09-0.18).

CONCLUSIONS: EHR data collected from the entire hospitalization can accurately predict readmission risk among patients hospitalized for pneumonia. This approach outperforms a first-day, pneumonia-specific model, the Centers for Medicare & Medicaid Services pneumonia model, and two commonly used pneumonia severity of illness scores. TH

ALSO IN JHM THIS MONTH

Evaluating automated rules for rapid response system alarm triggers in medical and surgical patients

AUTHORS: Santiago Romero-Brufau, MD; Bruce W. Morlan, MS; Matthew Johnson, MPH; Joel Hickman; Lisa L. Kirkland, MD; James M. Naessens, ScD; Jeanne Huddleston, MD, FACP, FHM

Prognosticating with the Hospital-Patient One-year Mortality Risk score using information abstracted from the medical record

AUTHORS: Genevieve Casey, MD, and Carl van Walraven, MD, FRCPC, MSc

Automating venous thromboembolism risk calculation using electronic health record data upon hospital admission: The Automated Padua Prediction Score

AUTHORS: Pierre Elias, MD; Raman Khanna, MD; Adams Dudley, MD, MBA; Jason Davies, MD, PhD; Ronald Jacolbia, MSN; Kara McArthur, BA; Andrew D. Auerbach, MD, MPH, SFHM

Hospital medicine and perioperative care: A framework for high quality, high value collaborative care

AUTHORS: Rachel E. Thompson, MD, MPH, SFHM; Kurt Pfeifer, MD, FHM; Paul Grant, MD, SFHM; Cornelia Taylor, MD; Barbara Slawski, MD, FACP, MS, SFHM; Christopher Whinney, MD, FACP, FHM; Laurence Wellikson, MD, MHM; Amir K. Jaffer, MD, MBA, SFHM

IN THE LITERATURE

ITL: Physician reviews of HM-centric research

By Ethan Cumbler, MD, FACP, FHM; Tejas Patil, MD; Karen Orjuela, MD; Caitlin Dietsche, MD; David Ecker, MD; and Tyler Anstett, DO

Division of Hospital Medicine, University of Colorado School of Medicine, Aurora

IN THIS ISSUE

By Ethan Cumbler, MD, FACP, FHM

1 Antipsychotics ineffective for symptoms of delirium in palliative care

CLINICAL QUESTION: Do antipsychotics provide symptomatic benefit for delirium in palliative care?

BACKGROUND: Antipsychotics are frequently used for the treatment of delirium and guideline recommended for delirium-associated distress. However, a 2016 meta-analysis found antipsychotics are not associated with change in delirium duration or severity. Antipsychotics for palliative management of delirium at end of life is not well studied.

STUDY DESIGN: Double-blind randomized controlled trial with placebo, haloperidol, and risperidone arms.

SETTING: Eleven Australian inpatient hospice or palliative care services.

SYNOPSIS: 247 patients (mean age, 74.9 years; 88.3% with cancer) with advanced incurable disease and active delirium were studied. Most had mild-moderate severity delirium. All received nonpharmacological measures and plan to address reversible precipitants. Patients were randomized to placebo (84), haloperidol (81), or risperidone (82) for 72 hours. Dose titration was allowed based on delirium symptoms. In intention to treat analysis the delirium severity scores were statistically higher in haloperidol and risperidone arms, compared with placebo. This reached statistical significance although less than the minimum clinically significant difference. Mortality, use of rescue medicines, and extrapyramidal symptoms were higher in antipsychotic groups.

Dr. Cumbler

BOTTOM LINE: Antipsychotics cause side effects without efficacy in palliation of symptoms of delirium.

CITATIONS: Agar MR, Lawlor PG, Quinn S, et al. Efficacy of oral risperidone, haloperidol, or placebo for symptoms of delirium among patients in palliative care: a randomized clinical trial. JAMA Intern Med. 2017 Jan;177:34-42.

2 Assessment of goals of care in nursing home reduces hospitalization for patients with dementia

CLINICAL QUESTION: For patients with advanced dementia, does a goals-of-care intervention improve communication and care outcomes?

BACKGROUND: Patients with advanced dementia are frequently admitted from nursing homes for acute conditions. Prior research demonstrates deficits in documentation of advanced directives.

STUDY DESIGN: Single-blind cluster randomized trial.

SETTING: Twenty-two nursing homes in North Carolina.

SYNOPSIS: Three hundred and two patient/families enrolled. Intervention included video and print decision aids followed by a structured goals of care discussion with trained nursing home staff. Quality of communication results, the primary outcome, at 3 months were mixed. Family perception of communication with nursing home staff was better in the intervention. Family–health care provider concordance on primary goal of care and treatment consistent with preferences were not significantly different. By the end of the study at 9 months there was no difference in symptom control but some secondary outcomes were encouraging including greater completion of MOST advanced directives (35% vs. 16%; $P = .05$) and half as many hospital transfers. Multiple comparisons merits future verification of secondary outcome findings.

BOTTOM LINE: Goals of care discussions for patients with advanced dementia appears to reduce hospitalizations.

CITATIONS: Hanson LC, Zimmerman S, Song MK, et al. Effect of the goals of care intervention for advanced dementia: a randomized clinical trial. JAMA Intern Med. 2017 Jan;177:24-31.

Dr. Cumbler is the associate chief of hospital medicine, Division of Hospital Medicine, University of Colorado School of Medicine, Aurora.

BY TEJAS PATIL, MD

3 Readmission rates after passage of the hospital readmissions reduction program

CLINICAL QUESTION: Did hospitals receiving the highest penalties for readmissions have accelerated improvement in this metric after passage of Medicare Hospital Readmissions Reduction Program (HRRP)?

BACKGROUND: Medicare passed the HRRP to incentivize reductions in readmission rates. The impact of penalties on relative hospital improvement rates remains unknown.

STUDY DESIGN: Retrospective pre-post analysis.

SETTING: Query of national Medicare Provider Analysis and Review files.

SYNOPSIS: 2,868 hospitals were identified as candidates for analysis and were stratified into four risk groups based on penalty size under HRRP: highest-performing, average-performing, low-performing, and lowest-performing. The primary outcomes were hospital-specific, 30-day, all-cause risk-standardized readmission rates (RSRRs) for patients discharged with acute MI, HF, or pneumonia. The investigators separated data into a pre-law period and post-law period. They fitted a logistic regression model to pre-law RSRRs and developed a piecewise linear model on post-law RSRRs with pre-law data as the dependent variable. All hospital groups had reductions in RSRRs, with the lowest quartile demonstrating greatest improvement.

Dr. Patil

BOTTOM LINE: HRRP has resulted in reductions in RSRRs with greatest improvement in hospitals with lowest pre-law performance.

CITATIONS: Wasfy JH, Zigler CM, Choirat C, et al. Readmission rates after passage of the hospital readmissions reduction program: a pre-post analysis. Ann Intern Med. 2017 Mar;166(5):324-31.

4 Perioperative pharmacological thromboprophylaxis in patients with cancer: a systematic review and meta-analysis

CLINICAL QUESTION: What are the benefits and harms of perioperative pharmacological thromboprophylaxis in cancer patients undergoing surgery?

BACKGROUND: Both cancer and surgery increase the risk of venous thromboembolism (VTE). In postsurgical patients with cancer, the benefits and harms of anticoagulation remain unknown.

STUDY DESIGN: Systematic review and meta-analysis.

SYNOPSIS: Thirty-nine trials were deemed eligible for inclusion in the meta-analysis. Twenty-five of these were prospective and 14 were retrospective. The overall incidence of deep venous thrombosis (DVT) and pulmonary embolism was 0.9% (across 20 studies) and 0.3% (across 19 studies), respectively. Pharmacologic prophylaxis overall reduced DVT incidence (0.5% vs. 1.2%; relative risk, 0.51; $P = .03$). Subgroup analysis demonstrated this was significant for abdominal/pelvic surgeries and with low molecular weight heparin. Six studies compared duration of stand-

CONTINUED ON PAGE 18

Patients older than 65 years have lower 30-day mortality and readmission rates when receiving inpatient care from a female internist, compared with care by a male internist.

ard prophylaxis (10 days) with extended prophylaxis (4 weeks), with a lower VTE rate in the extended group. Bleeding events were noted in 13 studies and pharmacologic prophylaxis significantly increased bleeding risk (2.7% vs. 8%; RR, 2.51; *P* less than .0001).

BOTTOM LINE: Perioperative pharmacologic prophylaxis reduces DVT risk in patients with cancer, with greatest risk reduction seen in patients undergoing abdominal/pelvic surgeries. This comes at the cost of increased bleeding complications.

CITATIONS: Guo Q, Huang B, Zhao J, et al. Perioperative pharmacological thromboprophylaxis in patients with cancer: a systematic review and meta-analysis. Ann Surg. 2016 Nov. doi: 10.1097/SLA.0000000000002074.

Dr. Patil is a clinical instructor, Division of Hospital Medicine, University of Colorado School of Medicine, Aurora.

BY KAREN ORJUELA, MD

5 End-of-rotation resident transition in care and mortality among hospitalized patients

CLINICAL QUESTION: Are hospitalized patients experiencing an increased mortality risk at the end-rotation resident transition in care and is this association related to the Accreditation Council for Graduate Medical Education (ACGME) 2011 duty-hour regulations?

Dr. Orjuela

BACKGROUND: Prior studies of physicians' transitions in care were associated with potential adverse patient events and outcomes. A higher mortality risk was suggested among patients with a complex hospital course or prolonged length of stay in association to house-staff transitions of care.

STUDY DESIGN: Observational, retrospective multicenter cohort study.

SETTING: 10 University-affiliated U.S. Veterans Health Administration hospitals.

SYNOPSIS: 230,701 patient discharges (mean age, 65.6 years; 95.8% male sex; median length of stay, 3 days) were included. The transition group included patients admitted at any time prior to an end-of-rotation who were either discharged or deceased within 7 days of transition. All other discharges were considered controls.

The primary outcome was in-hospital mortality rate; secondary outcomes included 30-day and 90-day mortality and readmission rates. An absolute increase of 1.5% to 1.9% in a unadjusted in-hospitality risk was found. The 30-day and 90-day mortality odds ratios were 1.10 and 1.21, respectively. A possible stronger association was found among interns' transitions in care and the in-hospital and after-discharge mortality post-ACGME 2011 duty hour regulations. The latter raises questions about the interns' inexperience and their amount of shift-to-shift handoffs. An adjusted analysis of the readmission rates at 30-day and 90-day was not significantly different between transition vs. control patients.

BOTTOM LINE: Elevated in-hospital mortality was seen among patients admitted to the inpatient medicine service at the end-of-rotation resident transitions in care. The association was stronger after the duty-hour ACGME (2011) regulations.

CITATIONS: Denson JL, Jensen A, Saag HS, et al. Association between end-of-rotation resident transition in care and mortality among hospitalized patients. JAMA. 2016 Dec 6;316(21):2204-13.

6 Male vs. female hospitalists, a comparison in mortality and readmission rate for Medicare patients

CLINICAL QUESTION: Does physician sex affect hospitalized patient outcomes?

BACKGROUND: Previous studies had suggested different practice patterns between male and female physicians in process measure of quality. No prior evaluation of patient outcomes examining those differences was studied in the past.

STUDY DESIGN: Observational, cross-sectional study.

SETTING: U.S. national sample (20%) of Medicare beneficiaries aged 65 years or older, hospitalized with acute medical conditions.

SYNOPSIS: This observational study assessed the difference in patients' outcomes that were treated by a male or female physician. 30-days mortality rate was analyzed from 1,583,028 hospitalizations. The mortality rate of patients cared for by female physicians was lower and statistically significant: 11.07% vs. 11.49% (adjusted risk difference, –0.43%; 95% CI, –0.57% to –0.28%; *P* less than .001). The difference did not change after considering patient and physician characteristics as well as when looking at hospital fixed effects (that is, hospital indicators). In order to prevent one death, a female physician needs to treat 233 patients.

Also, 30-day readmission rate, after adjustment readmissions (from 1,540,797 hospitalizations) was 15.02% vs. 15.57% (adjusted risk difference, –0.55%; 95% confidence interval, –0.71% to 0.39%; *P* less than .001) showing that the care provided by a female physician can reduce one readmission when treating 182 patients.

BOTTOM LINE: Patients older than 65 years have lower 30-day mortality and readmission rates when receiving inpatient care from a female internist, compared with care by a male internist.

CITATIONS: Tsugawa Y, Jena AB, Figueroa JF, et al. Comparison of hospital mortality and readmission rates for Medicare patients treated by male vs. female physicians. JAMA Intern Med. 2017 Feb;177(2):206-13.

Dr. Orjuela is assistant professor of neurology at the University of Colorado School of Medicine, Aurora.

BY CAITLIN DIETSCHE, MD

7 Perioperative statin associated with reduction in all-cause perioperative mortality in noncardiac surgery

CLINICAL QUESTION: Does perioperative statin use reduce 30-day mortality in noncardiac surgery?

BACKGROUND: Current perioperative guidelines focus on continuation of existing therapy in long-term statin users with weak recommendations of potential efficacy in reducing perioperative complications.

STUDY DESIGN: Retrospective, observational cohort analysis.

SETTING: Veterans' Affairs Hospitals.

Dr. Dietsche

SYNOPSIS: Using the Veterans Affairs Surgical Quality Improvement Program database, 96,486 patients were studied who were undergoing elective or emergent noncardiac surgery (vascular, general, orthopedic, neurosurgery, otolaryngology, and urology). 96.3% were men. Patients who died the day of the surgery or the day after were excluded, as were patients with multiple surgeries during the assessment period. Statin exposure on the day of or the day after surgery was compared with no statin use. The primary outcome was 30-day mortality and the secondary outcomes were significant reduction in any other complication.

Statin exposure was associated with reduced 30-day all-cause mortality with a marginally favorable effect with longer-term statin use (6 months to 1 year before admission). For the secondary outcomes, there was significant risk reduction in cardiac, infectious, respiratory, and renal complications but no significant change in central nervous system or nonatherosclerotic thrombotic complications.

Statin exposure may be associated with adherence to medical treatment and follow-up thus causing a selection bias.

BOTTOM LINE: Perioperative statin use was associated with a reduction in 30-day mortality and other complications.

CITATIONS: London MJ, Schwartz GG, Hur K, Henderson WG. Association of perioperative statin use with mortality and morbidity after major noncardiac surgery. JAMA Intern Med. 2017 Feb 1;177(2):231-42.

8 Using shock index in the ED to predict hospital admission and inpatient mortality

CLINICAL QUESTION: Can shock index (SI) in the ED predict the likelihood for hospital admission and inpatient mortality?

BACKGROUND: SI is defined as heart rate divided by systolic blood pressure. It is postulated to have an inverse relationship to cardiac output. SI has been studied as a prognostic metric of poor outcomes in patients with myocardial infarction, gastrointestinal hemorrhage, sepsis, and trauma. There are no large studies on SI in the general ED population.

STUDY DESIGN: Retrospective chart review.

SETTING: Academic tertiary care center.

SYNOPSIS: All ED patients over 18 years of age over a 12-month period were included in the study for a total of 58,633 charts. Charts were excluded if the patient presented in cardiac arrest, left prior to full evaluation in the ED, or had an incomplete or absent first set of vital signs. Likelihood ratio (LR) values of greater than 5 and 10 were considered moderate and large increases in the outcomes, respectively. Authors found SI greater than 1.2 had a positive LR of 11.69 for admission to the hospital and a positive LR of 5.82 for inpatient mortality.

This study identified potential thresholds for SI but did not validate them. Whether SI would be a useful tool for triage remains unanswered.

BOTTOM LINE: Initial SI greater than 1.2 at presentation to the ED was associated with increased likelihood of hospital admission and inpatient mortality.

CITATIONS: Balhara KS, Hsieh YH, Hamade B, et al. Clinical metrics in emergency medicine: the shock index and the probability of hospital admission and inpatient mortality. Emerg Med J. 2017 Feb;34(2):89-94.

Dr. Dietsche is a clinical instructor, Division of Hospital Medicine, University of Colorado School of Medicine, Aurora.

BY DAVID ECKER, MD

9 Interventions, especially those that are organization-directed, reduce burnout in physicians

CLINICAL QUESTION: How efficacious are interventions to reduce burnout in physicians?

BACKGROUND: Burnout is characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment. It is driven by workplace stressors and affects nearly half of physicians practicing in the U.S.

STUDY DESIGN: Systematic review & meta-analysis.

SETTING: Randomized controlled trials and controlled before-after studies in primary, secondary, or intensive care settings; most conducted in North America and Europe.

SYNOPSIS: Twenty independent comparisons from 19 studies (1,550 physicians of any specialty including trainees) were included. All reported burnout outcomes after either physician- or organization-directed interventions designed to relieve stress and/or improve physician perfor-

Based on available evidence, it is reasonable to utilize an alpha blocker as medical expulsive therapy in patients with larger ureteric stones.

mance. Most physician-directed interventions utilized mindfulness-based stress reduction techniques or other educational interventions. Most organizational-directed interventions introduced reductions in workload or schedule changes.

Interventions were associated with small, significant reductions in burnout (standardized mean difference, –0.29; CI –0.42 to –0.16). A pre-specified subgroup analysis revealed organization-directed interventions had significantly improved effects, compared with physician-directed ones.


Dr. Ecker

The generalizability of this meta-analysis is limited as the included studies significantly differed in their methodologies.

BOTTOM LINE: Burnout intervention programs for physicians are associated with small benefits, and the increased efficacy of organization-directed interventions suggest burnout is a problem of the health care system, rather than of individuals.

CITATIONS: Panagioti M, Panagopoulou E, Bower P, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. JAMA Intern Med. 2017;177(2):195-205.

10 Alpha blockers may facilitate the expulsion of larger ureteric stones

CLINICAL QUESTION: Are alpha blockers efficacious in patients with ureteric stones?

