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Scope of services
continues to evolve

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KEY CLINICAL QUESTION

Managing CIED
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The Hospitalist

VOLUME 21 No. 7 | JULY 2017

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Pediatric hospitalists march toward recognition

By Larry Beresford

Pediatric hospital medicine is moving quickly toward recognition as a board-certified, fellowship-trained medical subspecialty, joining 14 other pediatric subspecialties now certified by the American Board of Pediatrics (ABP).

It was approved as a subspecialty by the American Board of Medical Specialties (ABMS) at its October 2016 board meeting in Chicago in response to a petition from the ABP. Following years of discussion within the field,¹ it will take 2 more years to describe pediatric hospital medicine's specialized knowledge base and write test questions for biannual board exams that

PEDIATRIC CONTINUED ON PAGE 17



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Meet the two newest SHM board members

By Richard Quinn

SHM's two newest board members – pediatric hospitalist Kris Rehm, MD, SFHM, and perioperative specialist Rachel Thompson, MD, MPH, SFHM – will bring their expertise to bear on the society's top panel.

However, neither woman sees her role as shaping the board. In fact, they see themselves as lucky to be joining the team.

"It's a true honor to be able to sit on the board and serve the community of hospitalists," said Dr. Thompson, outgoing chair of SHM's chapter support committee and head of the section of hospital medicine at the University of Nebraska in Omaha.



Dr. Thompson

"I really want to hear everyone's voice, and I hope to see how we can all move to better places together," added Dr. Rehm, associate professor of clinical pediatrics and director of the division of hospital medicine at Vanderbilt University in Nashville, Tenn.

Both board members were officially seated for 3-year terms at HM17 in Las Vegas. They replace former SHM president Robert Harrington, MD, SFHM, and veteran pediatric hospitalist Erin Stucky Fisher, MD, MHM.

Each of the new board members brings a strong perspective to the panel.

For Dr. Thompson, that viewpoint is based in engagement. She is the former chair of SHM's Pacific Northwest chapter and has spent the past few years leading the perioperative issues for the society's work group.

"We get to a certain point in our career as hospitalists, and if we're just
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Q&A

SHM MEMBER
SPOTLIGHT

Pediatrics Committee
chair grows with SHM

Sandra Gage, MD, PhD,
SFHM

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Hospitalist movers and shakers

Three members of the hospital medicine community – **Thiruvoipati Nanda Kumar, MD, MS, FACP**, and **Angela Aboutalib, MD** – recently were honored for their work by the International Association of HealthCare Professionals, earning spots in its publication, *The Leading Physicians of the World*.

Hospitalist and internist Dr. Nanda Kumar serves patients at Vibra Hospital in Redding, Calif., where he is also a clinical associate professor at the University of California at Davis. He is a member of both the Society of Hospital Medicine and the American Diabetes Association.

Dr. Aghenta is a 17-year veteran internist who currently serves as medical director for Coronado Healthcare Center in Phoenix. There, he also is affiliated with St. Joseph's Hospital and Medical Center. A member of SHM, Dr. Aghenta also has the title of Fellow of the American College of Physicians.

Three members of the hospital medicine community recently were honored for their work by the International Association of HealthCare Professionals.

Dr. Aboutalib, whose experience as an internist includes expertise in hospital medicine, serves as hospitalist and medical director of clinical operations at U.S. Acute Care Solutions, Canton, Ohio. Previously, this member of the American College of Physicians served South Physicians as a hospitalist at Mercy Hospital in Chicago.

Andrew Dunn, MD, MPH, FACP, SFHM, recently was named chair-elect of the Board of Regents of the American College of Physicians (ACP), the national organization of internists. He assumed the role at the start of the ACP's annual scientific meeting held in San Diego, March 30-April 1.

Dr. Dunn is chief of hospital medicine of the Mount Sinai Health System, N. Y., and serves as professor of medicine at the Icahn Mount Sinai School of Medicine. He has been an ACP Board of Regents member and was chair of its Board of Governors, as well as governor of the ACP's Manhattan/Bronx chapter.

Susan Herson, MD, has been named the new chief of staff at the Bath, N.Y., Veterans Affairs Medical Center. Dr. Herson

comes to Bath from the Sioux Falls (N.Y.) VA, where she was a hospitalist and a hospitalist-clinician educator, while also serving as clinical assistant professor for New York Medical College and medical director at Norwalk (Conn.) Hospital.



Dr. Whelan

Dr. Herson served in the U.S. Navy, doing her training at Walter Reed Medical Center, Bethesda, Md. She was a general medical officer while stationed at U.S. Marine Corps Base Camp Lejeune in Jacksonville, N.C.