BACKGROUND: A multicenter, randomized controlled trial by Pickard and colleagues demonstrated an alpha blocker to be no more efficacious than placebo as medical expulsive therapy. There are no systematic reviews that include this recent study.

STUDY DESIGN: Systematic review & meta-analysis.

SETTING: Randomized controlled trials (RCTs); most conducted in Europe and Asia.

SYNOPSIS: Fifty-five unique RCTs (5,990 subjects) examining alpha blockers as the main treatment of ureteric stones versus placebo or control were included regardless of language and publication status.

Treatment with alpha blockers resulted in a 49% greater likelihood of stone passage (RR, 1.49; CI, 1.39-1.61) with a number needed to treat of four. A priori subgroup analysis revealed treatment was only beneficial in patients with larger stones (5mm or greater) independent of stone location or type of alpha blocker.

Secondary outcomes included reduced time to stone passage, fewer episodes of pain, decreased risk of surgical intervention, and lower risk of hospital admission with alpha blocker treatment without an increase in serious adverse events.

The meta-analysis was limited by the overall lack of methodological rigor of and clinical heterogeneity between the pooled studies.

BOTTOM LINE: Based on available evidence, it is reasonable to utilize an alpha blocker as medical expulsive therapy in patients with larger ureteric stones.

CITATIONS: Hollingsworth JM, Canales BK, Rogers MA, et al. Alpha blockers for treatment of ureteric stones: systematic review and meta-analysis. BMJ. 2016;355:i6112.

Dr. Ecker is the assistant director of education, Division of Hospital Medicine, University of Colorado School of Medicine, Aurora.

BY TYLER ANSTETT, DO

11 Principles learned from a successful improvement program can increase compliance and reduce hospital acquired VTEs (HA-VTEs) across multiple institutions

CLINICAL QUESTION: Can a single institution's VTE prophylaxis program be scaled to increase prophylaxis and reduce HA-VTEs across multiple institutions?

BACKGROUND: HA-VTEs are a preventable cause of avoidable harm. Despite recommendations and use as a quality benchmark, inpatient VTE prophylaxis is suboptimal. By implementing a quality improvement program, the University of California, San Diego increased VTE prophylaxis and reduced the number of HA-VTEs.

STUDY DESIGN: prospective, unblinded, open-intervention study

SETTING: Inpatient medical and surgical services at five independent, cooperating academic hospitals

SYNOPSIS: Each site used common principles to develop their own multi-pronged VTE prophylaxis program including structured order-sets, simplified risk-assessment, feedback to providers, and education programs.

306,906 inpatient discharges were evaluated with average VTE prophylaxis bundle compliance reaching 89% across all institutions. HA-VTE rates declined from 0.90% to 0.69% (RR, 0.76; CI, 0.68-0.85) – equivalent to averting 81 pulmonary emboli and 89 deep venous thrombi. Of note, HA-VTE rates only declined at three of the five institutions with the greatest improvement at those with the highest baseline rates. Further, while HA-VTE rates improved across all patient populations, the incidence reduction was statistically significant in Oncologic and Surgical populations.

BOTTOM LINE: Hospital systems can reduce HA-VTE and increase VTE prophylaxis by implementing a bundle of interventions and these efforts are highest yield for Oncologic and Surgical populations.

CITATIONS: Jenkins IH, White RH, Amin AN, et al. Reducing the incidence of hospital-associated venous thromboembolism within a network of academic hospitals: findings from five University of California medical centers. J Hosp Med. 2016;11:S22-8.

12 When one patient decompensates, others on the ward may follow

CLINICAL QUESTION: How does the clinical decompensation of a ward patient affect the likelihood of another patient's decompensation?

BACKGROUND: Previous research has attempted to identify patient-specific characteristics for risk of decompensation, but there may be environmental factors that contribute.

STUDY DESIGN: Observational cohort study.

SETTING: Thirteen geographically distinct, adult medical-surgical wards at an academic medical center.

SYNOPSIS: Of 83,723 admissions to medical-surgical wards, 4,286 patients experienced cardiac arrest (179) or were transferred to the ICU (4,107). When one or more of these events occurred, other patients on the same ward had an increased risk for either event over the subsequent 6 (OR 1.18; CI, 1.07-1.31) and 12 hours and the risk was higher if more than one event occurred. Importantly, for patients exposed to other patients on the same ward decompensating, there were no differences in the severity of illness for patients transferred to ICU or in overall mortality.


Dr. Anstett

Intuitively, when one patient becomes critically ill, other patients receive less attention. Though the effect was small, this study highlights that diversion of resources may increase other patients to greater risk. Surprisingly, the increased risk was not significant during night-time hours, when resources are more limited, but data collection may have been also affected.

BOTTOM LINE: When a patient becomes critically ill, another patient on the same ward is more likely to decompensate within the next 6-12 hours, but the effect is small.

CITATIONS: Volchenboum SL, Mayampurath A, Göksu-Gürsoy G, et al. Association between in-hospital critical illness events and outcomes in patients on the same ward. JAMA. 2016;316(24):2674-5. TH

Dr. Anstett is Hospital Medicine Fellow in Quality and Systems Leadership, Division of Hospital Medicine, University of Colorado School of Medicine, Aurora.

PEDIATRIC HM LITERATURE | By Carl Galloway, MD, FAAP

Dr. Galloway is a pediatric hospitalist at Sanford Children's Hospital in Sioux Falls, S.D., assistant professor of pediatrics at the University of South Dakota Sanford School of Medicine, and vice chief of the division of hospital pediatrics at USD SSOM and Sanford Children's Hospital.

Data-driven HR, RR parameters might help reduce alarm fatigue

New research shows 55.6% fewer out-of-range vital sign measurements for CRA, RRT activation

Thinkstock

CLINICAL QUESTION: Can alarm fatigue in pediatric inpatient settings be safely mitigated by modifying alarm limits with data-driven vital sign reference ranges?

BACKGROUND: The management of patient alarms in the hospital is a significant safety issue, with the large majority of alarms (85%-99%) either false or not clinically significant. This leads to provider desensitization or alarm fatigue, which has been shown to contribute to adverse events.

In 2014, the Joint Commission made the issue of alarm system safety and alarm fatigue a priority for hospitals.[1] Multiple studies have been published addressing alarm fatigue in hospitalized adult patients, but this issue is less well studied in pediatrics, including little guidance on optimizing alarm parameters. Widely used reference ranges and guides are based on limited evidence, primarily based on observational data in healthy outpatients or consensus data.

A 2013 study used vital sign data from hospitalized children to develop percentile curves for heart rate (HR) and respiratory rate (RR) and estimated that 54% of vital sign measurements in hospitalized children are out of range using currently accepted reference ranges.[2]

To safely decrease the number of out-of-range vital sign measurements resulting from current reference ranges, this study used data from non–critically ill hospitalized children to develop HR and RR percentile charts, and then performed retrospective safety analysis by evaluating effects of modifying the alarm limits on identification of cardiorespiratory arrests (CRA) and rapid response team (RRT) activations.

STUDY DESIGN: Retrospective, cross-sectional study.

SETTING: Single-site, 311-bed quaternary-care academic hospital, both general medical and surgical units.

SYNOPSIS: Vital signs were extracted from the institution's electronic health record (EHR) for all general medical and surgical patients discharged between Jan. 1, 3013, and May 3, 2014, excluding critically ill children and physiologically implausible vital signs. Two different sets were used, a training set (patients discharged between Jan. 1, 2013, and Dec. 31, 2013) and a validation set (Jan. 1, 2014-May 3, 2014). One HR and RR pair was randomly selected for each 4-hour interval during hospitalization, with a maximum of 10 HR and RR pairs per patient. Age-stratified percentiles were calculated using this data. The 5th and 95th percentile limits using the study data were compared with the 5th and 95th percentile values in the 2013 study, and the reference ranges currently in use at the institution (2004 National Institutes of Health ranges).[2]

The training set used 62,508 vital sign measurements for 7,202 patients to calculate percentiles for HR and RR among 14 different age groups. The validation set consisted of 82,993 vital sign measurements for 2,287 patients. Using the 5th and 95th percentiles for HR and RR resulted in 24,045 (55.6%) fewer out-of-range measurements in the validation set compared to NIH reference ranges (45% fewer HR values, 61% fewer RR values). This finding, as well as the vital sign percentile ranges, was consistent with the data published in the 2013 study.[2]

Data for all 148 out-of-ICU RRT and CRA events during the same time period were reviewed using manual chart review. Evaluating vital signs within the 12 hours preceding the events, 144 patients had out-of-range HR or RR measurements using NIH ranges. One hundred thirty-six (94.4%) of these 144 patients also had out-of-range measurements using the study-derived 5th and 95th percentile values.

Manual chart review of the remaining eight patients who had normal HR or RR demonstrated that the RRT or CRA interventions occurred for clinical indications that did no rely on HR or RR measurement (for example, desaturations, difficulty breathing, hematemesis), so the data-driven parameters did not miss any of these events.

BOTTOM LINE: In this retrospective study, using data-driven HR and RR parameters was at least as safe as the NIH-published reference ranges currently in use in this hospital. In addition to maintaining safety related to RRT and CRA events, use of the data-driven parameters resulted in 55.6% fewer out-of-range vital sign measurements in the studied population. This may reduce the frequency of false alarms and improve alarm fatigue, and should be studied prospectively in the future.

CITATION: Goel VV, Poole SF, Longhurst CA, et al. Safety analysis of proposed data-driven physiologic alarm parameters for hospitalized children. *J Hosp Med.* 2016;11(12):817-23. TH

References

1. The Joint Commission. Alarm system safety. Available at: https://www.jointcommission.org/assets/1/18/R3_Report_Issue_5_12_2_13_Final.pdf. Published December 11, 2013.

2. Bonafide CP, Brady PW, Keren R, Conway PH, Marsolo K, Daymont C. Development of heart and respiratory rate percentile curves for hospitalized children. Pediatrics. 2013;131(4):e1150-1157. Dr. Galloway is a pediatric hospitalist at Sanford Children's Hospital in Sioux Falls, S.D., assistant professor of pediatrics at the University of South Dakota Sanford School of Medicine, and vice chief of the division of hospital pediatrics at USD SSOM and Sanford Children's Hospital.

QUALITY

Create hospitalist-patient partnerships for safety and quality

Study reports sharing tool strengthens relationships, improves safety

Hospitalists can help enlist patients in the movement toward improved patient safety, and they can begin simply by sharing their notes.

OpenNotes offers a new platform to do that, according to a *BMJ Quality & Safety* article, "A patient feedback reporting tool for OpenNotes: implications for patient-clinician safety and quality partnerships."[1]

"OpenNotes has the potential to help close the gap between ambulatory visits and transitions of care, where safety threats can arise," says lead author Sigall K. Bell, MD. "The patient reporting tool was designed with patients as partners from the first step, and it has the capacity to improve safety and strengthen patient-clinician relationships."

In their study, the researchers invited 6,225 patients to read clinicians' notes and, through a patient portal, provide feedback. Forty-four percent of patients read the notes; nearly all (96%) respondents reported understanding the notes; 1 in 12 submitted feedback.

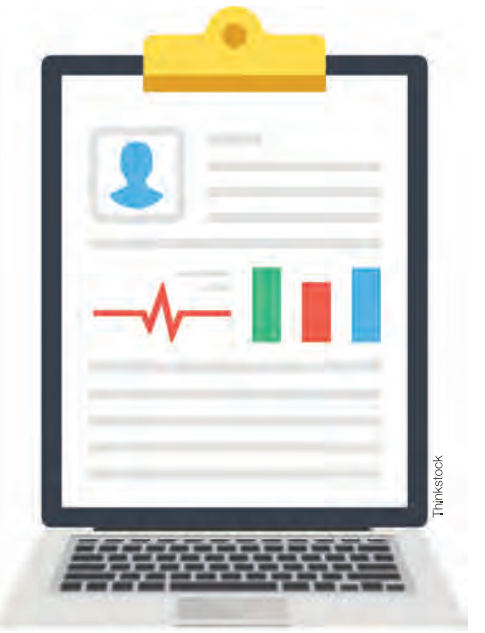
"Patients can [and did] find documentation errors in their notes and were willing to report them without any apparent negative effect on the patient-clinician relationship," Dr. Bell says. "The majority of patients also wanted to share positive feedback with their providers. Sharing notes can also facilitate information transfer across care settings."

Investigators also reported on feedback from patients that hearing the notes helped them to remember next steps.

"Reading discharge summaries and visit notes from follow-up visits after a hospitalization may prove particularly important," Dr. Bell says. "Providing patients with access to their notes may help them to adhere to the care plan, better remember recommended follow up tests or visits, and potentially stem preventable readmissions."

What hospitalists can do now, Dr. Bell adds, is:

- Share their notes with patients and families (by printing the discharge summaries if they are not available on the portal and/or sharing notes from postdischarge follow-up visits).
- Emphasize for patients and families the important role they play as safety partners.
- Ask patients who receive care in other healthcare centers if they have OpenNotes, which can help hospitalists obtain medical records quickly and efficiently.
- Encourage patients to sign up for the patient portal and ask for their notes, for ambulatory visits to begin with ,and for in-patient notes when they become available. TH



Reference

1. Bell SK, Gerard M, Fossa A, et al. A patient feedback reporting tool for OpenNotes: implications for patient-clinician safety and quality partnerships [published online ahead of print, Dec. 13, 2016]. *BMJ Qual Saf*. doi: 10.1136/bmjqs-2016-006020.

QUALITY

Hospitalists seek tools for more efficient admissions

Moving patients safely and efficiently through the admission process is always a priority for hospitalists. Is there a way to optimize and standardize the process?

"In hopes of improving admission efficiency, while simultaneously increasing quality of care, we decided to use Lean/Six Sigma methodology to streamline our admission process," says Escher Howard-Williams, MD, lead author of an abstract called "Standardizing the admission process using Lean/Six Sigma One Piece Flow."[1]

A basic tenet of the methodology is called "one piece flow" (OPF), the idea that standardized processes are more efficient and less prone to error when completed from start to finish without interruption. In the study, hospitalists committed to performing all patient admissions in OPF, focusing on one patient from initiation of chart review through exam, order entry and documentation, without interruption. Researchers then analyzed times, including time to call back to ED, time at initiation of chart review, time of evaluation of patient, time orders were placed, and time of sign-out note completed, before and after implementation of OPF. They found a substantial reduction in time of the admission process across all time points with OPF.

"When you are trying to improve quality of care in your institution, dissecting the overall work flow will allow you to discover areas that hinder the overall process," Dr. Howard-Williams says. "Reframing your process to focus on providing excellent quality care will allow you to find workable solutions to improve the quality of care and efficiency in your practice. As part of this process, developing a team with an appropriate variety of members lays the foundation for success."

Dr. Howard-Williams hopes that the study will inspire others to reflect on their own practices.

"If, during that reflection, they can identify areas that they would like to improve quality, we would encourage them to join us," she says. "They will have the opportunity to build their personal work flow maps, find choke points and devise a plan for moving forward with new solutions." TH

Reference

1. Howard-Williams E, Liles A, Stephens J, Ianza-Kaduce K. Standardizing the admission process using Lean/Six Sigma One Piece Flow [abstract]. *J Hosp Med*. 2016;11(suppl 1). Available at http://www.shmabstracts.com/abstract/standardizing-the-admission-process-using-lean-six-sigma-one-piece-flow/. Accessed March 7, 2017.

TECHNOLOGY

Enlisting social networks for better health outcomes

As a hospitalist, you typically have little, if any, contact with patients outside the hospital, and, at most you'll spend only a couple of hours a year in front of any particular patient. The vast majority of the determinants of your patients' health occur when you're not there.

In a commentary in the *New England Journal of Medicine* entitled "Engineering social incentives for health," lead author David A. Asch, MD, MBA, addresses that issue.[1]

"The motivation for the piece is that the people who are in a position to influence a patient's health are their friends and family, and yet so much of how we have structured health care is between a clinician and a patient," he says. "We often fail to engage the people in patients' everyday lives, who can be quite willing partners in improving health care. There are all sorts of things they can do to help patients with hard-to-control diabetes or ... heart failure, or anything that might have put them in the hospital in the first place."

The column describes a ladder of social engineering strategies, from very simple to complex. One example on the simple end might be to help a patient remember a daily medication by having him place the medication bottle where his partner can see him taking – or not taking – it. (The alternative is that medications are taken in a private place, such in the bathroom, where no one might be watching over the routine to keep the patient on track.)

Moving up the ladder, a hospitalist might help set up a network of other patients with heart failure, so that they can help each other in a kind of peer mentorship.

"These peer-to-peer connections might require Web-based platforms or social support groups, so that kind of activity is a lot more complicated, but the general theme is: Can hospitalists think about ways to constructively engage the social networks that already surround patients, so they don't need to invoke the health system to do it?"

It's long been known that people with more social support do better: People who are married do better; people who have more friends do better. "Up until now, it's just been an observation," Dr. Asch says. "I think we're at a point where we could begin to prescribe social support in the way we might prescribe a diuretic. I'd like to try it out at least. I think that's the call to action." TH

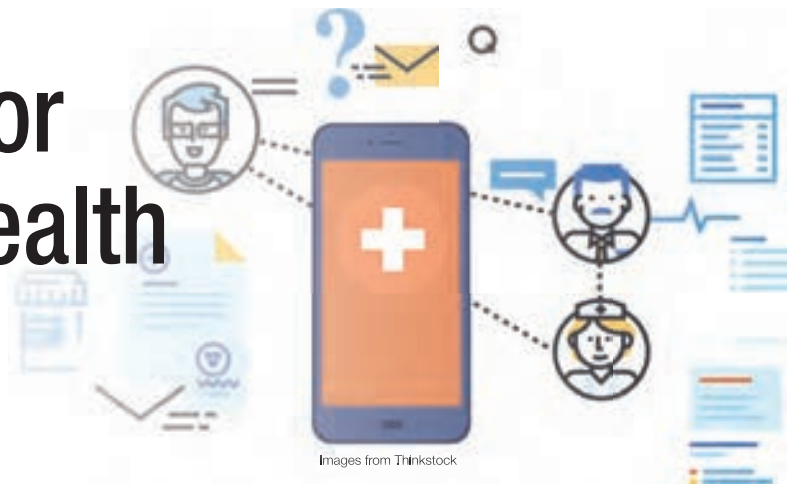
Reference

1. Asch DA, Rosin R. Engineering social incentives for health. *NEJM.* 2016;375:2511-3.

TECHNOLOGY

Consider apps for better patient health

Patient-facing apps have potential to help high-need, high-cost populations, but technology also poses risks



Images from Thinkstock

Hospitalists should not overlook apps as tools for better health: Smartphone ownership is rising among all demographic groups, and more than 165,000 health apps exist in app stores. Many apps are aimed at helping caregivers and patients with complex medical conditions.

"Patient-facing mobile health applications (mHealth apps) – those intended for use by patients to manage their health – have the potential to help high-need, high-cost populations manage their health, but a variety of questions related to their utility and function have not previously been explored," Karandeep Singh, MD, MMSc, said in "Many mobile health apps target high-need, high-cost populations, but gaps remain."[1]

He and his team identified and evaluated 137 high-performing, patient-facing health apps on iOS and Android. Questions they tried to answer included:

- How well do apps serve the needs of patients with varying levels of engagement with their health?
- Can we infer an app's clinical utility or usability based on its app store rating?
- Do apps appropriately respond to information entered by the user indicating that he or she might be in danger?
- How well do apps protect the privacy and security of user-entered health data?
- Are app costs a barrier to patients' purchasing and using them?
- The study team found a variety of apps for patients with chronic conditions.

"While many apps allow users to track health information, most apps did not respond appropriately when a user entered potentially dangerous health information," Dr. Singh says. "Consumers' ratings of apps on the iOS and Android app stores were poor indications of the apps' clinical utility or usability. Finally, we found that many apps enable sharing of information with others but primarily through insecure means. This is especially problematic because just under two-thirds of apps we evaluated had a privacy policy."

He cautions hospitalists that app ratings may have little bearing on its clinical utility as judged by a physician.

"Additionally, for patients tracking health findings using apps during an inpatient stay, the most secure way of sharing this information is the old-fashioned way, in person or in print," he explains. "Unlike hospital-based health information systems, health data stored in apps is generally not regulated by HIPAA. Hospitalists should not assume that a 'secure messaging' system provided by a patient-facing app is actually secure."

The American Medical Association, American Heart Association, Healthcare Information and Management Systems Society, and digital health nonprofit DHX Group are the founders of the new guideline-writing organization called Xcertia. Xcertia will provide guidance for developing, evaluating, or recommending mHealth apps.

"I hope that hospitalists keenly interested in apps will take an active role in Xcertia, to ensure that their voices are heard in what looks to be an unprecedented large-scale effort in the United States," Dr. Singh says. "While a medication list printed on a discharge summary cannot remind patients to take their meds, apps can do this quite well." TH

Reference

1. Singh, K, Drouin, K, Newmark, L, et al. Many mobile health apps target high-need, high-cost populations, but gaps remain. *Health Affairs.* 2016;35(12):2310-8.

Suzanne Bopp is a freelance medical writer in New York City.

QUICK BYTE

ACA jump-starts 61,000 demo projects

Center for Medicare and Medicaid Innovation lauded as proving ground for health care experimentation

Since 2010, the Affordable Care Act's Center for Medicare and Medicaid Innovation has run, financed, or partnered on 61,000 demonstration projects, allowing people and institutions to try new things and scale up what works, according to The New York Times article "A Bipartisan Reason to Save Obamacare."[1]

A YMCA course called the Diabetes Prevention Program is the first preventive program to qualify for scale up. According to the report, the U.S. health system previously was willing to pay an extra $16,000 to treat someone with complex diabetes but wouldn't cover a $500 program for group classes in changing eating habits to prevent the disease. The YMCA's diabetes program saved Medicare $2,650 per person over 15 months, while substantially reducing the risk of future diabetes. TH

Reference

1. Rosenberg T. A bipartisan reason to save Obamacare. *The New York Times*. January 4, 2017. Available at http://www.nytimes.com. Accessed January 10, 2017.

Every Hospital Is Unique

So Are the Needs of Your Smallest Patients

View a current Table of Contents at hospitalpediatrics.org

now indexed in *MEDLINE*

shopAAP
shop.aap.org

Read to Support Pediatric Research

Subscribe to *Hospital Pediatrics*®, the Monthly Peer-Reviewed Journal from the American Academy of Pediatrics

Choose a 1- or 2-year individual subscription terms in Online Only or Print and Online formats.
shop.aap.org/Hospital-Pediatrics

OR

Get a site license for your organization. Order directly through the AAP.

PHONE 847/434-4000
EMAIL **institutions@aap.org**
ONLINE **AAPLibrary.org**

Save 20% On Your Order
Enter Promo Code ***HOSPEDS20***

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

PREVIEW HM17 LAS VEGAS

What's new at HM17

Articles by Richard Quinn

There is only one annual meeting dedicated to hospitalists, designed by hospitalists, and focusing purely on issues important to hospitalists. But even that isn't enough to make sure more hospitalists show up every year.

That's because a yearly conference can't just be a rehash of the last one.

A valuable conference, certainly one worth spending the bulk of a continuing medical budget on, offers something new every year. Or, to look at the schedule for HM17, a *lot* of new every year.

"One of our top priorities on the planning committee is to create a diversity of topics," said Kathleen Finn, MD, FHM, assistant course director for HM17 and a hospitalist at Massachusetts General Hospital in Boston. "We keep detailed records of talks given at prior meetings and make sure that we are rotating topics and refreshing ideas for that exact reason. Because hospitalists are generalists, the content area hospitalists need exposure to is broad. If we limited ourselves to the same topics at every meeting, the planning committee would not be serving the needs of practicing hospitalists."

That's an unlikely complaint this year. The annual meeting schedule for May 1-4 at Mandalay Bay Resort and Casino includes five new educational tracks: High Value Care, Clinical Updates, Health Policy, Diagnostic Reasoning, and Medical Education.

"We're really excited to be able to offer more clinical content," said HM17 course director Lenny Feldman, MD, FAAP, FACP, SFHM.

Dr. Feldman sees each of the new tracks as filling separate and specific needs of HM attendees who vary from nonphysician providers to hospitalists to medical students.

Take, for instance, the High Value Care, Clinical Updates, and Diagnostic Reasoning sessions that are debuting.

"We wanted to make sure that we had as many clinically oriented sessions as possible," Dr. Feldman said. "Which meant we needed to increase the amount of clinical content we have offered compared to the past few years. The new clinical track allows us to add probably 12 or so different sessions that will fill the needs of our attendees."

The Diagnostic Reasoning and High Value Care tracks, in particular, highlight the annual meeting's continued evolution toward a focus on evidence-based care, as that mantra becomes a bedrock of clinical treatment.

"Training our hospitalists to use the best dialogistic reasoning in their approach to their patients is a big push in hospital medicine right now," Dr. Feldman said, "Hopefully, a track on that topic will excite people who love thinking about medicine, who got into medicine because of the mystery and want a renewed focus on how to be a great diagnostician."

Dr. Feldman also noted that the High Value Care track should be a hot topic, as hospitalists want to learn how to provide high quality and high value care to patients at the same time. The new tracks should appeal to different groups and make the annual meeting more appealing to a variety of attendees, not just rank-and-file doctors.

The mini Medical Education track, for instance, is a subset of a half-dozen sessions tailored directly to medical educators in academic settings who face different challenges than their counterparts in community settings. The same goes for the Health Policy track, which will offer a handful of sessions suitable for novices looking to learn more in an age of reform, or policy wonks hoping to expand their knowledge.

Meeting evolving needs

New offerings aren't limited to the main conference schedule. The 2017 roster of pre-courses includes one titled, "Bugs, Drugs and You: Infectious Diseases 'Boot Camp' for Hospitalists." This daylong session hasn't been held since 2013, and copresenter Jennifer Hanrahan, DO, associate professor of medicine at Case Western Reserve University in Cleveland, says the timing is good.

"I don't know that the percentage of people hospitalized for infection has increased," she said. "Because we are doing things more quickly than we did in the past, length of stays are shorter and there is a lot of pressure to get patients out of the hospital. There is a lot of consultation with Infectious Disease."

Dr. Hanrahan, who also serves as medical director of infection prevention at Cleveland's MetroHealth Medical Center, says that with so many patients hospitalized for infections, the value of updating one's knowledge every few years is critical.

"I've been an infectious disease physician for 18 years and I'm also a hospitalist," she said. "The types of questions I get vary a great deal depending on the experience of the hospitalist. My hope would be that we would be able to provide a basic level of understanding so that people would be more confident in approaching these problems."

Another new feature this year is offer some of the most popular sessions at multiple times. In years past, popular sessions – such as "Update and Pearls in Infectious Diseases" and "Non–Evidence-Based Medicine: Things We Do for No Reason" – are standing room–only events with attendees sitting on floors or gathered to eavesdrop from doorways.

"That says something about the content that's being delivered, but that's not very comfortable for folks who want to sit

CONTINUED ON PAGE 27

We wanted to make sure that we had as many clinically oriented sessions as possible.

—Dr. Feldman

One of our top priorities on the planning committee is to create a diversity of topics.

—Dr. Finn

2017 HOSPITAL MEDICIN
MAY 1-4, 2017
MANDALAY BAY RESORT AND CASINO
LAS VEGAS, NEVADA

The future of health care policy

The first two plenary addresses at HM17 are focused on policy at a time when the dynamically evolving U.S. health care delivery system may seem daunting, opaque, and labyrinthine.

Some might view the health care landscape as hopelessly confusing. Yet both of the keynote speakers use the same word for what they hope to leave their listeners with: optimism.


Dr. DeSalvo

"Though it feels uncertain in the headlines, the reality is that the health care world feels pretty united in that we need to continue the progress we've made on moving away from the fee-for-service model and to let people practice medicine the way they want – to work better as teams and focus on patients and outcomes," said Karen DeSalvo, MD, MPH, MSc, former acting assistant secretary for health in the U.S. Department of Health & Human Services (HHS) and former national coordinator for health information technology.

Patrick Conway, MD, MSc, MHM, deputy administrator for Innovation and Quality at the Centers for Medicare & Medicaid Services and director of the Center for Medicare and Medicaid Innovation, is also optimistic, despite concerns about the rollback of the Affordable Care Act and what that could mean for access to care.

"I would view it as an opportunity as well," said Dr. Conway, who still moonlights as a pediatric academic hospitalist on weekends in greater Washington, D.C. "I think the pieces are coming together. Everything from data, to new payment models, to the MACRA Medicare Physician payment legislation, really suggests a time of positive change."

Dr. DeSalvo, a former political appointee, joined HHS as the national coordinator for health information technology in 2014 and soon thereafter assumed the acting assistant secretary role. Dr. Conway has attained one of the country's highest-ranking public health care jobs since joining CMS in 2011. He retained the top post at CMS while President Donald J. Trump's nominee to lead the agency, Seema Verma, awaited a confirmation hearing before the U.S. Senate. Dr. Conway's prior title was principal deputy administrator and CMS chief medical officer.

Dr. DeSalvo, who will speak about "Public Health 3.0, the Role of the Hospitalist and the Hospital," says that, despite the current tumult, hospitalists are well positioned to drive the discussion about health care reform. But she said that conversation need not bog down in insurance-coverage issues that, while important, are more the purview of bureaucrats and wonks than of physicians.

"I don't want people to lose sight of the fact that there's this entire care system that everybody's working and innovating in every day, trying to find more efficient, effective ways to get better outcomes," she said. "Hospitalists, quite frankly, have been leading that for their entire existence. They really understand in great granular detail what it takes."

Dr. DeSalvo believes that the progress of the past 5 years has established a path that must be followed. The public sector move away from fee-for-service has combined with emerging technology platforms to create a new age where physicians and insurers can judge, in real time, how well care is working.


Photo courtesy of SHM

Dr. Conway is confident that value-based payment innovation and delivery system reform will continue to be critical aspects of improving U.S. health care.

"We're now in a feedback loop where we can say – 'When we've built a care system like this or when we pay this way, we are actually seeing improved outcomes' – and change doesn't take as long," Dr. DeSalvo said.

Dr. Conway, whose working title for his speech is "Health Care System Transformation," said hospitalists should be encouraged by how well the field has already adapted to the proliferation of accountable care organizations (ACOs), value-based purchasing (VBP), alternative payment models (APM), and the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. He noted that, as innovations lead to better and more coordinated patient care, hospitalists, patients, and hospitals would all benefit.

"I want to leave people with the idea that value-based payment innovation and delivery system reform will continue to be critical aspects of improving our health system," he said. "I also want hospitalists to continue to stay engaged with these new payment models, help lead them, and provide better patient care as a part of them." TH

Adapting to change: Dr. Robert Wachter

Photo courtesy of SHM

Dr. Robert helped coin the term "hospitalist" in a 1996 New England Journal of Medicine paper.

Robert Wachter, MD, MHM, has given the final plenary address at every SHM annual meeting since 2007. His talks are peppered with his one-of-a-kind take on the confluence of medicine, politics, and policy – and at least once he broke into an Elton John parody.

Where does that point of view come from? As the "dean" of hospital medicine says in his ever-popular Twitter bio, he is "what happens when a poli sci major becomes an academic physician."

That's a needed perspective this year, as the level of political upheaval in the United States ups the ante on the tumult the health care field has experienced over the past few years. Questions surrounding the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the continued struggles experienced by clinicians using electronic health records (EHR) are among the topics to be addressed.

"While [President] Trump brings massive uncertainty, the shift to value and the increasing importance of building a strong culture, a method to continuously improve, and a way to use the EHR to make things better is unlikely to go away," Dr. Wachter said. His closing plenary is titled, "Mergers, MACRA, and Mission-Creep: Can Hospitalists Thrive in the New World of Health Care?"

In an email interview with The Hospitalist, Dr. Wachter, chair of the department of medicine at the University of California San Francisco, said the Trump administration is a once-in-a-lifetime anomaly that has both physicians and patients nervous, especially at a time when health care reform seemed to be stabilizing.

The new president "adds an amazing wild card, at every level," he said. "If it weren't for his administration, I think we'd be on a fairly stable, predictable path. Not that that path didn't include a ton of change, but at least it was a predictable path."

Dr. Wachter, who famously helped coined the term "hospitalist" in a 1996 New England Journal of Medicine paper, said that one of the biggest challenges to hospital medicine in the future is how hospitals will be paid – and how they pay their employees.

"The business model for hospitals will be massively challenged, and it could get worse if a lot of your patients lose insurance or their payments go way down," he said.

But if the past decade of Dr. Wachter's insights delivered at SHM annual meetings are any indication, his message of trepidation and concern will end on a high note.

The veteran doctor in him says "don't get too distracted by all of the zigs and zags." The utopian politico in him says "don't ever forget the core values and imperatives remain."

Perhaps that really is what happens when a political science major becomes an academic physician. TH

HM17's "must-see sessions"

11 editorial board recommendations for pre-courses, breakout sessions, and workshops

Not to sound like a Sin City come on, but pick a course, any course.

No, seriously.

Hospitalists and other attendees at HM17 next month will do well to figure out what sessions they want to attend before arriving at the Mandalay Bay Resort and Casino. The 4-day Super Bowl of hospital medicine prides itself on offering more than any attendee can find time for. This year is no exception, as the annual meeting has added five new educational tracks: High Value Care, Clinical Updates, Health Policy, Diagnostic Reasoning, and Medical Education.

"The committee that plans this meeting is from a wide representation of the entire hospitalist community. The [goal] is to say, 'Hey, what are you guys struggling with? What's out there? What are people working on. What's new?'" says Kathleen Finn, MD, FHM, assistant course director for HM17 and a hospitalist at Massachusetts General Hospital in Boston. "We really bring to the forefront what everybody is learning about and new."

The committee does its job to fill the meeting with best-in-class educational sessions. Now allow *The Hospitalist*'s physician editors and volunteer editorial board do theirs. Here are some of the group's recommendations for this year's meeting:

Photo courtesy of SHM

HM17 attendees can choose from sessions within 5 new educational tracks.

1 The Hospitalist's Role in the Opioid Epidemic

Tuesday, May 2; 1:35 p.m. - 2:35 p.m.

2 Opioids for Acute Pain Management in the Seriously Ill - How to Safely Prescribe

Wednesday, May 3; 2:50 p.m. - 3:30 p.m.

3 Non-opiate Pain Management for the Hospitalist

Wednesday, May 3; 4:20 p.m. - 5 p.m.

Elizabeth Cook, MD, medical director of the hospitalist division of Medical Associates of Central Virginia in Lynchburg, Va.: "The historical emphasis on pain control has helped contributed to the current epidemic of opioid abuse, overdoses and deaths. Hospitalists have a need to use these medications for care of the hospitalized patient but have an important part to play in leading the way to appropriate use and patient education regarding the dangers of these medications. These sessions will provide hospitalists with some tools to use in beginning to effect a shit in pain management strategies and responsible use of narcotic pain medications."

Miguel Angel Villagra, MD, FACP, FHM, hospitalist department program medical director at White River Medical Center in Batesville, Ark.: "As primary front-line providers in the acute care setting, we face the everyday struggles in the management of chronic opioid users. Acquiring some general guidelines can help us tailor our approach within an ethical focus to improve the care of this population."

Sarah Stella, MD, an academic hospitalist at Denver Health: "This is a crucial and timely topic. Hospitalists have had a hand in perpetuating the opioid epidemic and can play an important role in helping to end it. In this regard, there are many opportunities to do good, such as judicious prescribing and tapering medications for acute pain, starting eligible patients on suboxone in-house and arranging substance and arranging substance abuse treatment follow up."