Chad Whelan, MD, has been elevated to president of the Loyola University Medical Center, Chicago, moving up from his chair as senior vice president and chief medical officer. This longtime hospitalist also serves as a professor of medicine in the Loyola Stritch School of Medicine.

Dr. Whelan is a former director of hospital medicine at Loyola and has held various positions, including associate chief medical officer, at the University of Chicago. He is an associate editor of the *Journal of Hospital Medicine*.

Kevin Tulipana, DO, recently was promoted to medical director of hospital medicine at Cancer Treatment Centers of America's Southwest Regional Medical Center in Tulsa, Okla. Previously, Dr. Tulipana was a hospitalist in the special care unit at CTCA Tulsa.

Mustafa Sardini, MD, has been named Envision Physician Services' 2017 Hospital Medicine Physician of the Year. Dr. Sardini is the site medical director as Baylor Scott & White Medical Center, Sunnyvale, Texas. EPS presents the award to a hospitalist who peers deem as a leader in the industry.

Business moves

Physicians' Alliance (PAL) recently announced plans to partner with Penn State Health. As the largest independent physician group in Lancaster County, Pa., they will bring its more than 120 physicians, hospitalists, and dietitians to central Pennsylvania giant Penn State.

The alliance will allow patients of PAL physicians access to advanced care at Milton S. Hershey Medical Center and Penn State Children's Hospital in Hershey.

Envision Healthcare, Greenwood Village, Colo. has created the **Envision Physical Services (EPS)** as a result of a merger with AmSurg ambulatory surgical center in December 2016. EPS combines EmCare and Sheridan Healthcare's physician services divisions.

EPS specializes in hospital medicine, anesthesia, emergency medicine, radiology, and surgical services. **TH**

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

Here's what's trending at SHM

Get the latest news about upcoming events, new programs, and SHM initiatives

By Brett Radler

Updated Clinical Documentation & Coding resources now available

SHM's Clinical Documentation & Coding for Hospitalists, formerly CODE-H, has been updated for 2017.

It's "an exciting program that offers valuable insight into the coding and billing challenges of hospitalist services. Whether you are a new or seasoned physician, SHM's Clinical Documentation & Coding for Hospitalists provides you with a solid foundation for documentation, identifies common problems, and offers strategies for success." — Carol Pohlig, BSN, RN, CPC, ASC Senior Coding and Compliance Specialist

For more information, visit hospitalmedicine.org/codeh.

Registration now open for NP/PA Bootcamp

Whether you're new to hospital medicine or in need of a refresher on the latest topics, this course from the AAPA and SHM is perfect for you and offers up to 34.75 AAPA Category 1 CME credits.

At the Adult Hospital Medicine Bootcamp, you will cover commonly encountered diagnoses and diseases of adult hospitalized patients while networking with other hospital-based practitioners. Plus, attend optional precourses on reimbursement, hands-on ultrasound, or hospital medicine basics.

Join us at the 9th annual Adult HM Bootcamp, Sept. 27-Oct. 1, in San Diego. Register and learn more at aapa.org/bootcamp.

Learn how your HMG stacks up with the State of Hospital Medicine report

Did you know that hospitalist compensation typically consists of 80% base pay and 20% supplemental income based on production and performance? SHM's State of Hospital Medicine Report continues to be your best source of information about how hospital medicine groups (HMGs) operate.

Don't miss the new additions to the report for the 2016 version, including:

- Percentage of the hospital's total patient volume the HMG was responsible for.
- Presence of medical hospitalists within the HMG focusing their practice in a specific medical subspecialty.
- Value of CME allowances for hospitalists.
- Utilization of prolonged service codes by hospitalists.
- Charge-capture methodologies being used by HMGs.
- The dollar amount of financial support provided for nonclinical work, for academic HMGs.

Order your print or digital copy at hospitalmedicine.org/sohm.

Enhance your leadership skills at SHM's Leadership Academy

SHM's Leadership Academy is the only leadership program designed specifically for hospitalists. The 2017 meeting will be held

October 23-26 at the JW Marriott Camelback Inn in Scottsdale, Ariz.

New for 2017, Essential Strategies (formerly Leadership Foundations), Influential Management, and Mastering Teamwork are available to all attendees without a prerequisite. Participant recommendations have been made to help interested registrants determine which course fits them best.

Course highlight: Leadership mastering teamwork

Developed in response to high demand from previous Leadership Academy attendees, this course focuses on strengthening teams and institutions. Participants learn how to critically assess program growth opportunities and develop operational plans; utilize the principles of SWARM intelligence; lead, manage, and motivate teams in complex hospital environments; and develop effective communication strategies.

On completion of this course, participants will be able to apply communication strategies that allow others to fully experience their message, lead teams in complex environments to achieve the best results, invest in themselves as leaders to optimize their professional growth and career path, and critically assess program growth opportunities and implement the necessary infrastructure for success.