4 Focus on POCUS - Introduction to Point-of-Care Ultrasound for Pediatric Hospitalists

Tuesday, May 2; 10:35 a.m. - 11:35 a.m.

5 Things We Do for No Reason in Pediatrics

Wednesday, May 3; 11 a.m. - noon

Weijen Chang, MD, SFHM, FAAP, chief of the Division of Pediatric Hospital Medicine, Baystate Medical Center/Baystate Children's Hospital, Springfield, Mass.: "This is the first pediatric POCUS session offered at SHM ever. And it does not require an additional cost ... the pediatric track is critically important, as a substantial number of athlete attendees are either Peds or Med-Peds. I think SHM aims to create a pediatric track that discusses topics that are less covered in other meetings, such as the value equation and issues facing women leaders in HM."

6 Foundations of a Hospital Medicine Telemedicine Program

Wednesday, May 3; 415 p.m. - 5:20 p.m.

Dr. Villagra: "Telemedicine is a new innovative technology with the promise of overcoming geographical barriers to healthcare providers. A lot of new companies and software development has made this technology more user/patient friendly."

CONTINUED ON PAGE 29

SHM to honor new Fellows, Award winners

Vineet Arora, MD, understands the unique value of being named one of this year's three Masters in Hospital Medicine. It's an honor bestowed for hospitalists, by hospitalists.

"I take a lot of pride in an honor determined by peers," said Dr. Arora, an academic hospitalist at University of Chicago Medicine. "While peers are often the biggest support you receive in your professional career, because they are in the trenches with you, they can also be your best critics. That is especially true of the type of work that I do, which relies on the buy-in of frontline clinicians – including hospitalists and trainees – to achieve better patient care and education."

The designation of new Masters in Hospital Medicine is a major moment at SHM's annual meeting. The 2017 list of awardees is headlined by Dr. Arora and the other MHM designees: former SHM President Burke Kealey, MD, and Richard Slataper, MD, who was heavily involved with the National Association of Inpatient Physicians, a predecessor to SHM. The 3 new masters bring to 24 the number of MHMs the society has named since unveiling the honor in 2010.

Dr. Arora understands that, after 20 years as a specialty, just two dozen practitioners have reached hospital medicine's highest professional distinction.

"I think of 'mastery' as someone who has achieved the highest level of expertise in a field, so an honor like Master in Hospital Medicine definitely means a lot to me," she said. "Especially given the prior recipients of this honor, and the importance of SHM in my own professional growth and development since I was a trainee."

Dr. Arora

Dr. Kealey

Dr. Slataper

In addition to the top honor, HM17 will see the induction of 159 Fellows in Hospital Medicine (FHM) and 58 Senior Fellows in Hospital Medicine (SFHM). This year's fellows join the thousands of physicians and nonphysician providers (NPPs) that have attained the distinction.

SHM also bestows its annual Awards of Excellence (past winners listed here include Dr. Arora and Dr. Kealey) that recognize practitioners across skill sets. The awards are meant to honor SHM members "whose exemplary contributions to the hospital medicine movement deserve acknowledgment and respect," according to the society's website.

The 2017 Award winners include:

- ***Excellence in Teamwork in Quality Improvement:*** Johnston Memorial Hospital in Abingdon, Va.
- ***Excellence in Research:*** Jeffrey Barsuk, MD, MS, SFHM.
- ***Excellence in Teaching:*** Steven Cohn, MD, FACP, SFHM.
- ***Excellence in Hospital Medicine for Non-Physicians:*** Michael McFall.
- ***Outstanding Service in Hospital Medicine:*** Jeffrey Greenwald, MD, SFHM.
- ***Clinical Excellence:*** Barbara Slawski, MD.
- ***Excellence in Humanitarian Services:*** Jonathan Crocker, MD, FHM.

Dr. Arora, who has served on the SHM committee that analyzes all nominees for the annual awards, recognizes the value of honoring these high-achieving clinicians.

"There is great value to having our specialty society recognize members in different ways," she said "The awards of excellence serve as a wonderful reminder of the incredible impact that hospitalists have in many diverse ways … while having the distinction of a fellow or senior fellow serves as a nice benchmark to which new hospitalists can aspire and gain recognition as they emerge as leaders in the field." TH

Photo courtesy Las Vegas News Bureau

WHAT'S NEW

CONTINUED FROM PAGE 24

through a session," Dr. Feldman said. "We've decided to add repeat sessions of popular presentations. We want everyone to be comfortable while they're learning the important clinical content that's being delivered at these sessions."

The 2017 focus on healthcare policy is also new. Educational sessions on the policy landscape will be formally buttressed by plenary presentations from Patrick Conway, MD, MSc, MHM, deputy administrator for Innovation and Quality at the Centers for Medicare & Medicaid Services and director of the Center for Medicare and Medicaid Innovation, and Karen DeSalvo, MD, MPH, MSc, a former acting assistant secretary for health at the U.S. Department of Health & Human Services and national coordinator for health information technology.

"There's a thirst for [policy news] among members of the Society of Hospital Medicine," Dr. Feldman said. "It is easy to get lost in the day-to-day work that we do, but I think most of us really enjoy hearing about the bigger picture, especially when the bigger picture is in flux."

"Right now, this is critical," added Dr. Finn. "Health insurance coverage has a huge impact on hospitals. I think all practicing hospitalists will need to engage with the hospital C-suite if insurance and coverage changes. Since we are hospital based, we are directly tied to anything that the federal government does in terms of health care changes. It's important for hospitalists to be knowledgeable about health policy."

One major highlight of the meeting calendar – less new and more historically underappreciated, in Dr. Feldman's view – should be the 18 workshop presentations, which are essentially 90-minute dissertations, whittled down from roughly 150 submissions.

"These are the best submissions that we received," Dr. Feldman said. "We worked hard to make sure that the workshops encompass the breadth and depth of hospital medicine. It is not just one area that's covered in every workshop. We'll have workshops ranging from clinical reasoning and communication with patients to quality improvement issues and high value care discussions, as well as a case-based approach to inpatient dermatology."

While annual meetings' new offerings are always an important draw, Dr. Feldman says that the annual "standbys," such as practice management and pediatrics, are necessary to keep attendees up to date on best practices in changing times.

"It's pretty self-evident that if we're going to be an important specialty, we need to serve those who are caring for patients day in and day out, as well as folks who are researching how we can do it better," he said. "Then we must make sure that data is disseminated to all of us who are taking care of patients. That's one of the really important parts of this meeting: dissemination of the important work." TH

DAY-AT-A-GLANCE

TUESDAY, MAY 2

7:00 - 8:00 A.M. **BREAKFAST** • MANDALAY BAY FOYER
8:00 - 8:10 A.M. **OPENING AND WELCOME** • **LEONARD FELDMAN, MD, FAAP, FACP, SFHM AND BRIAN HARTE, MD, SFHM** • MANDALAY BAY EFGH
8:10 - 8:40 A.M. **INDUCTION OF SHM FELLOWS** • **BRIAN HARTE, MD, SFHM** • **PRESIDENT'S ADDRESS** • **BRIAN HARTE, MD, SFHM**
PRESIDENT-ELECT'S ADDRESS • **RON GREENO, MD, FCCP, MHM**
8:40 - 9:30 A.M. **RETHINKING HEALTH: THE VITAL ROLE OF HOSPITALS AND THE HOSPITALIST** • **KAREN DESALVO, MD, MPH, MSC** • MANDALAY BAY EFGH
9:30 - 10:30 A.M. **BREAK IN EXHIBIT HALL** • SHORELINE EXHIBIT HALL
9:45 - 10:15 A.M. **MEDTalks** • PRODUCT THEATERS 1-3

RAPID FIRE OCEANSIDE C	RAPID FIRE OCEANSIDE D	CLINICAL UPDATES MANDALAY BAY BCD	HIGH-VALUE CARE OCEANSIDE B	EARLY-CAREER HOSPITALISTS MANDALAY BAY I	PEDIATRIC MANDALAY BAY J	PRACTICE MANAGEMENT REEF BCEF	ACADEMIC/ RESEARCH MANDALAY BAY K	QUALITY BREAKERS EFKL	WORKSHOPS SURF EF	WORKSHOPS SURF AB
MORNING BREAKOUT SESSIONS										
10:35 - 11:15 A.M.					**10:35 - 11:35 A.M.**				**10:35 A.M. - 12:05 P.M.**	
Troubleshooting Acute Ventilator Issues *Peter Clardy*	Non-invasive Cardiac Imaging and Inpatient Stress Testing including Rapid Protocols to Rule Out Myocardial Infarction (ROMI) *Marlene Williams*	Betting on the House: Update in Palliative Care *Tammie Quest*	Overcoming a Culture Overrun with Overuse *Christopher Moriates*	Hospitalist Careers: So Many Options *Alfred Burger, Brian Markoff*	Focus on POCUS - Introduction to Point-of-Care Ultrasound for Pediatric Hospitalists *Nilam Soni, Ria Dancel, Thomas Conlon, Daniel Schnobrich*	A Transitionalist Model for Readmissions Reduction *Neera Ahuja*	How to Engage Leadership to Ensure Success *Jeffrey Glasheen*	Value: How to Make QI Pay *Luke Hansen*	Ethics in the Hospital: A Case-Based Approach to Complex Medical Decision-Making *Jack Chase, Elizabeth Dzeng, Madhavi Dandu, Sirisha Narayana*	Thinking Doctors: Solve a Clinical Unknown with a Team, Sharpen Your Clinical Reasoning and Discover the "Sand-Traps" of Our Minds *Kathleen Finn, Daniel Hunt, Christiana Iyasere, Victor Chiappa*
11:20 A.M. - NOON										
Hospital Delirium: New Evidence in Diagnosis & Treatment *Ethan Cumbler*	UTI-Challenging Cases? Length of Treatment, Fosfomycin, Fungus *Jennifer Hanrahan*	Update in Critical Care: Don't Sit on SOFA, Sepsis, and a Whole Lot More! *Patricia Kritek*	Finding High-Value Inpatient Care at the End of Life *Deborah Korenstein*	The Flipside to Mentorship, How to Be a Great Mentee *Patrick Rendon, Dennis Chang, Brian Kwan*						

11:35 A.M. - 1:35 P.M. - **LUNCH IN EXHIBIT HALL** • SHORELINE EXHIBIT HALL
NOON - 1:00 P.M. - **EARLY-CAREER ACADEMIC HOSPITALIST SPEED-MENTORING SESSION** (PRE-REGISTRATION REQUIRED) • BREAKERS GH
NOON - 1:00 P.M. - **RESIDENT AND STUDENT LUNCHEON**
NOON - 1:00 P.M. - **PRODUCT THEATERS (SEE HM17 DAILIES FOR DETAILS).**

EARLY AFTERNOON BREAKOUT SESSIONS										
1:10 - 1:50 P.M.					**1:35 - 2:35 P.M.**				**12:45 - 2:15 P.M.**	
Anaphylaxis, Penicillin Allergies and Desensitization and Contrast Allergies *Paige Wickner*	Cirrhosis and Liver Disease for the Hospitalist *Jeffrey Crippin*	Update and Pearls in Infectious Diseases *John Sanders*	How to Talk to Inpatients About HVC *Emily Gottenborg*	Hospitalists in the Making - Student Scholarship QI Presentations *Haverly Snyder, Joseph Moo-Young, Aram Namavar, Shane Ali*	Follow Me! How to Become a Successful Female Leader in Pediatric Hospital Medicine *Jennifer O'Toole, Kris Rehm*	Leading Your Way to Success: Five Key Leadership Lessons Learned *Nasim Afsar, Eric Howell*	See Your Name in the Lights: Boosting the Academic Output of Your Hospital Medicine Group *Michelle Mourad*	The Hospitalist's Role in the Opioid Epidemic *Shoshana Herzig, Hilary Mosher*	Beyond 'Good Job': Using Feedback to Improve Performance of Our Learners and Colleagues *Justin Roesch, Bradley Sharpe, Patrick Rendon, Grace Huang*	Demystifying Difficult Discussions: Strategies and Skills to Equip Hospitalists for High-Quality Goals of Care Conversations with Seriously Ill Patients and Their Families *Barbara Egan, Julia Ragland, Brett Hendel-Paterson, Nancy Berlinger*
1:55 - 2:35 P.M.										
Management of *Staph Aureus* Bacteremia: Pearls and Pitfalls *Glenn Wortmann*	Abdominal Pain Zebras *Aline Charabaty*	Update in Heart Failure *Dustin Smith*	Non-evidence Based Medicine: Things We Do for No Reason *Tony Breu*	Choosing Wisely: A Trainee's Guide to Getting Involved with High-Value Care *Vineet Arora, Christopher Moriates*						

2:40 - 3:15 P.M. - **BREAK IN EXHIBIT HALL** • SHORELINE EXHIBIT HALL
2:35 - 3:10 P.M. - **MEDTalks** • PRODUCT THEATERS 1-3

LATE AFTERNOON BREAKOUT SESSIONS										
3:05 - 3:45 P.M.					**3:15 - 4:20 P.M.**				**2:50 - 4:20 P.M.**	
Why We Fail at Work Life Balance *Dawna Ballard*	Syncope *Daniel Dressler*	Update in Nephrology: Now You're Money, Vegas Baby! *Deidra Crews*	Best of HVC Abstract Submissions *September Wallingford, Leonard Feldman, Christopher Moriates*	Adding to Your Toolbox: QI Methodologies *Darlene Tad-y, Anjala Tess*	Updates in Antibiotics – Determining Duration & When to Switch to PO *Samir Shah*	Re-Defining Co-Management in Hospital Medicine *William Atchley, Mark Goldin, Corey Karlin-Zysman*	The Most Interesting Man in the World: The Art of Story in Delivering Memorable Lectures *Ethan Cumbler*	Systems, Behaviors and Accountability: Why Is a Just Culture So Critical to Quality and Safety Improvement and What Can Hospitalists Do? *Christian Dankers, Allen Kachalia*	The Quadruple Aim: Strategic Initiatives to Foster Engagement and Build Resilience Across the Continuum of Hospital Medicine *Lauren Meade, Eileen Barrett, Elizabeth Harry, Sima Desai*	Make Cognitive Errors in an App, Not on the Wards: Online Case Simulations to Enhance Diagnostic Reasoning *Zaven Sargsyan, Stephanie Sherman, Reza Manesh*
3:50 - 4:20 P.M.										
CPAP, BIPAP, High-Flow and Cases *Peter Clardy*	I Can't Breathe: Acute Exacerbations - Asthma and COPD *Patricia Kritek*	Update in Pharmacology: Drug Safety, New Drugs, and De-prescribing for the Hospitalist in 2017 *Joseph Li*	Imaging Wisely: Improving the Value of Medical Imaging *Rebecca Smith-Bindman*	A Trainee's Guide to Getting Published *Valerie Press, Vineet Arora*						

4:30 - 5:25 P.M. - Special Interest Forums: Academic and Research, Advocacy and Public Policy, Canadian Hospitalists, Care for Vulnerable Populations, Community-Based Hospitalists, Global Health and Human Rights Section, Hospitalists Trained in Family Medicine, Information Technology, International Hospital Medicine, Leadership in Hospital Medicine, Med-Peds Hospitalists, Multi-Hospital Leadership, Nurse Practitioner/Physician Assistant, Oncology Hospitalists, Palliative Care, Patient Experience, Pediatric Hospitalists, Post-Acute Care Providers, Practice Administrators in Hospital Medicine, Quality Improvement, Rural Hospitalists, VA Hospitalists and Women in Hospital Medicine. *See the HM17 at Hand app for locations and details.*

5:30 - 7:30 P.M. - **RECEPTION WITH RESEARCH AND INNOVATIONS POSTER COMPETITION** • SHORELINE EXHIBIT HALL

7:30 - 9:30 P.M. - **SATELLITE SYMPOSIA (SEE HM17 DAILIES FOR DETAILS).**

Networking: A skill worth learning

Networking expert Ivan Misner says the best way to become an effective networker is to go to events with the idea of being willing to help people. Cultivate professional relationships with time and tenacity and don't expect them to be instant.

Ivan Misner once spent one week on Necker Island – the tony 74-acre island in the British Virgin Islands that is entirely owned by billionaire Sir Richard Branson – because he met a guy at a convention.

Mr. Misner is *really* good at networking.

"I stayed in touch with the person, and when there was an opportunity, I got invited to this incredible ethics program on Necker where I had a chance to meet Sir Richard. It all comes from building relationships with people," said Mr. Misner, founder and chairman of BNI (Business Network International), a 32-year-old global business networking platform based in Charlotte, N.C., that has led CNN to call him "the father of modern networking."

One of HM17's biggest draws will be the opportunity for hospitalists and other attendees to connect with their counterparts across the country. Sometimes it's to broaden one's network in the hopes of advancing on a career path. Other times it's to get introduced to practice leaders in medical niches such as anticoagulation. Still other times it's to be exposed to thought leaders, top researchers, and national power brokers who could provide access, insight, or both in the future.

The why doesn't matter most, Mr. Misner said. A person's approach to networking, regardless of the hoped-for outcome, should always remain the same.

"The two key themes that I would address would be the mindset and the skill set," he said.

The mindset is making sure one's approach doesn't "feel artificial," Mr. Misner said.

"A lot of people, when they go to some kind of networking environment, they feel like they need to get a shower afterward and think, 'Ick, I don't like that,'" Misner said. "The best way to become an effective networker is to go to networking events with the idea of being willing to help people and really believe in that and practice that. I've been doing this a long time and where I see it done wrong is when people use face-to-face networking as a cold-calling opportunity."

Instead, Mr. Misner suggests, approach networking like it is "more about farming than it is about hunting." Cultivate relationships with time and tenacity and don't just expect them to be instant. Once the approach is set, Mr. Misner has a process he calls VCP – visibility, credibility, and profitability.

"Credibility is what takes time," he said. "You really want to build credibility with somebody. It doesn't happen overnight. People have to get to know, like, and trust you. It is the most time consuming portion of the VCP process ... then, and only then, can you get to profitability. Where people know who you are, they know what you do, they know you're good at it, and they're willing to refer a business to you. They're willing to put you in touch with other people."

But even when a relationship gets struck early on, networking must be more than a few minutes at an SHM conference, a local chapter mixer, or a medical school reunion.

It's the follow-up that makes all the impact. Mr. Misner calls that process 24/7/30.

Within 24 hours, send the person a note: an email, or even the seemingly lost art of a handwritten card. (If your handwriting is sloppy, Mr. Misner often recommends services that will send out legible notes on your behalf.)

Within a week, connect on social media. Focus on whatever platform that person has on their business card, or email signature. Connect where they like to connect to show the person you're willing to make the effort.

Within a month, reach out to the person and set a time to talk, either face-to-face or via a telecommunication service like Skype.

Richard Quinn is a freelance writer in New Jersey.

DAY-AT-A-GLANCE

WEDNESDAY, MAY 3

7:00 - 7:45 A.M. **BREAKFAST** • MANDALAY BAY FOYER
7:45 - 8:40 A.M. **BEST OF RESEARCH AND INNOVATIONS IN 2017** • **VINEET ARORA, MD, IAN JENKINS, MD AND NADER NAJAFI, MD** • MANDALAY BAY EFGH
8:40 - 9:05 A.M. **AWARDS OF EXCELLENCE** • **BRIAN HARTE, MD, SFHM** • MANDALAY BAY EFGH
9:05 - 9:20 A.M. **STATE OF SHM** • **LAURENCE WELLIKSON, MD, MHM** • MANDALAY BAY EFGH
9:20-10:00 A.M. **HEALTH CARE SYSTEM TRANSFORMATION** • **PATRICK H. CONWAY, MD, MSC** • MANDALAY BAY EFGH
10:00 - 11:00 A.M. **BREAK IN EXHIBIT HALL** • SHORELINE EXHIBIT HALL
10:15 - 10:45 A.M. **MEDTalks** • PRODUCT THEATERS 1-3

RAPID FIRE OCEANSIDE C	RAPID FIRE OCEANSIDE D	CLINICAL UPDATES MANDALAY BAY BCD	DIAGNOSTIC REASONING MANDALAY BAY I	REPEATED SESSIONS OCEANSIDE B	PEDIATRIC MANDALAY BAY J	PRACTICE MANAGEMENT REEF BCEF	QUALITY BREAKERS EFKL	ORAL PRESENTATIONS OCEANSIDE E	WORKSHOPS SURF EF	WORKSHOPS SURF AB
EARLY MORNING BREAKOUT SESSIONS										
11:00 - 11:40 A.M.					**11:00 A.M. - NOON**				**11:00 A.M. - 12:30 P.M.**	
Endocrine Emergencies for the Hospitalist *Marilyn Tan*	CT to PET Scans: What Every Hospitalist Needs to Know *Timothy Kasprzak*	Achieving Favorable Odds: Update in Perioperative & Consultative Medicine *Barbara Slawski, Steven Cohn*	Stump the Professor 1 *Gurpreet Dhaliwal*	Pulmonary Embolism *Steven Deitelzweig*	Things We Do for No Reason in Pediatrics *Leonard Feldman*	The Complex Care Team: A ultidisciplinary Approach to Addressing Long Length-of-Stay Patients *Mitchell McClure, Debra Hernandez, Michelle Wallace, Ajay Kumar*	Strategies for Implementing a Successful Handoff Program for Hospitalists: Lessons Learned from the SHM-IPASS Mentored mplementation Program Cohort 2 *Amy Starmer, Courtney Edgar-zarate*	Top 15 Advances in Research & Innovations *Refer to the HM17 at Hand app for details.*	Costly Conversations: Leading Conversations That Drive High-Value Care with Patients, Colleagues and Supervisors *Reshma Gupta, Vineet Arora, September Wallingford, Christopher Moriates*	A Case-based Approach to Inpatient Dermatology *Daniela Kroshinsky, Kathleen Finn, Melissa Mauskar, Arturo Dominguez*
11:45 A.M. - 12:25 P.M.										
Hyponatremia Management in the Hospitalized Patient: Don't Drink the Water *Thomas Yacovella*	What's New in the Management of Pneumonia? *Joanna Bonsall*	The Arrhythmia that Never Sleeps...Not So Fast: Update in Atrial Fibrillation *Samuel Hanon*	Solutions to Diagnostic Error: 3 Rapidly Implementable Tools *Benji Mathews, Andrew Olson, Robert El-Kareh*	Update and Pearls in Infectious Diseases *John Sanders*						
NOON - 1:00 P.M. - PRODUCT THEATERS (SEE HM17 DAILIES FOR DETAILS).										
NOON - 1:00 P.M. - SATELLITE SYMPOSIA (SEE HM17 DAILIES FOR DETAILS).										
NOON - 1:30 P.M. - LUNCH AND VISIT THE EXHIBIT HALL • CLINICAL VIGNETTES POSTER COMPETITION • SHORELINE EXHIBIT HALL										
1:40 - 2:40 P.M. - UPDATE IN HOSPITAL MEDICINE - CHAD S. MILLER, MD, FACP, FHM AND RACHEL THOMPSON, MD, MPH, SFHM • MANDALAY BAY EFGH										
EARLY AFTERNOON BREAKOUT SESSIONS										
2:50 - 3:30 P.M.						**2:50 - 4:05 P.M.**			**2:50 - 4:20 P.M.**	
Opioids for Acute Pain Management in the Seriously Ill - How to Safely Prescribe *Jeanie Youngwerth*	Rheumatology Pearls for the Inpatient Provider *Neal Birnbaum*	Update of Newest Breakthrough in Cancer Therapy: Immune checkpoint inhibitors and What Every Hospitalist Needs to Know *Kerry Reynolds*	Teaching Clinical Reasoning: Approaches, Methods & Strategies *Robert Trowbridge*	Update in Heart Failure *Dustin Smith*	BRUE Guidelines *Joel Tieder*	Innovations in APP Practice Models *Emilie Thornhill, Meredith Wold*	Preventing Common Hospital Infections: A Hospitalist's How-To Guide to Implementation *Sanjay Saint, Valerie Vaughn*	Top 15 Advances in Research & Innovations *Refer to the HM17 at Hand app for details.*	QI on a Dime: Free Online Tools for Implementing and Teaching QI *Anunta Virapongse, Darlene Tad-y, Elizabeth Harry, Ryan Murphy*	Lights, Camera, Advocate! Moving Beyond the Peer-Review to Reach the Masses *Phuoc Le, Sriram Shamasunder, Rupa Marya, David Tuller*
3:35 - 4:15 P.M.										
Management of Inpatient Hypertension *R. Neal Axon*	Urologic Emergencies Hospitalists Need to Know *John Vazquez*	Casino Smoke and Other Issues: Update in Pulmonary Medicine *Enid Neptune*	Addressing Diagnostic Error: Definitions, Incidence & Causes *Mark Graber*	Hospital Delirium: New Evidence in Diagnosis & Treatment *Ethan Cumbler*	Updates in Child Abuse *Premi Suresh*					
LATE AFTERNOON BREAKOUT SESSIONS										
4:20 - 5:00 P.M.					**4:20 - 5:20 P.M.**	**4:15 - 5:20 P.M.**		**4:15 - 5:45 P.M.**	**4:30 - 6:00 P.M.**	
Non-opiate Pain Management for the Hospitalist *Theresa Vettese*	How to Pick the Drugs to Fight the Bugs *James Kim*	Look Around, Guess Who Is Gambling... Update in Geriatric Medicine *Melissa Mattison*	Stump the Professor 2 *Daniel Brotman*	Non-evidence Based Medicine: Things We Do for No Reason *Tony Breu*	Community Hospitalists Affiliated with Academic Centers: Challenges & How to Address Them *James O'Callaghan, Francisco Alvarez*	Foundations of a Hospital Medicine Telemedicine Program *Shannon Carpenter, Mac McCormick*	Medication Reconciliation Implementation: A Hospital Case Study *Hasan Shabbir, Jeffrey Schnipper*	Top 15 Advances in Research & Innovations *Refer to the HM17 at Hand app for details.*	Developing Collaborative Perioperative Care Programs *Rachel Thompson, Kurt Pfeifer, Barbara Slawski, Amir Jaffer*	Back to Basics: Empowering Hospitalists to Teach Physiology at the Bedside *Sirisha Narayana, Adam Garber, Stephanie Tang*
5:05 - 5:45 P.M.										
Pulmonary Embolism *Steven Deitelzweig*	Pitfalls in the Management of Elderly Hospitalized Patients *Colleen Christmas*	Update in Neurology *Andrew Josephson*	Medical Chopped *Alberto Puig, Mangla Gulati*	Syncope *Daniel Dressler*						
5:00 – 6: 30 P.M. - CRITICAL ROLE OF HOSPITALISTS AS LOCAL LEADERS OF ALTERNATIVE PAYMENT MODELS - RON GREENO MD, MHM, JJUSTIN PSAILA, MD, MBA, FHM, FACP, BRETT STAUFFER, MD, MHS, FHM, MA WILLIAMS, MD, FHM & NASIM AFSAR, MD, SFHM • BREAKERS ABGH										
5:30 - 6:30 P.M. - PEDIATRIC UPDATE: TOP ARTICLES IN PEDIATRIC HOSPITAL MEDICINE 2016 - AKSHATA HOPKINS, M.D., FAAP AND AMIT SINGH, MD • MANDALAY BAY J										
5:30 - 6:30 P.M. - MASTERING THE JOB INTERVIEW - SKILLS WORKSHOP FOR STUDENTS AND RESIDENTS - DARLENE TAD-Y, PATRICK RENDON, DANIEL STEINBERG, JOSH ALLEN-DICKER, ALFRED BURGER, CHRISTIE DONAHUE • OCEANSIDE G										
5:30 - 6:30 P.M. - MYTHS, MISUNDERSTANDINGS, MEDICARE & MONEY: PA/NP AND PHYSICIAN TEAMS IN HOSPITAL MEDICINE - TRICIA MARRIOTT, PA-C, MPAS, MJ HEALTH LAW, CHC • MANDALAY BAY K										
7:30 - 9:30 P.M. - SATELLITE SYMPOSIA (SEE HM17 DAILIES FOR DETAILS).										

Credibility is what takes time. You really want to build credibility with somebody. It doesn't happen overnight. People have to get to know, like, and trust you. It is the most time consuming portion of the VCP process ... then, and only then, can you get to profitability.

—*Mr. Misner*

"It's these touch points that you make with people that build the relationship," Mr. Misner said. "Without building a real relationship, there is almost no value in the networking effort because you basically are just waiting to stumble upon opportunities as opposed to building relationships and opportunities. It has to be more than just bumping into somebody at a meeting. ... Otherwise you're really wasting your time."

Misner also notes that the point of networking is collaboration at some point. That partnership could be working on a research paper or a pilot project. Or just even getting a phone call returned to talk about something important to you.

"It's not what you know or who you know, it's how well you know each other that really counts," he added. "And meeting people at events like HM17 is only the start of the process. It's not the end of the process by any means, if you want to do this well." TH

DAY-AT-A-GLANCE

THURSDAY, MAY 4

RAPID FIRE OCEANSIDE C	POTPOURRI OCEANSIDE D	CO-MANAGEMENT/ PERIOPERATIVE-MEDICINE OCEANSIDE B	HEALTH POLICY MANDALAY BAY I	PRACTICE MANAGEMENT REEF BCEF	ACADEMIC/ RESEARCH MANDALAY BAY K	QUALITY BREAKERS EFKL	WORKSHOPS SURF EF	WORKSHOPS SURF AB	WORKSHOPS LAGOON KL
7:00 - 7:40 A.M. - BREAKFAST • MANDALAY BAY FOYER									
7:40 - 8:15 A.M.			**7:40 - 8:35 A.M.**						
Inpatient Diabetes Management for the Hospitalist *Guillermo Umpierrez*	Physical Exam Pearls – The "One-Minute Exam" for Dermatology and Neurology *Andrew Josephson, Lindy Fox*	Perioperative Pitfalls: All Cardiac, All the Time *Steven Cohn, Avital O'Glasser, Christopher Whinney, Kurt Pfeifer*	Hot Topics in Health Policy for Hospitalists *Ron Greeno, Jennifer Bell, Josh Boswell*	Making "Everything We Say and Do" a Positive Patient Experience *Mark Rudolph*	The Next 'Aha' Moment in Hospital Medicine: Where & How to Find It *Heather Gilmartin, Sanjay Saint*	My QI Project Didn't Work!: Fundamentals of QI and How to Avoid Common Pitfalls of Quality Improvement *Christine Soong, Flora Kisuule*			
8:20 - 8:55 A.M.							**8:00 - 9:30 A.M.**		
LGBT Health in the 21st Century *Henry Ng*	A Case-based Approach to Difficult Conversations *Diane Sliwka*	What Went Wrong? *Paul Grant*							
9:00 - 9:40 A.M.			**8:45 - 9:40 A.M.**						
Take Your PICC: Choosing the Right Vascular Access *Vineet Chopra*	Three Communication Essentials That Ensure a Positive Patient Experience: The Nuts and Bolts *Jeremy Blanchard*	Pugnacious Perioperative Polemics *Kurt Pfeifer, Steven Cohn*	The Impact of the New Administration on Healthcare Reform *Ron Greeno, Rich McKeown, Jennifer Bell*	Updates on the Changing Landscapes of Patient Status and Documentation *Aziz Ansari*	Building a Mentorship Program *David Gallagher, Luci Leykum, Doug Carlson*	Improving Quality in the Community Hospital: Key Facilitators *Camille Upchurch, Anirudh Sridharan*	Surviving Sepsis on the Medical Wards: Using the SHM-SCCM Collaborative Experience to Drive Change at Home and Save Lives Tomorrow *Lisa Shieh, Aroop Pal, Caleb Hale, Andrew Odden*	Systems Engineering in the Hospital: What Is in Your Toolkit? *Vimal Mishra, Heather Masters, Joseph Heim, James Benneyan*	You May Want It but Can You Get It? Ways to Improve your Negotiation Skills *Carrie Herzke, Stephanie Rennke, Susan Hunt, Steven Ludwin*
9:45 - 10:25 A.M.									
GI Bleed *Linda Lee*	Updates on Mobile Apps in Healthcare *Anoop Agrawal*	Anti-thrombotic Therapy and the Procedural Patient *Scott Kaatz*	**MEDICAL EDUCATION** MANDALAY BAY I Building Effective Mini-Lectures for Teaching on the Wards *Bradley Sharpe*						
10:30 - 11:10 A.M.			**9:50 - 10:45 A.M.**				**10:00 - 11:30 A.M.**		
Skin and Soft Tissue Infections: How to Approach, Who to Consult and When to Panic *Lindy Fox*	Alcohol and Drug Withdrawal *Jesse Theisen-Toupal*	Perioperative Pitfalls: The Heart Is Not Enough *Jeffrey Bates, Efren Manjarrez, Heather Nye, Kurt Pfeifer*	From Learning Theory to Learning Success: Dissecting the Habits of Highly Effective Educators *Daniel Ricotta*	Healthcare Payment Reform for Hospitalists 2017: Tips for MIPS and Beyond *Greg Seymann*	Bite-Sized Teaching to Engage Trainees and Improve Academic Conferences *Kimberly Manning*	Patient Safety Pearls *Harry Cho, Karyn Baum*	Efficient and Effective Communication with Patients around Plans: The Evidence-Based ART Method *Lynnea Mills, Alpa Sanghavi, Peter Lichstein, Diane Sliwka*	Cutting Out Things We Do for No Reason *Amit Pahwa, L. Scott Sussman, Richard Wardrop, Christopher Moriates*	Hospitalists as Leaders in Patient Flow and Hospital Throughput *Christopher Kim, Anneliese Schleyer, Gabrielle Berger, Vikas Parekh*
11:15 - 11:50 A.M.				**10:55 - 11:50 A.M.**					
Bleeding You Dry: Updates to Relieve Transfusion Confusion *Jeffrey Rohde*	The History of Medicine: Discoveries that Shaped Our Profession *Alberto Puig*	Potpourri of Periop: Everything Not Cardiac and Not Pulmonary *Njeri Wainaina*	Visualizing the 21st Century Physical Exam: Bedside Point-of-Care Ultrasound *Daniel Schnobrich*	Making Hospital Medicine a Career (Sustainability, Retention, Engagement, Wellness, Morale) *Flora Kisuule, Christie Masters*	Attributes and Behaviors Associated with Exemplary Inpatient Teaching: How Great Attending Physicians Do It *Nathan Houchens, Sanjay Saint*	Early Discharge: Building Capacity by Increasing Throughput at an Academic Medical Center *Katherine Hochman, Nicole Adler*			

12:00 P.M. - 12:10 P.M. WHAT HAVE WE LEARNED WRAP-UP - **KATHLEEN M. FINN, MD, M. PHIL, FACP, FHM** • MANDALAY BAY EFGH

12:10 P.M. - 1:10 P.M. PLANNING FOR THE FUTURE IN A WORLD OF CONSTANT CHANGE: WHAT SHOULD HOSPITALISTS DO?
ROBERT WACHTER, MD, MHM • MANDALAY BAY EFGH

COURSE LEGEND

- Clinical Update
- Practice Management
- Academic/Research
- Quality
- High-Value Care
- Pediatric
- Diagnostic Reasoning
- Potpourri
- Co-Management Perioperative Medicine
- On Demand
- Repeated Session
- MOC Credit

MUST-SEE SESSIONS

CONTINUED FROM PAGE 26

7 Hot Topics in Health Policy for Hospitalists

Thursday, May 4; 7:40 a.m. - 8:35 a.m.