View the schedule, faculty, and more at shmladershipacademy.org/masteringteamwork.

Improve glycemic control efforts in your hospital with online resources & mentorship

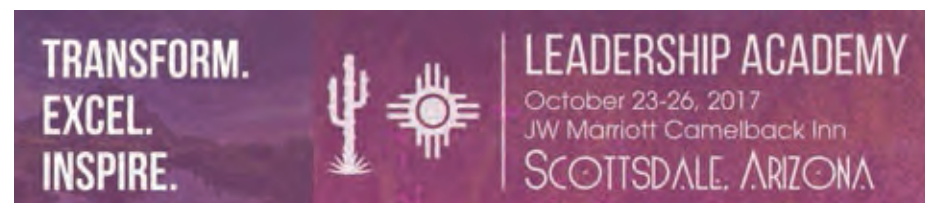
SHM offers a variety of resources to improve glycemic control in your hospital. Glycemic Control Electronic Quality Improvement Programs (eQUIPS) are designed to enhance the efficiency and reliability of your quality improvement efforts to close the gap between best practices and methods for caring for the inpatient with hyperglycemia.

Benefits of SHM's eQUIPS include:

- Data and performance tracking tools.
- Step-by-step instructions for improving glycemic control, preventing hypoglycemia, and optimizing care of inpatients with hyperglycemia and diabetes.
- An online community and library of tools and documents, including sample order sets and protocols, awareness campaigns, patient educational materials, and supplemental articles.
- Toolkit of clinical tools and interventions, research materials, literature reviews, case studies, teaching slide sets, and more.

SHM's Glycemic Control Mentored Implementation program sites receive 1 year of individualized mentoring including:

- On-site mentoring and training for the entire care team to help members interpret needs and resource assessments, map system processes, and develop site-specific action and intervention plans.
- Monthly coaching calls with the mentor to develop, modify, and implement interventions, establish evaluation processes, and



monitor performance over time.

- SHM-facilitated calls with live webinars with other collaborative sites to share success stories and experiences.
- Access to the online community to share ideas, documents, and other resources.
- Data collection and analysis tools to generate on-demand reports and benchmark against other program participants.

Learn more about all offerings by watching the recorded webinar from June 28, 2017, at hospitalmedicine.org/gc.

Earn CME with SHM's Learning Portal

SHM's Learning Portal is the online learning destination for hospitalists, featuring all of SHM's eLearning initiatives in one place. Members can access more than 85 CME

credits for free within the Learning Portal.

Featured topics currently include perioperative medicine, anticoagulation, quality improvement, cardiac arrhythmia, and antimicrobial stewardship.

Try out the most popular modules:

- The Role of the Medical Consultant.
- Pulmonary Risk Management in the Perioperative Setting.
- Perioperative Medication Management.
- Venous Thromboembolism Prophylaxis in Surgical Patients.
- Perioperative Cardiac Risk Assessment.
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Mr. Radler is communications specialist at the Society of Hospital Medicine.

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Empowering hospitalists. Transforming patient care.

Hospitalists' scope of services continues to evolve

By Johnbuck Creamer, MD,
SFHM

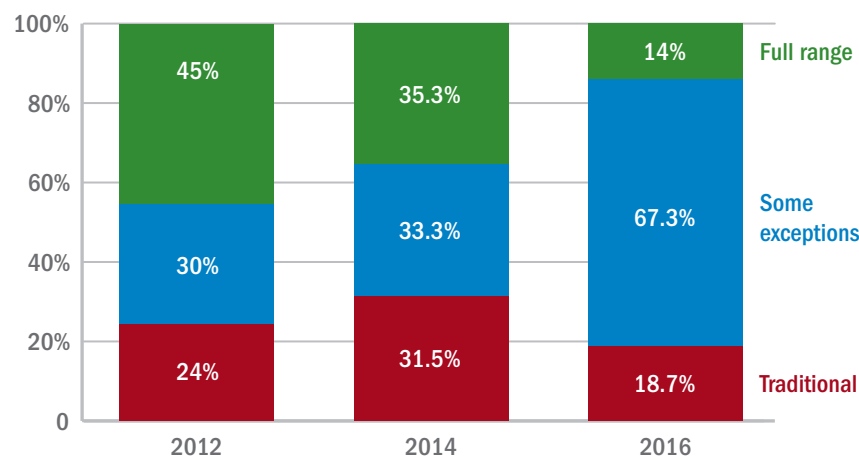
Over the course of serial iterations of the State of Hospital Medicine (SOHM) Report, SHM has presented survey data that describe the evolving role hospitalists play in patient care. The 2016 SOHM Report shows the continuation of prior trends in hospital medicine groups' (HMGs) scope of admittance and comanagement services. Some downturns are notable among previously increased specialty services.