8 The Impact of the New Administration on Healthcare Reform

Thursday, May 4; 8:45 a.m. - 9:40 a.m.

9 Healthcare Payment Reform for Hospitalist 2017: Tips for MIPS and Beyond

Thursday, May 4; 9:50 a.m. - 10:45 a.m.

Dr. Stella: "As a safety-net hospitalist in Colorado, a state which largely expanded Medicare under the Affordable Care Act (ACA), I am concerned about the impact repealing the ACA would have on my patients as well as on safety-net hospitals such as my own. I hope that these sessions will increase my understanding of the issues and my ability to advocate for my patients."

Dr. Cook: "The U.S. government is functioning in historically unprecedented ways with major shifts in healthcare policy expected to occur over the next 4 years. It is essential that physician leaders play an active role in shaping the discussion around these important topics ... hospitalists have an opportunity to provide leadership in this arena and these sessions will help participants being to build the knowledge about these complex issues that is crucial to being an active part of the dialogue."

10 Workshop: Hospitalists as Leaders in Patient Flow and Hospital Throughput

10 a.m. - 11:30 a.m.

Dr. Stella: "Recently, I was appointed to a leadership role on a major initiative to improve hospital patient flow at my institution. We are concentrating on several different areas including avoidable hospitalizations, preventable excess days, delayed discharges, and variable access to services. I was excited to see a workshop this year dedicated to how hospitalists can successfully lead such initiatives. I will definitely be attending this session as I am interested in what others are doing in their institutions to creatively overcome patient flow challenges."

11 Hospitalist Careers: So Many Options

Tuesday, May 2; 10:35 a.m. - 11:15 a.m.

Dr. Villagra: "Hospital medicine has so many pathways for a full career development and is not a pit stop before fellowship. Early- and mid-career hospitalists can benefit from interaction with senior hospitalists for the understanding of what hospital medicine has to offer for their professional growth." TH

RIV: Always a highlight

Look back at the history of SHM's annual Research, Innovations, and Clinical Vignettes poster competition – better known as the RIV – and it may seem inevitable that it's grown into one of the main highlights of the conference. The RIV has become so popular that the number of submissions has nearly tripled from 634 in 2010 to 1,712 this year.

But inevitability has nothing to do with it, said Margaret Fang, MD, MPH, FHM, and program chair for HM17's scientific abstracts competition, RIV's more formal sobriquet.

"Certainly, there is some natural evolution," said Dr. Fang, a hospitalist, researcher, and anticoagulation clinic director at the University of California San Francisco. "But not all specialty societies embrace research or encourage its growth, so I would give a lot of credit to the Society of Hospital Medicine for being very deliberate in trying to strengthen its research program, highlight the research that hospitalists do, and make research a core pillar of what SHM stands for."

The efforts have clearly worked, as RIV is a major driver for annual meeting attendance. The poster competition draws massive crowds that snake their way through the accepted posters. For those interested in a deeper dive, SHM chooses a dozen or so top abstracts for oral presentations that are, in Dr. Fang's words, "the creme de la creme of all the research and innovations for the given year."

The growth of the abstracts competition comes, of course, as the specialty itself has seen its ranks skyrocket. Hospitalists now number an estimated 52,000 nationally, and in addition to providing direct clinical care, hospitalists have taken ownership of key health care drivers like patient safety, quality improvement, and systems change.

"We do what we do for the good of health care and ultimately for the good of our patients," Dr. Fang said. "Sometimes that's rounding and taking care of patients in a clinical fashion, and sometimes it's contributing to the medical literature. It could have been really easy for a specialty to say, 'Not our problem,' or 'No, we're just rounding.' "

HM17 course director Lenny Feldman, MD, FAAP, FACP, SFHM, believes that the commitment of SHM's founding generation to do research for the past decade has created a group of mentors that push younger hospitalists to do more of the same.

"If we didn't have the research engine part of hospital medicine, if we didn't have the folks who are getting into administration and other important leadership areas, we wouldn't see the maturation of this specialty and we would in many ways be stuck at the point at which we started," Dr. Feldman said. "The only way for us to move forward is to do the research, to be in position to make sure that hospital medicine continues to grow in a direction that is good for our patients, for us and for the entire system."

That perspective is what motivates hospitalists to make the RIV bigger each year, said Dr. Fang.

"Having your abstract accepted as a poster or an oral presentation showcases all the work that you've put into it," Dr. Fang said. "There's a huge amount of pride in showing what you've been able to achieve. The driving force is the desire to see what other people are doing, and network to share ideas. That's the really wonderful part of the RIV competition." TH

Photo courtesy of SHM

The annual RIV abstracts competition is larger in 2017 than ever before.

Northwestern Medicine®

Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, Illinois 60045-9989
847.234.5600
nm.org

Join the thriving Pulmonary Critical Care team at Northwestern Medicine Lake Forest Hospital as an ICU Hospitalist. We seek a physician who can work night shifts, is dedicated to exceptional clinical care, quality improvement, and medical education.

ABOUT US

Northwestern Medicine Lake Forest Hospital is a community hospital with nearly 200 beds and is located approximately 30 miles north of downtown Chicago in scenic and charming Lake Forest. Care is provided through the main hospital campus in Lake Forest and multiple outpatient facilities including one in Grayslake, IL, which also includes a free-standing emergency center. Lake Forest Hospital is served by a medical staff of more than 700 employed and affiliated physicians. It continues to be recognized by U.S. News & World Report as one of the top hospitals in Illinois and Chicago and also received Magnet re-designation in 2015, the gold standard for nursing excellence and quality care. A new state-of-the-art hospital facility is scheduled to open in 2017.

Northwestern Medicine Lake Forest Hospital

Northwestern Medicine is a growing, nationally recognized health system that provides world-class care at seven hospitals and more than 100 locations in communities throughout Chicago and the North and West suburbs. Together with Northwestern University Feinberg School of Medicine, we are pushing boundaries in our research labs, training the next generation of physicians and scientists, and pursuing excellence in patient care.

Our vision and values are deeply rooted in the idea that patients come first in all we do. We value building relationships with our patients and their families, listening to their unique needs while providing individualized primary, specialty and hospital-based care. Our recent affiliations and ongoing growth make it possible for us to serve more patients, closer to where they live and work.

Northwestern Memorial HealthCare, a nonprofit organization, is the corporate parent of Northwestern Medicine and all of its entities, including Northwestern Medicine Lake Forest Hospital, Northwestern Memorial Hospital, Northwestern Medicine Central DuPage Hospital, Northwestern Medicine Delnor Hospital, Northwestern Medicine Kishwaukee Hospital, Northwestern Medicine Valley West Hospital and Northwestern Medicine Marianjoy Rehabilitation Hospital.

If you are interested in advancing your career as an ICU Hospitalist with Northwestern Medicine Lake Forest Hospital, please e-mail your CV and cover letter to:

LFPCCRecruitment@nm.org

†PIKEVILLE MEDICAL CENTER

SEEKING BOARD ELIGIBLE/CERTIFIED HOSPITALISTS: Located in the picturesque mountains of Pikeville, Kentucky, Pikeville Medical Center (PMC) is a 300 bed tertiary care center. Currently in our 92nd year, PMC offers more than 400 services in every specialty and most subspecialties. With nearly 400 credentialed providers and over 3,000 employees, PMC upholds the highest of standards meeting our mission of providing world-class quality health care in a Christian environment. As a proud member of Mayo Clinic's Care Network and Kentucky's only Level II Trauma Center, PMC offers experienced support staff in a modern, state-of-the-art facility. We invite you to practice in "The City that Moves Mountains."

COMPENSATION & BENEFITS

- Competitive salary & excellent benefit package
- Student Loan repayment (negotiable)
- Moving expenses paid
- Stipends offered if situation is applicable
- CME expenses paid
- Paid KY & DEA licenses and society dues
- Medical malpractice insurance paid
- H1B Cap-exempt facility

PHYSICIAN INCENTIVES

- Flexible 7 days on/7 days off schedule
- Closed ICU
- Intensivists in-house
- Nocturnist coverage
- Extensive specialty backup

For more information, contact: **ashley.mccoy@pikevillehospital.org • annie.carter@pikevillehospital.org • alison.lovely@pikevillehospital.org**

911 Bypass Road • Pikeville, KY 41501 • 606-218-4915

Pikeville Medical Center is an Equal Opportunity Employer

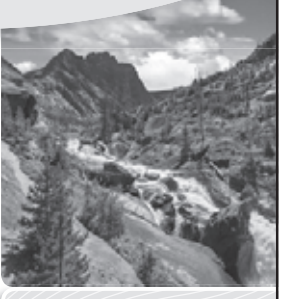
Physician-Led Medicine in Montana

Hospitalist

Billings Clinic

Seeking BE/BC Hospitalists to join our group in Montana's premier, state-of-the-art medical center, which serves as the region's tertiary referral center. Our seasoned team values work-life balance and collegiality.

- Extremely flexible scheduling
- Generous salary with yearly bonus
- Signing bonus
- Student loan repayment
- No procedures required
- Teaching opportunities
- "America's Best Town of 2016" – *Outside Magazine*



Please visit us at booth #903 at the 2017 Hospital Medicine Conference in Las Vegas!

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

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

BEST HOSPITALS U.S.News NATIONAL RANKINGS

The Ohio State University Wexner Medical Center

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.

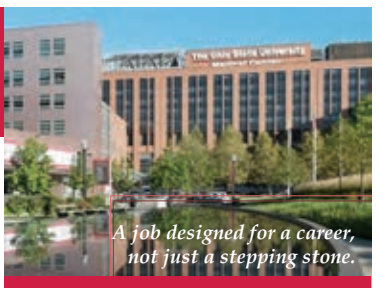
Practice Locations:

- 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



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

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Martha Jefferson Hospital

SENTARA®

Hospitalist Opportunity, Charlottesville, Virginia - **Martha Jefferson Hospital, a member of Sentara**, is currently recruiting for a full time hospitalist.

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

We offer competitive salary, benefits, and a cohesive work environment. Charlottesville is a university town, consistently rated as one of the best places to live, raise a family, with excellent schools, metropolitan dining, and outdoor activities.

Not a J-1/H1-B Visa opportunity.

Contact
Paul Tesoriere, MD
PJTESORI@sentara.com.

Expand your reach

with an ad in the *Journal of Hospital Medicine*, SHM's clinical content journal

For rates or to place an ad, contact:
Heather Gentile • 973-290-8259 • hgentile@frontlinemedcom.com
OR
Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

Ask about our combination discount when advertising in both *JHM* and *The Hospitalist*.

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

Hospitalists

Minnesota and Wisconsin

Be part of something bigger at HealthPartners, where we focus on health as it could be, affordability as it must be, and relationships built on trust. HealthPartners Medical Group (HPMG) is a large, nationally recognized multi-specialty physician practice, based at clinics and hospitals throughout metropolitan Minneapolis/St. Paul, central Minnesota and western Wisconsin.

Our Hospital Medicine Department is seeking BC/BE IM or FM physicians to work in our high functioning, multi-disciplinary team environment. Whether you seek an urban, suburban, semi-rural or rural community practice, HPMG has a variety of opportunities within thriving family-oriented communities with top school systems, healthy economies, sports and theatre and bountiful lakes and outdoor recreation.

- Regions Hospital is our tertiary hospital and regional referral center in St. Paul. We are a major teaching affiliate for the University of Minnesota with a dedicated Hospital Medicine Pathway in their residency program.
- We are nocturnist-supported and have additional nocturnist opportunities available with pay differentials.
- We have a strong Advanced Practice Provider (APP) team and a dedicated APP fellowship training program.
- We have ample opportunities to expand your professional interests in palliative care, community hospital medicine, surgical co-management, telemedicine, research, quality improvement and medical education.
- Our hospital locations in western Wisconsin's beautiful St. Croix River Valley offer community-based practices with convenient connections to metro area support.
- Our scheduling system offers flexibility, allowing for travel, CME and a good work-life balance.
- We offer a generous, competitive compensation and benefits package and an exciting practice within a prestigious, respected healthcare organization.

Apply online at **healthpartners.com/careers** or email your CV, cover letter and references directly to **lori.m.fake@healthpartners.com**. For more details, contact: Department Chair Jerome Siy, M.D., SFHM or Lori Fake at 800-472-4695, x1. H-1B visa eligible. EOE

HealthPartners®

healthpartners.com

Johnston Memorial Hospital
Mountain States Health Alliance

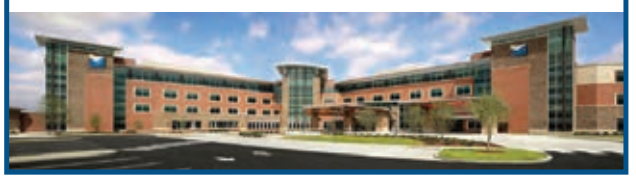
HOSPITALISTS & NOCTURNISTS

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

- Hospital Employed (earning potential up to $300k per year)
- Day Shift (7 days on -7 days off) (7am - 7pm)
- Nocturnist (7 days on - 7 days off) (7pm - 7am)
- Competitive Annual Salary
- Performance Bonus & Production Bonus
- Excellent Benefits
- Generous Sign On Bonus
- Relocation and Educational Loan Assistance
- Teaching and Faculty opportunities with the JMH FM/IM Residency Training Programs
- Critical Care Physician Coverage in CCU/PCU

Please view our online job tour:
www.mshajobtour.com/jmh

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



WHERE A LANDSCAPE OF OPPORTUNITIES AWAITS
FM OR IM TRAINED HOSPITALISTS

A work environment and schedule sustainable for your entire career

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

Practice highlights:

- 7 on 7 off schedule
- Team established in 2002 with high retention rate and growth
- Rotate though all internal medicine hospital services: observation unit, inpatient admissions, consults, night float
- 26-member internal medicine hospitalist team comprised of 16 physicians and 10 associate staff
- Primary responsibility will be adult inpatient care
- Manageable daily census
- Direct involvement with teaching family medicine or internal medicine residents
- Competitive compensation and benefits package, including loan forgiveness

Visit gundersenhealth.org/MedCareers

Send CV to Kalah Haug
Medical Staff Recruitment
kjhaug@gundersenhealth.org
or (608) 775-1005

Equal Opportunity Employer

GUNDERSEN HEALTH SYSTEM®
Where Caring Meets Excellence

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

Contact:

Heather Gentile • 973.290.8259
hgentile@frontlinemedcom.com

or

Linda Wilson • 973.290.8243
lwilson@frontlinemedcom.com

shm Society of Hospital Medicine The Hospitalist

Now you have **more digital options** available for your recruiting

- The country's largest, 100%-validated U.S. physician database—the only one that's BPA audited
- Candidates who are guaranteed to be licensed, practicing U.S. physicians
- Banner and native ads in the SHM member e-newsletter
- Customized searches to match your job to the exact physician profiles you want

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

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.

MOUNT AUBURN HOSPITAL

Mount Auburn Hospital is searching for a physician to serve as a NOCTURNIST academic hospitalist. The selected candidate will provide clinical care and teaching of medical students and medical residents in a busy community teaching hospital, both on the inpatient medical floors and the step down unit. There will be opportunity for leadership of some aspect of the teaching program such as the inpatient medical consult rotation for medical residents. The selected candidate will receive a Harvard Medical School faculty appointment commensurate with their experience.

We are an Equal Opportunity Employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law. We strongly encourage both women and minorities to apply.

Applicants should send CV and a brief cover letter to: **searchco@mah.harvard.edu**, or fax to: 617-499-5620.

NOCTURNIST

Visit with our Hospitalist Recruitment Team, Booth # 726, at the SHM National Conference in Las Vegas, May 1st through May 4th, 2017, and Discover How a Practice With Banner Health is the Safe Bet to Your Career Jackpot!

Banner Health®

EMPLOYED BC/BE HOSPITALIST OPPORTUNITIES

BANNER HEALTH, one of the country's premier, non-profit health care networks has employed practice opportunities for HOSPITALISTS in NORTHERN COLORADO and ARIZONA, including Tucson and the greater Phoenix metropolitan area. Banner Health is recognized for its leadership and dedication to the communities we serve. We offer attractive compensation including paid malpractice, paid CME days plus allowance, recruitment incentives and flexible benefits package options that provide security for you and your family. ***Join our growing team of employed physicians as we expand our Hospitalist program in these outstanding locations.***

NORTHERN COLORADO. ***Greeley, Loveland and Fort Collins*** are some of the finest places to live and work in the entire nation. Enjoy spectacular views along the Rocky Mountain Front Range, great weather (over 300 days of pure Colorado sunshine a year), endless recreational activities, numerous educational and professional opportunities and so much more!

TUCSON, AZ. A city of 750,000 inhabitants, 45 miles from the U.S. border with Mexico, is a growing economic and recreational center with a multi-cultural population that reflects the richness of the Southwest. The city shares common borders with the Tohono O'odham and Pascua Yaqui Nations, and is surrounded by majestic desert and rugged mountains rising to more than 9,000 feet. Southern Arizona has more than three hundred days of sunshine per year, more than any other region in the U.S.

PHOENIX, AZ. America's sunniest metropolis and the cosmopolitan heart of Arizona. It's a city that basks in sunshine during 85 percent of daylight hours and is surrounded by stunning Sonoran Desert scenery. Phoenix is the United States sixth-largest city with a population of over 1.4 million. Greater Phoenix (which includes, among others, the cities of Chandler, Glendale, Scottsdale and Tempe) has a population of nearly 4.3 million. Greater Phoenix is home to more than 200 golf courses, and Spring training home to 15 Major League Baseball teams.

PAYSON, AZ. Situated along the mountains of the Mogollon Rim: a 7,000-foot, 200-mile long escarpment provides a beautiful backdrop that envelops this scenic and friendly town. At an elevation of 5,000 feet, the area enjoys a mild climate that accommodates year-round outdoor exploration, but not at the expense of missing out on seasonal changes. Outdoor recreational opportunities of many types are found in and around Payson. Not to mention Payson is just over an hour away from Scottsdale and Mesa.

SUBMIT YOUR CV, TO: Melanie Mrozek, Physician Recruiter, Sr. Consultant, at: doctors@bannerhealth.com **For questions, please call:** 602.747.2256. **Visit our website, at:** www.bannerhealth.com As an equal opportunity and affirmative action employer, Banner Heath recognizes the power of a diverse community and encourages applications from individuals with varied experiences and backgrounds. Banner Health is an EEO/AA - M/W/D/V Employer.

shm Society of Hospital Medicine The Hospitalist

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

Contact:

Heather Gentile • 973.290.8259
hgentile@frontlinemedcom.com
or
Linda Wilson • 973.290.8243
lwilson@frontlinemedcom.com

Looking to fill an open position?

to advertise in the *Hospitalist* or the *Journal of Hospital Medicine,* contact:

Heather Gentile • 973-290-8259 • hgentile@frontlinemedcom.com
OR
Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

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

PARDEE
UNC HEALTH CARE

Nocturnist Hospitalist Opportunity Hendersonville, NC (Near Asheville!)

Employed Nocturnist Hospitalist opportunity. Full Time, seven on/seven off, 7:00 pm - 7:00 am. Average 6 - 8 admissions/consults per shift. Employed opportunity offers competitive base salary plus wRVU incentive, annual quality bonus, CME/Dues allowance, sign-on, relocation, paid professional liability insurance. Pardee Hospital is licensed for 222-beds and is a county, not-for-profit hospital affiliated with UNC Health Care. Must be BC in IM, FP or HM.

Live in the "Land-of-Sky," with the unmatched scenic beauty of the southern Appalachian Mountains and located in one of the fastest growing regions in North Carolina. The area boasts a great public school system as well as a wide variety of private and charter schools. The area is regularly featured in travel magazines and major publications as an area that attracts vacationers, retirees, and families because of the safety of the community and exceptional quality of life.

No Recruitment or Placement Firm Inquiries.
No Visa sponsorship.

Contact: Lilly Bonetti, Physician Recruiter
office (828) 694-7687
email Lillian.bonetti@unchealth.unc.edu
www.pardeehospital.org

St Luke's
UNIVERSITY HEALTH NETWORK

Network Medical Director for 7 Hospital System in PA/NJ

The Medical Director, Hospitalist Service, is responsible for providing on-site clinical leadership and management for the Network. This individual will serve as the clinical lead and will work closely with physicians, Site Medical Directors, AP leadership and Staff to assure consistent high quality in keeping with the goals of the organization and the group. Must have three to five years' experience in Hospital Medicine and be board certified; leadership experience strongly preferred. Excellent compensation and benefit package.

SLUHN is a non-profit network comprised of more than 450 physicians, 200 advanced practitioners and 7 hospitals, providing care in eastern Pennsylvania and western NJ. 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

YOU OWN THE NIGHT

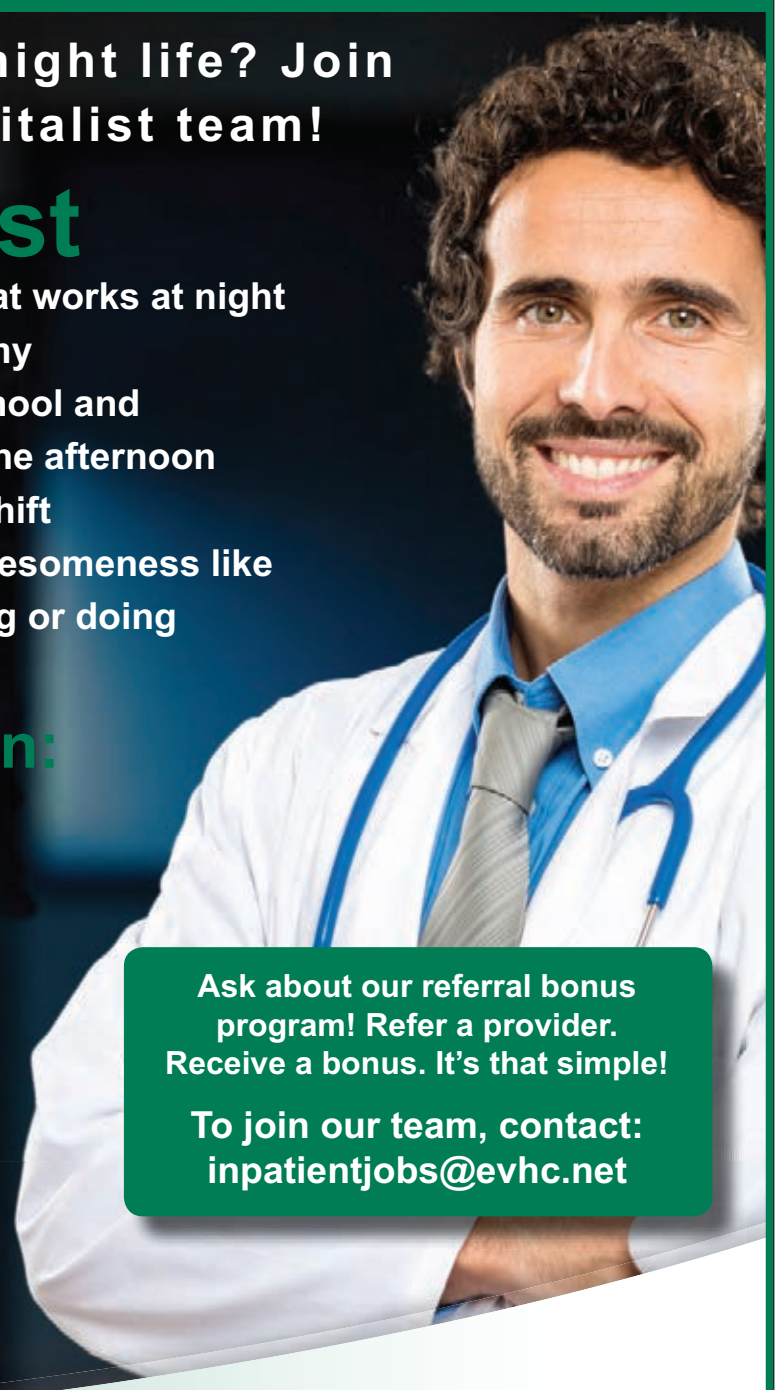
Do you love the night life? Join the EmCare hospitalist team!

noc•tur•nist

- **Superstar Hospitalist that works at night**
- **Enjoys practice autonomy**
- **Home to take kids to school and help with homework in the afternoon**
- **No rushing to an early shift**
- **Freedom for daytime awesomeness like bike riding, rock climbing or doing absolutely nothing**

Opportunities in:

Augusta, GA
Atlanta, GA
Chattanooga, TN
Ft Pierce, FL
Ft. Walton, FL
Kansas City, MO
Miami, FL
Nashville, TN
Panama City, FL



Ask about our referral bonus program! Refer a provider. Receive a bonus. It's that simple!

To join our team, contact: inpatientjobs@evhc.net

Quality people.
Quality care.
Quality of **LIFE**.™

EmCare®
Hospital Medicine
MAKING HEALTHCARE WORK BETTER™

Physicians, you're just one click away from your next job with the new **SHM Career Center**

You've never had a more powerful ally in making your next career move. The new SHM Career Center is designed for busy doctors. Now you can:

- Create job alerts
- Save your jobs
- Quickly search for jobs on your smartphone — works seamlessly!

Create a candidate profile and get matched to your ideal job

Find your next job today.
Visit www.shmcareers.org

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

MIDWEST HOSPITALIST OPPORTUNITIES

Franciscan Physician Network includes more than 800 physicians and advanced practice providers at over 260 locations. This organization brings together, under one name, the many primary care and specialty physician groups associated with Franciscan Health's hospitals and access points across Indiana, Illinois and Michigan. Current Hospitalist opportunities are available in:

- **Northwest Indiana, including Dyer, Hammond, Michigan City**
- **Central Indiana, Mooresville**

A career with Franciscan Physician Network offers work-life balance as well as many other benefits. Contact us for more information on our compensation and benefits packages.

Franciscan PHYSICIAN NETWORK

For more information on current opportunities:
(844) FPN-DOCS /(844) 376-3627
Email us at *Practice@franciscanalliance.org*
Apply online at *Jobs.FranciscanHealth.org*

Mercy Medical Group
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 400 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.

Intermountain Healthcare has both outpatient opportunities for INTERNAL MEDICINE & HOSPITALIST positions throughout Utah in all major cities.

INTERNAL MEDICINE
- Enjoy a 4 day work week
- Loan repayment and signing bonus
- Stipend available for those still in training
- Outpatient only with mental health integration
- Pension, 401k match, and relocation

HOSPITALIST
- Reasonable patient load
- Flexible work schedule
- Competitive salary, signing bonus
- Pension, 401k match, and relocation

TOP REASONS TO CHOOSE UTAH:
World-Class Year-Round Skiing, Hiking, and Biking
4 Distinct Seasons
5 National Parks
Best State for Business
Endless Outdoor Recreation Opportunities

Intermountain® Healthcare

physicianrecruit@imail.org • 800.888.3134 • *PhysicianJobsIntermountain.org*

HOSPITALISTS DAY AND NOCTURNIST POSITIONS

White Plains Hospital has a reputation for both clinical excellence and outstanding personalized care. The state-of-the-art hospital is a twelve-time winner of the Consumer Choice Award, an honor given to the nation's top hospitals by the National Research Corporation, and received Magnet re-designation in 2016 from the the American Nurses Credentialing Center (ANCC). It is also the only hospital in New York State to be included by Soliant Health in its 20 Most Beautiful Hospitals in the United States for 2016.
Our expanding Adult Hospitalist Program is seeking exceptional candidates interested in **Full Time Day and Night positions**. Candidates must be BC/BE in Internal Medicine and have the ability to work well in a professional, collegial atmosphere.

- **Ranked by CNN Money as one of the best cities to live in**
- **Only 25 minutes north of New York City**
- **Hospitalists are employed by the hospital/ICU covered by Intensivists**
- **Competitive salary including employment and incentive bonus programs, paid vacation & paid CME**
- **Comprehensive benefits include: health/dental/vision, paid malpractice, 403(b)plan**
- **State-of the-art electronic medical records system**

If you are interested in joining a professional and dynamic team of 30 Hospitalists in an award winning facility, please send your CV to:

Attn: David Bigham, H.R. Director
E-mail: hospitalist@wphospital.org
White Plains Hospital, 41 East Post Road, White Plains, NY 10601
Fax: 914-681-2590

White Plains Hospital
Exceptional, every day.

www.wphospital.org **EOE M/F**

Bassett Healthcare Network
A.O. Fox Hospital

HOSPITALIST

A.O. Fox Memorial Hospital, an acute care community hospital and affiliate of the Bassett Healthcare Network, is seeking a BC/BE Hospitalist to serve our patient population in Oneonta, NY.

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

Nestled in the foothills of the Catskill Mountains, the City of Oneonta offers diversity, stability and beauty. Oneonta is home to two colleges, State University of New York at Oneonta and Hartwick College, a private liberal arts college. The area also boasts many cultural and four season recreational advantages including theater, music, museums, golf, sailing, hiking, and skiing.

EOE

For confidential consideration, please contact:
Debra Ferrari, Manager, Medical Staff Recruitment
Bassett Healthcare Network
phone: 607-547-6982; fax: 607-547-3651 or email:
debra.ferrari@bassett.org
or for more information visit our web-site at
www.bassett.org

shm Society of Hospital Medicine **The Hospitalist**

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

Contact:

Heather Gentile • 973.290.8259
hgentile@frontlinemedcom.com
or
Linda Wilson • 973.290.8243
lwilson@frontlinemedcom.com

Expand your reach

with an ad in the *Journal of Hospital Medicine*, SHM's clinical content journal

For rates or to place an ad, contact:
Heather Gentile • 973-290-8259 • hgentile@frontlinemedcom.com
OR
Linda Wilson • 973-290-8243 • lwilson@frontlinemedcom.com

Ask about our combination discount when advertising in both *JHM* and *The Hospitalist*.

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

Classified Advertising

FIND THE PERFECT FIT!

For more information on placing your classified advertisement in the next available issue, contact:

Heather Gentile • 973.290.8259
hgentile@frontlinemedcom.com
or
Linda Wilson • 973.290.8243
lwilson@frontlinemedcom.com

shm The Hospitalist

THIS IS YOUR PRACTICE

"CEP America is trustworthy, transparent, and has great physician leaders. This is our practice, and we get involved."

Amina Martel, MD
HOSPITAL MEDICINE PARTNER

CEP America currently has hospitalist, intensivist, and skilled nursing practices in California, Illinois, New Jersey, Oregon, and Washington, 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
- Walnut Creek

ILLINOIS
- Alton
- Belleville

NEW JERSEY
- Passaic

OREGON
- Roseburg

WASHINGTON
- Edmonds

INTERESTED IN TRAVEL?
Check out our Reserves Program.

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®

Hilton Head Regional Physician Network

Hospitalists needed for our hospital system-employed group in beautiful Hilton Head Island, South Carolina

Please visit us at SHM in Las Vegas-Booth 345

Join our team at Hilton Head Hospital (93 beds) or Coastal Carolina Hospital (41 beds) and the Hilton Head Regional Physician Network.

- 7 on/7 off, 12 hour shifts, days or nights are available
- Procedures are handled by the ER physicians, open ICU
- OB and Peds are not seen by the hospitalist team
- Competitive salary & comprehensive benefits

Hilton Head Regional Healthcare is located on the beautiful island of Hilton Head, SC, 25 minutes from Savannah, Georgia.

With endless possibilities for recreation, cultural activities, over 250 restaurants that offer a wide-range of culinary riches, schools recognized for high levels of academic achievement, and a true sense of community, this could be the place you call home!

For more information, email CV to
Lane.Mitnick@tenethealth.com

Hospitalist/Nocturnist Opportunities in PA Starting Bonus and Loan Repayment

St Luke's University Health Network (SLUHN) has hospitalist/nocturnist opportunities in eastern Pennsylvania. We are recruiting for BC/BE Nocturnists at our Bethlehem/Anderson Campuses Hospitalist positions at other campuses in PA including our newest hospital in Monroe County that opened in October of 2016. This group focuses on outstanding quality and enjoys a collegial atmosphere.

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

St Luke's University Health Network

SLUHN is a non-profit network comprised of more than 450 physicians, 200 advanced practitioners and 7 hospitals, providing care in eastern Pennsylvania and western NJ. 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

UNIVERSITY *of* MISSOURI

Academic Hospitalists

The University of Missouri-Columbia, Division of Hospital Medicine is seeking full-time academic Hospitalists to join our well-established program. Our rapidly growing hospitalist group provides inpatient support for a multi-hospital academic health system. We seek applicants who have exemplary clinical skills and a strong interest in teaching. This position comes with competitive salary, benefits, and work hours. We seek applicants whom are BE/BC for the following titles, Clinical Instructor or Assistant or Associate Professor of Medicine. MU Health Care offers more than 50 primary and specialty clinics and a comprehensive system of 6 hospitals. Columbia is rated by *Forbes* as 5th best small place for business and careers in America and is consistently rated a top place to live by *Money* magazine. Columbia also offers a low cost of living and excellent schools. This is a comprehensive department, offering a full complement of fellowship programs.

The University of Missouri is fully committed to achieving the goal of a diverse and inclusive academic community of faculty, staff and students. We seek individuals who are committed to this goal and our core campus values of respect, responsibility, discovery and excellence.

To apply for this position, please visit the MU web site at **hrs.missouri.edu/find-a-job/academic/.** For additional information about the position, please contact Syed Naqvi, Director, Division of Hospital Medicine **(naqvis@health.missouri.edu).**

Active review of applications will begin immediately, and the search will continue until the position is filled.

An Equal Opportunity/Access/Affirmative Action/Pro Disabled and Veteran Employer. To request ADA accommodations, please call the Disability Inclusion and ADA Compliance Manager at 573-884-7278.

Dignity Health.
Hello humankindness

Seeking Superstar Hospitalists

SANTA CRUZ, CALIFORNIA

Come Join a Provider of Choice with Physicians Who Have Been in the Community for Over 30 years!

Dignity Health Medical Group – Dominican (http://dhmf.org/dominican), a service of Dignity Health Medical Foundation, is seeking energetic, passionate, hardworking and outgoing Hospitalists to join our vibrant team. We are a multi-specialty, physician-owned group with more than 70 physicians and advanced practitioners and still growing. We are affiliated with Dominican Hospital, a 223-bed hospital (http://dominicanhospital.org).

WHY JOIN US?
- Located in sunny Santa Cruz, CA (1-1/2 hours from San Francisco, 30 minutes from San Jose)
- Shareholder opportunity
- Excellent shift pay plus incentives
- Residency signing stipend, transition and relocation bonuses, CME and benefits
- Aligned with one of the largest health systems in the nation and the largest hospital system in California

PRACTICE HIGHLIGHTS:
- 7 on/7 off schedule
- Practice autonomy with administrative support
- Only 1 hospital location
- Hospitalist Discharge RN on team
- Subspecialty referrals readily accessible

PLEASE SEND YOUR CV AND CONTACT:
Dignity Health
Lori Hart, Physician Recruiter
Toll Free: 888.599.7787 | providers@dignityhealth.org
www.dignityhealth.org/physician-careers

Now you have **more digital options** available for your recruiting

- The country's largest, 100%-validated U.S. physician database—the only one that's BPA audited
- Candidates who are guaranteed to be licensed, practicing U.S. physicians
- Banner and native ads in the SHM member e-newsletter
- Customized searches to match your job to the exact physician profiles you want

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

Hospitalist or Nocturnist

Montgomery County, PA

Now is a great time to join Einstein Physicians, part of Einstein Healthcare Network! We are a patient-centric and physician-led multispecialty practice of more than 500 physicians with a very broad scope of services and striving to be the premier practice in Philadelphia. We are offering the opportunity for you to become part of our team and build a successful, meaningful career alongside an extraordinary group of physicians and staff.