The SOHM Report characterizes HMGs by their general scope of admitted patients – as admitters of purely traditional internal medicine or pediatric hospitalized patients; full-range, nearly universal admitters who admit most patients within their age designation except OB and emergency surgery patients; or traditional admitters with some exceptions (for example, limited classically surgical patients).

Among HMGs who serve adults and those who serve both adults and children, some exceptions seems to be becoming the rule, registering as the predominant category in the 2016 Report. Pediatric HMGs continue to favor either the full-range or traditional ends of the spectrum, in 2016 more so the traditional.

As adult and adult-ped HMGs make up almost 97% of survey respondents, the predominance of the “some exceptions” category seems to represent a serious trend in much of Hospital Medicine practice. This could mean that HMGs have worked out more specific arrangements as to which patients they will admit or that the definitions are more in flux. It comes at a time when concerns figure prominently in national discussions over the stretching of hospitalists by their expanding scope of care and the need for ever more coordinated care

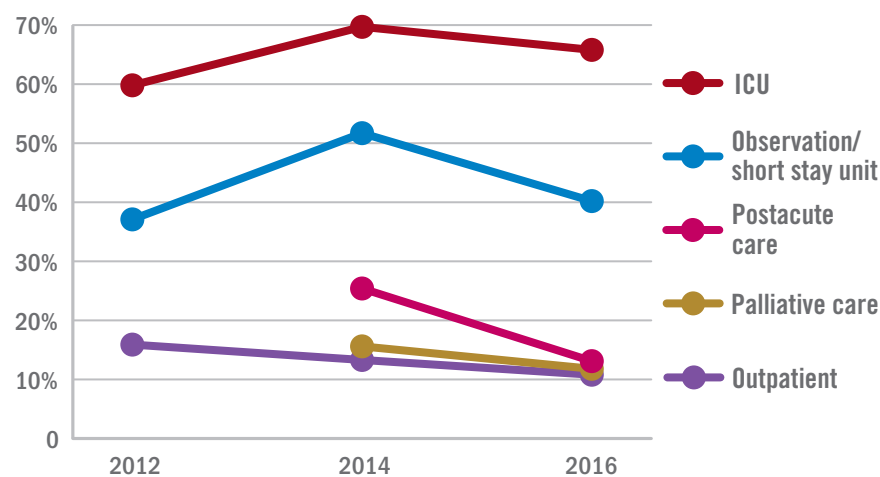
Scope of services: Groups serving adults only



Note: Based on data from the 2014 and 2016 State of Hospital Medicine reports.

Source: Dr. Creamer

Services routinely provided: Groups serving adults only



Note: Based on data from the 2014 and 2016 State of Hospital Medicine reports.

Source: Dr. Creamer

between hospitalists and specialists.

For another viewpoint, let's look at the evolution of Hospital Medicine's role in comanagement patients. The vast major-

ity of HMGs provide both surgical and medical specialty comanagement services. Within these relationships, we are assuming more primary responsibility than ever

for the comanaged patients, increasingly reporting an attending/admitting role rather than a consulting role. This, in particular, points at our expanding opportunity and responsibility to lead in health care quality and reform efforts for hospitalized patients.

Again, with these opportunities, concerns have arisen about scope-creep and its potential deleterious effects on patient care. Hospitalists have been noted to be prodded into providing critical, geriatric, and palliative care, without specialty training in these areas.¹ Interestingly, however, specialty work reported by HMGs has largely shown a downturn since 2014, when most specialty services had appeared to be on the rise.

Note that, while postacute care and palliative care were both reported by fewer groups in 2016 than in 2014, we have only two data points for these two services. In 2014, palliative care was newly added to the Survey, and postacute care replaced skilled nursing facility as a response.

Whether this means that there is relief from scope-creep or that it is “just a blip” will remain to be seen in future data. If HMGs are able to capture the opportunity to improve outcomes through greater involvement in postacute care, this particular area may be one to watch, despite its apparent downturn since the 2014 report.

Thus, it is as imperative as ever that HMGs participate in the State of Hospital Medicine survey. **TH**

Dr. Creamer is a member of SHM's Practice Analysis Committee. He is a hospitalist and informaticist with the MetroHealth System in Cleveland.

Reference

1. Wellikson, L. Hospitalists Stretched as Their Responsibilities Broaden. *The Hospitalist*. 2016 Nov;2016.

Crossing the personal quality chasm: QI enthusiast to QI leader

Start with localized goals, move toward the Triple Aim.

By Claudia Stahl

Editor's Note: This SHM series highlights the professional pathways of quality improvement (QI) leaders. This month features the story of John Bulger, DO, chief medical officer for Geisinger Health Plan.

As chief medical officer for Geisinger Health Plan, John Bulger, DO, MBA, is intimately acquainted with the daily challenges that intersect with the delivery of safe, quality-driven care in the hospital system.

He's also very familiar with the intricacies of carving out a professional road map. When Dr. Bulger began practicing as an internist at Geisinger Health System in the late 1990s, there wasn't a formal hospitalist designation. He created one and became director of the hospital medicine program. Years later, when the opportunity arose to become chief quality officer, Dr. Bulger was a natural fit for the position, having led many improvement-centered committees and projects while running the hospital medicine group.

But the quality know-how did not come without additional

training. “While competencies like problem solving and being a good listener and team player are part of the job of being a hospitalist, they don't make you an expert in QI,” Dr. Bulger said. “There are learned skills that you need to spend time developing.”

Early in his QI immersion, Dr. Bulger sought training where available from sources such as ACP and SHM, while familiarizing himself with methodologies such as PDSA and Lean. There are far more QI training opportunities available to hospitalists today than when Dr. Bulger began his journey, but the fundamentals of success come back to finding the right mentors, team building, and implementing projects built around SMART goals.

Getting started, Dr. Bulger suggests to “pick something within your scope, like medical reconciliation for every patient, or ensuring that every patient who leaves the hospital gets an appointment with their primary physician within 7 days. Early on, we were working on issues like pneumonia core measures and providing discharge instructions.”



Dr. Bulger

He cautions those starting out in QI against viewing unintended outcomes or project setbacks as failure. “If your goal is to take a (scenario) from bad to perfect, you'll end up getting discouraged. Any effort toward making things better is helpful. If it doesn't work you try something else.”

While Dr. Bulger is fully supportive of the impact that quality improvement projects make at the institutional level, he encourages clinicians and researchers to always keep the Institute for Healthcare Improvement Triple Aim in sight.

“We need better measures and more discussion about what is best for patients,” Dr. Bulger said. “The things we talk about in (health care) – readmission rates, glycemic control – have a minimal impact on people's health, but the social determinants of health – the patient's housing and economic situation – play a bigger role than anything else. As we move from provider- to patient-centric communities by fixing the Triple Aim, the experience will be better for both providers and patients.” **TH**

Ms. Stahl is content manager for SHM.

Everything we say and do: Take time to leave a good impression

By Meghan Sebasky, MD, FHM

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

What I say and do

I say "thank you" to each patient at the close of the clinical encounter and ask if there is something I can do for him or her before leaving the room.

Why I do it

The beginning and the end of a medical visit each have a significant impact on how patients view their overall experience with the physi-

cian. Devoting energy and thought to these critical moments during the patient-physician interaction is simple and rewarding, and helps leave patients with a good impression.

Closing the visit in a deliberate manner, by thanking the patient and asking if there is some way I can assist before departing, ensures that I remain attentive and engaged until the encounter concludes, shows compassion, and helps patients feel appreciated and understood.

How I do it

At the close of each patient visit, whether in the emergency department with a new admission or during daily rounds, I incorporate a thank you prior to leaving the room. For example, I thank the patient for going over the details of her history with me; I know she has repeated the same information several times already. I thank the patient who brought in a detailed home medication list that made medication reconciliation a breeze for his organization. If I discussed a sensitive or difficult topic with the patient,



Whatever the task may be, offering to help before departing humanizes the interaction between physician and patient and is sure to be appreciated and remembered.


—Dr. Meghan Sebasky

such as substance use, I thank the patient for being honest. Another option is to thank the patient for trusting me with his care during the hospitalization. My favorite thank you, and one that will work in any situation, is to thank a patient for his or her patience. Whether it is waiting for a procedure, waiting to eat, or waiting for the green light to go home, our patients' patience is tremendous and absolutely deserves to be recognized.

After saying thank you, I close with a simple but powerful question: "Is there something I can do for you before I leave? I have time." Perhaps I can assist with a refill of ice chips, help find the call button,

or relay a message to the bedside nurse. Whatever the task may be, offering to help before departing humanizes the interaction between physician and patient and is sure to be appreciated and remembered. Furthermore, taking a pause in the hectic pace of the day to show patients that we care can give busy hospitalists a moment to recharge before moving on to the next item on the to-do list. Any way you look at it, thanking our patients and offering to help is time well spent. **TH**

Dr. Sebasky is assistant clinical professor at the University of California, San Diego.



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Hospitalist meta-leader: Your new mission has arrived

By Leonard J. Marcus, PhD

If you are a hospitalist and leader in your health care organization, the ongoing controversies surrounding the Affordable Care Act repeal and replace campaign are unsettling. No matter your politics, Washington's political drama and gamesmanship pose a genuine threat to the solvency of your hospital's budget, services, workforce, and patients.