Einstein Medical Center Montgomery (EMCM) seeks candidates for Hospitalist and Nocturnist positions. EMCM is located on 87 acres along Germantown Pike in East Norrition, PA, and was built from the ground up around patient comfort, safety and the demands of evolving medical technology.

Candidates must be physicians who are board-certified/board-eligible in Internal Medicine and who wish to join our practice on a full-time basis. We offer H-1B/Green Card sponsorship if requested, and some of our practices qualify for J-1 waivers.

If you are a dedicated, energetic and ambitious Hospitalist, learn more by sending your CV to **hannanki@einstein.edu** or by calling Kimberly Hannan at **(267) 421-7435.**

Einstein HEALTHCARE NETWORK

EOE

Maximize your Career with Emory's Premier Academic Hospital Medicine Division

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

We are recruiting now for both Nocturnist and Daytime positions, so apply today. Applications will be considered as soon as they are received. Emory University is an Equal Opportunity Employer.

A career with Emory includes:
- Generous salary, benefits, and incentives
- Faculty appointments commensurate with experience
- Broad range of clinical, academic, and research experiences
- On-site medical directors
- Flexible scheduling options
- Full malpractice and tail coverage

Apply now for immediate openings!
Email your cover letter and CV to:
Dr. Dan Hunt, Director
c/o Danielle Moses, Physician Services Coordinator/Recruiter for Medicine
Phone: 404-778-7726
danielle.moses@emoryhealthcare.org

medicine.emory.edu/hospital-medicine | emoryhealthcare.org/hospital-medicine

Our Programs:
Emory University Hospital
Emory University Hospital Midtown
Emory Saint Joseph's Hospital
Emory Johns Creek Hospital
Emory University Orthopaedics & Spine Hospital
Grady Memorial Hospital
Veterans Affairs Medical Center, Atlanta

EMORY UNIVERSITY SCHOOL OF MEDICINE

EMORY HEALTHCARE

ATLANTA'S BEST AND BRIGHTEST COMPANIES TO WORK FOR WINNER 2016

shm Career Center

Find your next job today!

visit **WWW.SHMCAREERS.ORG**

Bridgton Hospital
The Central Maine Medical Family

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

Benefits include medical student loan assistance, competitive salary, highly qualified colleagues and excellent quality of life.

For more information visit our website at
www.bridgtonhospital.org
Interested candidates should contact
Julia Lauver, CMMC Physician Recruitment
300 Main Street, Lewiston, ME 04240
email: **LauverJu@cmhc.org**
call: 800/445-7431 fax: 207/755-5854

TEAMHealth®

Join our Hospital Medicine Team in Kentucky!

We are looking for a dedicated **Nocturnist** to join our Hospital Medicine team full-time at **UK Good Samaritan Hospital** in **Lexington, Kentucky**. Our ideal candidate will work 7-on/7-off with the support of 2 APCs and be BE/BC in IM or FM with Hospitalist experience. You'll have a manageable patient load. We have an open ICU and you'll be responding to codes with our ED. We have an open ICU and no procedures required.

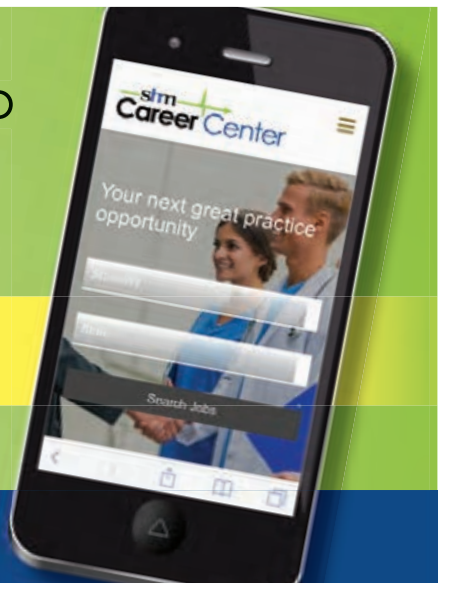
Centrally located in the heart of thoroughbred horse country, Lexington offers a moderate year-round climate with four well-defined seasons, the University of Kentucky, lots of horse farms, fantastic golf courses, and diverse cultural events.

To learn more about these or other Hospital Medicine opportunities, contact **Sarah Roberts** at **954.377.3135** or **Sarah_Roberts@teamhealth.com**, or visit **www.teamhealth.com**.

Physicians, you're just one click away from your next job with the new **SHM Career Center**

You've never had a more powerful ally in making your next career move. The new SHM Career Center is designed for busy doctors. Now you can:
- Create job alerts
- Save your jobs
- Quickly search for jobs on your smartphone — works seamlessly!

Create a candidate profile and get matched to your ideal job



Find your next job today.
Visit www.shmcareers.org

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

Evolution of a movement

Looking back on a year of progress, looking forward to remaining active with SHM

One of the most enduring lessons I have learned during my time in hospital medicine is that hospitalists are always evolving, much like the specialty and healthcare system of which they are a part. And during my time as president of the Society of Hospital Medicine (SHM), I have come to realize how SHM provides its members with the resources to help us continue that evolution through our career journeys as a part of the hospital medicine movement.

Over a year ago, I ascended to president of SHM's board of directors at HM16, the annual meeting in San Diego. Now, I am eagerly looking forward to HM17 next month, in Las Vegas, which we expect to be, yet again, the biggest, best, most innovative, and most energetic gathering of hospitalists. As that meeting will mark the end of my tenure as president of the board, I'm also inclined to look back and survey what has happened over the last year, both personally and professionally.

The personal perspective is easy. I have a different position within my organization: president of Cleveland Clinic Akron General and the Southern Region, one which I would and could never have anticipated a year ago. It challenges, exhausts, exhilarates, and teaches me every day. I am also celebrating my 15th wedding anniversary and have three amazing children who seem to evolve in front of my eyes every day.

And, professionally, at HM16 (and on these pages a year ago), I framed what I felt were four critical directions for SHM and have a few thoughts on the work we have done over the last year.

1 *Expand and engage SHM's membership.*

SHM continues to be the envy of professional organizations, growing each year. More important than sole growth is our pursuit of connecting hospitalists to SHM's resources and to each other; we have been incredibly active this past year. For instance, SHM is embarking on an engagement survey of HM groups, and is investing in new technologies to support membership. We are now a CME-accrediting organization and are moving the SHM Learning Portal to a new, enhanced platform. We launched a long-term communications strategy that is tied to engagement and a more nimble and mobile experience for our members. The SHM Leadership Academy sold out. HM17 is poised to be another success. And finally, we are increasingly appreciating that a strong SHM must have a vibrant chapter structure to ensure connections between our membership, staff, and board.

2 *Focus on patient- and family-centered care.*

A look at the HM17 curriculum reinforces SHM's awareness that patients and hospitalists must be more assertive in developing skills in communication and empathy. By doing so, they support a culture and environment wherein patients are active participants in their care. Members of our Patient Experience Committee are presenting courses and workshops in Las Vegas, and last year's annual meeting featured an entire pre-course on communication skills. Hospitalists play a signature role in the Cleveland Clinic's national conference on improving the patient experience, and the committee has an advisory council of patients and advocates to guide their work.

3 *Move assertively to define our role in an era of risk and reform.*

Last year's national election will probably create policy upheavals that are difficult to either anticipate or plan for. However, the evolution of Medicare, Medicaid, and commercial payers toward passing risk (and reward) onto physicians, hospitals, and systems, likely is unstoppable. SHM held a board retreat with key hospital leaders (including Patrick Conway, MD, MSc, MHM, chief medical officer of Medicare, and a keynote speaker at HM17) to outline a framework to engage and educate our membership by leveraging the work of our Public Policy, Education, and Practice Management committees.

4 *Define our stance regarding specialty recognition: The complexities of this issue are political as well as logistical.*

SHM has continued to build out the infrastructure for Recognition of Focused Practice with the launch of SPARK ONE (our Focused Practice in Hospital Medicine exam preparation product), but the gaps between the curricula of internal medicine and family medicine residencies, and our daily clinical realities, will continue to exist for the foreseeable future. Pediatrics has established a board requirement for pediatric hospital medicine, but it is still unclear if this is the future of adult hospital medicine.

In sum

As I prepare to the pass to baton to Dr. Ron Greeno for 2017-18, I am reminded of one of the pearls of a former boss and mentor of mine who preached that career satisfaction comes from finding opportunities to achieve three goals: addressing meaningful challenges, working with compelling individuals, and learning something new every day. I would like to thank the board, SHM CEO Larry Wellikson, MD, MHM, and the society staff and volunteers, and, most of all, the many SHM members with whom I have met and spoken over the last year for providing me with exactly that opportunity.

I look forward to continuing to serve an active role in SHM, an organization that can provide you with those same opportunities and resources to help you grow, evolve, and be an active participant in the hospital medicine movement. TH

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

Practice setting transitions

An abbreviated, step-by-step guide to your next job move

Mr. Harris is a nationally recognized health care attorney and a member of the law firm McDonald Hopkins LLC in Chicago. Write to him at sharris@mcdonaldhopkins.com.

You have decided it is time to move on from your current hospital or medical group position and transition into a new role. While this decision is exciting and well earned after years of hard work, it is critical that you make a plan and take specific steps to ensure that the transition is seamless.

The steps below are recommendations to make this process smoother.

STEP 1:
Determine how you are leaving the practice and your proposed timeline

Before anything else, you should decide how you are leaving your practice. Are you leaving the practice of medicine altogether, or are you simply leaving your current position for a different position elsewhere? This distinction will dictate what steps are necessary. Timing is also critical when leaving a practice, as it will dictate what steps should be taken and when. Having specific but realistic goals is imperative. Select a goal date for leaving the practice, but be aware that this goal may need to be adjusted.

STEP 2:
Create your team of advisers

Whether you are leaving your current practice or transitioning to a different position, it is extremely important to have the right individuals on your team. You should consider enlisting an attorney, a financial adviser, and an accountant to help facilitate the process. Enlisting lawyers with certain areas of expertise, such as in the areas of employment restrictive covenants, health care, or tax, may also be extremely beneficial and helpful throughout the process.

STEP 3:
Review your current employment agreement

It is quite likely that at the onset of your current employment arrangement, you signed an employment agreement with your hospital or group. You will want to carefully review this agreement, as it may contain provisions that can affect the steps you should take before you leave your current practice and work elsewhere. These provisions include the following:

a) Noncompetition provisions

It is critical to determine whether or not there are any restrictive covenants in your employment agreement that limit where you can work after you transition from your current practice into a new role. Restrictive covenants include noncompetition and nonsolicitation provisions, and prohibit employees from working at certain places or in certain geographic areas after they leave their current place of employment. Rules surrounding restrictive covenants vary from state to state. If there are restrictive covenants in your agreement, be sure to understand the scope of the covenant, including the geographic and temporal scope, as well as the types of medicine you are prohibited from practicing. If the covenants seem too broad or unnecessarily restrictive, consult with an attorney, as overly broad or unduly burdensome covenants are often unenforceable. However, a state-by-state analysis is required.

Thinkstock

b) Notice and termination provisions

It is important to review whether or not there are any notice requirements in your employment agreement, which may require you to notify your employer in advance of a departure. Make sure to comply with the time requirements in the notice provision to avoid a breach of the agreement. It is also critical to determine whether terminating an agreement early will result in any termination penalties. At times, employers will impose a penalty if an employee prematurely terminates a working relationship. Understanding the penalties associated with terminating your agreement will allow you to decide whether you want to cancel the agreement and pay the penalty or push back your timeline until the end of the agreement's term to avoid termination fees.

STEP 4:
Licensure obligations

To comply with licensure requirements on your behalf, you will want to determine the license obligations in the state you practice. If you are leaving your hospital job to work in another state, you will want to determine whether you need to become licensed in that new state. If you are transitioning into a nonmedical role, you will want to determine whether you have to change your license status in the state where you are licensed.

Further, if your practice bills Medicare, you will want to file certain forms with Medicare to show that you are either changing your practice location or leaving medicine. For example, if you are leaving the hospital or group to practice elsewhere, you will need to fill out forms in order for your old group to submit claims and receive payments for Medicare services you provided while you were still part of that group. Furthermore, you will need to file reassignment forms to allow your new practice to bill on your behalf. Understanding which forms to complete can be confusing, so enlisting the help of a healthcare attorney may be worthwhile.

STEP 5:
Discuss your transition with your insurance representative

Even after you leave your current practice, you may be exposed to litigation for services you provided while you were employed or otherwise retained by such practice. To ensure that you are protected, discuss your insurance policy with your insurance representative. Review whether your insurance policy is "occurrence" or "claims-made." If you have an occurrence policy, you are protected from covered incidents that occur during the policy period, regardless if your policy is still in existence. Claims-made policies provide coverage for claims only where both the incident and the claim occur during the policy period. For example, if you cancel your policy on March 1, and are sued on April 1 for an incident that allegedly occurred on Feb. 1, your claims-made insurance policy will not protect you. Therefore, it is important to analyze your policies to determine if tail insurance is needed.

There are a number of other issues you will want to address before you leave your practice, including financial responsibilities and medical record and privacy obligations. To ensure that you leave your practice properly, you should contact an experienced lawyer who can help you navigate this process. TH

How's your postacute network doing?

Hospitalists should understand who is in, and the selection criteria

Dr. Whitcomb is chief medical officer at Remedy Partners in Darien, Conn. He is a cofounder and past president of SHM.

By now, nearly all hospitals are developing networks of postacute facilities for some or all of their patients, such as those in Accountable Care Organizations (ACOs), bundled payments, or other value-based programs. Commonly referred to as preferred providers, performance networks, narrow networks, or similar, these networks of skilled nursing facilities (SNFs) and other entities that provide postacute care (like home health agencies) are usually chosen because they have demonstrated that they provide high quality, cost-effective care for patients after they leave the hospital.

While case managers are often the ones who counsel patients and caregivers on the details of the network, hospitalists should have at least a high-level grasp of which facilities are on the list and what the network selection criteria are. I would argue that hospitalists should lead the discussion with patients on postacute facility selection as it relates to which facilities are in the network and why going to a network facility is advantageous. Why? Because as hospitalist practices begin to share clinical and financial risk for patients, or at least become eligible to share in savings as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) encourages, they will have a vested interest in network facilities' performance.

Postacute care network selection criteria

There is a range of criteria – usually incorporating measures of quality and efficiency – for including providers like SNFs in networks. In terms of quality, criteria can include physician/provider availability, star ratings on Nursing Home Compare, care transitions measures, Department of Public Health inspection survey scores, and Joint Commission accreditation. The most notable efficiency measures include readmission rates (we won't debate here whether this should be a quality measure), cost, and length of stay in the facility. Another key driver of inclusion can be ownership status. If a SNF or other postacute provider is owned by the hospital, it may be included for that reason alone. Also, if the hospitalist group is creating the network, it may include facilities that are staffed by the group or by affiliated physicians/providers.

A few caveats regarding specific selection criteria:

Star ratings on Nursing Home Compare

These are derived from nursing staffing ratios, health inspections, and 16 quality measures. More than half of the quality measures pertain to long-stay residents who typically are not in the ACO or bundled payment program for which the network was created.

Spotmatik/Thinkstock

SNF length of stay

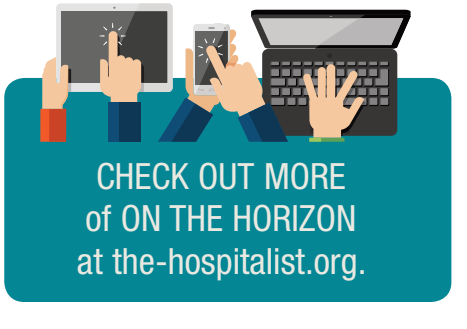
High readmission rates from a SNF can actually lower its length of stay, so including "balancing" measures such as readmissions should be considered.

What about patient choice?

Narrow postacute networks are not only becoming the norm, but there is also broad recognition from the Centers for Medicare & Medcaid Services, the Medicare Payment Advisory Commission, and industry leaders that value-based payment programs require such networks to succeed. That said, case managers and other discharge planners may still resist networks because they might be perceived as restricting patient choice. One approach to balancing differing views on patient choice is to give patients the traditional longer list of available postacute providers and also furnish the shorter network list and an explanation of why certain SNFs are in the network. Thankfully, as ACOs and bundles become widespread, resistance to narrow networks is dying down.

What role should hospitalists play in network referrals?

High functioning hospitalist practices should lead the discussion with patients and the health care team on referrals to network SNFs. Why? Patients are looking for their doctors to guide them on such decisions. Only if the physician opts not to have the discussion will patients look to the case manager for direction on which postacute facility to choose. A better option still would be for the hospitalists to partner with case managers to have the conversation with patients. In such a scenario, the hospitalist can begin the discussion and cover the major points, and the case manager can follow with more detailed information. For less mature hospitalist practices, the case manager can play a larger role in the discussion. In any case, as value-based models become ubiquitous, and shared savings become a driver of hospitalist revenue, hospitalists' knowledge of and active participation in conversations around narrow networks and referrals will be necessary. TH



DO YOU KNOW **A LEADER** WHEN YOU SEE ONE?

We do, too.

Leaders challenge convention and turn ideas into action.

Whether your leadership goals are large or small, CEP America will be there with you every step of your journey.

Download your own Leadership Growth Guide at:
go.cep.com/ReadyToLead

GOING TO HOSPITAL MEDICINE 2017?

VISIT US AT **BOOTH #325** FOR FUN PRIZES.

CEP America®

OWN YOUR CAREER