Health care has devolved into a political football, tossed from skirmish to skirmish. Political leaders warn of the implosion of the health care system as a political tactic, not an outcome that could cost and ruin lives. Both Democrats and Republicans hope that if or when that happens, it does so in ways that allow them to blame the other side. For them, this is a game of partisan advantage that wagers the well-being of your health care system.

For you, the situation remains *predictably unpredictable*. The future directives from Washington are unknowable. This makes your strategic planning – and health care leadership itself – a complex and puzzling task. Your job now is not simply leading your organization for today. Your more important mission is preparing your organization to perform in this unpredictable and perplexing future.

Forecasting is the life blood of leadership: Craft a vision and the work to achieve it; be mindful of the range of obstacles and opportunities; and know and coalesce your followers. The problem is that today's prospects are loaded with puzzling twists and turns. The viability of both the private insurance market and public dollars are – maybe! – in future jeopardy. Patients and the workforce are understandably jittery. What is a hospitalist leader to do?

It is time to refresh your thinking, to take a big picture view of what is happening and to assess what can be done about it. There is a tendency for leaders to look at problems and then wonder how to fit solutions into their established organizational framework. In other words, solutions are cast into the mold of retaining what you have, ignoring larger options and innovative possibilities. Solutions are expected to adapt to the organization rather than the organization adapting to the solutions.

The hospitalist movement grew as early leaders – true innovators – recognized the problems of costly, inefficient, and uncoordinated care. Rather than tinkering with what was, hospitalist leaders introduced a new and proactive model to provide care. It had to first prove itself, and once it did, a once revolutionary idea evolved into an institutionalized solution.

No matter what emerges from the current policy debate, the national pressures on the health care system persist: rising expectations for access; decreasing patience for spending; increasing appetite for breakthrough technology; shifting workforce requirements; all combined with a population that is aging and more in need of care. These are meta-trends that will redefine how the health system operates and what

it will achieve. What is a health care leader to do?

Think and act like a “*meta-leader*.” This framework, developed at the Harvard T.H. Chan School of Public Health, guides leaders facing complex and transformational problem solving. The prefix “meta-” encourages expansive analysis directed toward a wide range of options and opportunities. In keeping with the strategies employed by hospi-

your mindset and that of others for innovation, sharpening the curiosity necessary for fostering discovery and exploration of new ideas. Be ready to take appropriate risks.

The second dimension of meta-leadership practice is the *Situation*. This is what is happening and what can be done about it. You did not create the complex circumstances that derive from the political showdown in Washington. However,



As a meta-leader, you shape your mindset and that of others for innovation, sharpening the curiosity necessary for fostering discovery and exploration of new ideas. Be ready to take appropriate risks.

—Dr. Leonard J. Marcus

talist pioneers, rather than building solutions around “what already is,” meta-leaders pursue “what could be.” In this way, solutions are designed and constructed to fit the problems they are intended to overcome.

There are three critical dimensions to the thinking and practices of meta-leadership.

The first is the *Person* of the meta-leader. This is who you are, your priorities and values. This is how other people regard your leadership, translated into the respect, trust, and “followership” you garner. Be a role model. This involves building your own confidence for the task at hand so that you gain and then foster the confidence of those you lead. As a meta-leader, you shape

it is your job to understand them and to develop effective strategies and operations in response. This is where the “think big” of meta-leadership comes into play. You distinguish the chasm between the adversarial policy confrontation in Washington and the collaborative solution building needed in your home institution. You want to set the stage to meaningfully coalesce the thinking, resources, and people in your organization. The invigorated shared mission is a health care system that leads into the future.

The third dimension of meta-leadership practice is about building the *Connectivity* needed to make that happen. This involves developing the communication, coor-

dination, and cooperation necessary for constructing something new. Many of your answers lie within the walls of your organization, even the most innovative among them. This is where you sow adaptability and flexibility. It translates into necessary change and transformation. This is reorienting what you and others do and how you go about doing it, from shifts and adjustments to, when necessary, disruptive innovation.

A recent Harvard Business School and Harvard Medical School forum on health care innovation identified five imperatives for meeting innovation challenges in health care: 1) Creating value is the key aim for innovation and it requires a combination of care coordination along with communication; 2) Seek opportunities for process improvement that allows new ideas to be tested, accepting that failure is a step on the road to discovery; 3) Adopt a consumerism strategy for service organization that engages and involves active patients; 4) Decentralize problem solving to encourage field innovation and collaboration; and 5) Integrate new models into established institutions, introducing fresh thinking to replace outdated practices.

Meta-leadership is not a formula for an easy fix. While much remains unpredictable, an impending economic squeeze is a likely scenario. There is nothing easy about a shortage of dollars to serve more and more people in need of clinical care. This may very well be the prompt – today – that encourages the sort of innovative thinking and disruptive solution development that the future requires. Will you and your organization get ahead of this curve?

Your mission as a hospitalist meta-leader is in forging this process of discovery. Perceive what is going on through a wide lens. Orient yourself to emerging trends. Predict what is likely to emerge from this unpredictable policy environment. Take decisions and operationalize them in ways responsive to the circumstances at hand. And then communicate with your constituencies, not only to inform them of direction but also to learn from them what is working and what not. And then start the process again, trying on ideas and practices, learning from them, and through this continuous process, finding solutions that fit your situation at hand.

Health care meta-leaders today must keep both eyes firmly on their feet, to know that current operations are achieving necessary success. At the same time, they must also keep both eyes focused on the horizon, to ensure that when conditions change, their organizations are ready to adaptively innovate and transform. **TM**

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

Q&A

Pediatrics Committee's role amplified with subspecialty's evolution

New chair, Sandra Gage, MD, PhD, SFHM, experiences growth alongside SHM.

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. For more information on how you can lend your expertise to help SHM improve the care of hospitalized patients, log on to www.hospitalmedicine.org/getinvolved.

This month, *The Hospitalist* spotlights Sandra Gage, MD, PhD, SFHM, associate professor of pediatrics in the section of hospital medicine at the Medical College of Wisconsin, newly appointed chair of SHM's Pediatrics Committee, and SHM member of almost 20 years.

Why did you choose a career in pediatric hospital medicine, and how did you become an SHM member?

I would say that pediatric hospital medicine chose me. After obtaining a degree in physical therapy and spending 5 years treating children with a variety of neurological and neurodevelopmental disorders, I went back to school to get my MD and a PhD in neurobiology, thinking that I would specialize in either pediatric neurology or pediatric physical medicine and rehabilitation.

I always had an interest in treating children but never considered general pediatrics because spending my time in the outpatient clinic setting had little appeal for me. This was before the concept of being a "hospitalist" was widespread – and even before the phrase was coined – but there were a few providers in my academic pediatric group who focused on inpatient care.

The pace, variety, and challenge of treating hospitalized children was exactly what I was looking for, and, following completion of my pediatric residency, I slowly became a full-time hospitalist.

I joined SHM (then NAIP) on completion of my residency in 1998, shortly after the organization was founded, and was thrilled to find a national group of like-minded physicians.

Because of the constraints of a large family and rapidly growing clinical responsibilities, my initial involvement with SHM was mostly as an avid reader of the *Journal of Hospital Medicine* from afar. Over the last 10 years, I have been able to attend the annual meetings and get involved on the national level, which has exponentially increased the value of my membership.

What is the Pediatrics Committee currently working on, and what do you

hope to accomplish during your term as committee chair?

With subspecialty status coming soon, rapidly expanding interest in the profession and the introduction of hospitalists into more areas of care, the landscape of pediatric hospital medicine is ever-changing. This amplifies the importance of the Pediatrics Committee's role.

The overall goals of the committee are to promote the growth and development of pediatric hospital medicine as a field and to provide educational and practical resources for individual practitioners.

The 2017-2018 committee comprises enthusiastic members from a wide variety of practice settings. At our first meeting in May, we formulated many exciting and innovative ideas to achieve our goals. As we continue to narrow down our approach and finalize our tasks for the year, we are also beginning to determine the content for the pediatric track at HM18.

An example of a project the committee has executed in the past is the development of hospitalist-specific American Board of Pediatrics Maintenance of Certification modules for the SHM Learning Portal. In addition, the 2017 Pediatric Hospital Medicine (PHM) meeting is hosted by SHM this July in Nashville, and many Pediatrics Committee members are hard at work on finalizing those plans.

What advice do you have for fellow pediatric hospitalists during this transformational time in health care?

The direction of health care has provided fodder for lively discussion since I started my career 20 years ago. The nature of the practice of medicine is evolving, and, as physicians, we must be adept at navigating the changing climate while maintaining our goal of providing excellent care for our patients. As hospitalists, we have the opportunity to be in the forefront of the changes that will impact hospital care and utilization.

Whether our work is done at a local or a national level, as a group or as individuals, I believe that hospitalists will have an active role in directing the course of the future of medicine. We spend much of our clinical time advocating for our patients, but your experience is important and your voice can make an important contribution to the direction of health care for one child or for all children. Whether it is in the hospital hallway or on the Hill, continue to strive to do what you already do best. **TH**



Dr. Gage

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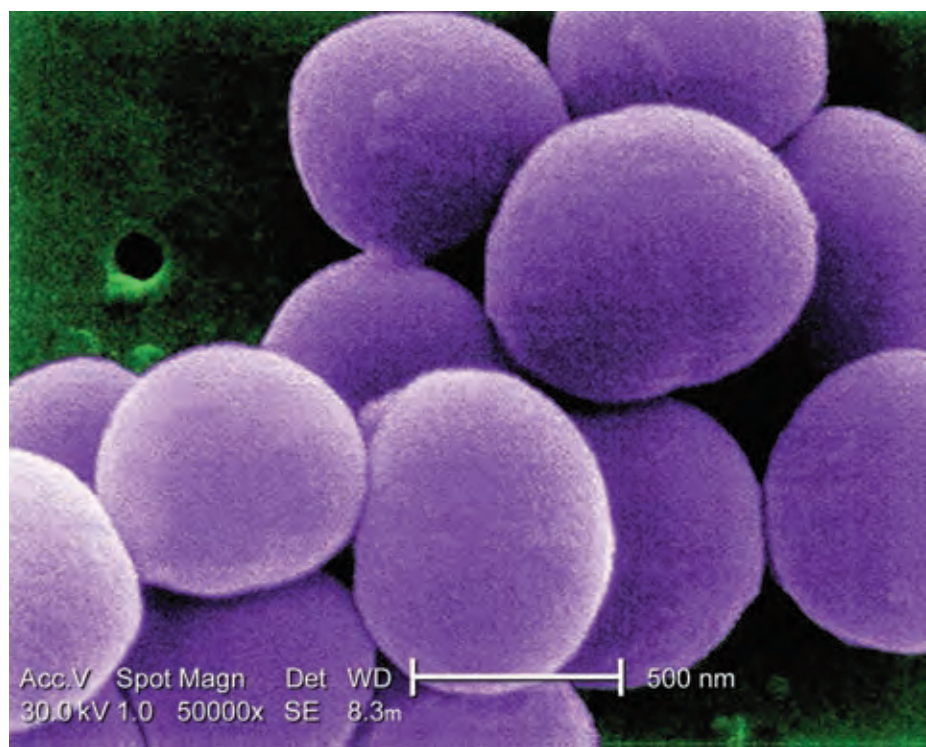
KEY
CLINICAL
QUESTION

What is the best approach for managing CIED infections?

By John L. Davisson, MD; Sean M. Lockwood, MD; and Joseph Sweigart, MD

KEY POINTS

- The risk factors for CIED infection fit into three broad categories: procedure, patient, and pathogen.
- Patients should have two sets of blood cultures drawn from two separate sites prior to administration of antibiotics.
- Guidelines recommend a transesophageal echocardiogram if suspicion for CIED infection is high.
- Initial empiric antimicrobial therapy should cover both oxacillin-sensitive and oxacillin-resistant strains.
- All patients with CIED infection require complete device removal.



This scanning electron micrograph shows a strain of *Staphylococcus aureus* bacteria taken from a vancomycin intermediate resistant culture.

The case

A 72-year-old man with ischemic cardiomyopathy and a left-ventricular ejection fraction of 15% had a cardioverter-defibrillator implanted 5 years ago for primary prevention of sudden cardiac death. He was brought to the ED by his daughter who noticed erythema and swelling over the generator pocket site. His temperature is 100.1° F. Vital signs are otherwise normal and stable.

What are the best initial and definitive management strategies for this patient?

When should a cardiac implanted electronic device (CIED) infection be suspected?

CIED infections generally present in one of two ways: as a local generator pocket infection or as a systemic illness.¹ Around 70% of CIED infections present with the former. Findings in such cases include pain, swelling, erythema, induration, and ulceration. Systemic findings range from vague constitutional symptoms to overt sepsis. It is important to note that systemic signs of infection are uncommon. Their absence does not rule out a CIED infection.^{1,2} As such, hospitalists must maintain a high index of suspicion in order to avoid missing the diagnosis.

Unfortunately, it can be difficult to distinguish between a CIED infection and less severe postimplantation complications such as surgical site infections, superficial pocket site infections, and noninfected hematoma.²

What are the risk factors for CIED infections?

The risk factors for CIED infection fit into three broad categories: procedure, patient, and pathogen.

Procedural factors that increase risk of infection include lack of periprocedural antimicrobial prophylaxis, inexperienced physician operator, multiple revision procedures, hematoma formation at the pocket site, and increased amount of hardware.¹

Patient factors center on medical comorbidities, including congestive heart failure, diabetes mellitus, chronic kidney disease, immunosuppression, and ongoing oral anticoagulation.¹

The specific pathogen also plays a role in infection risk. In one cohort study of 1,524 patients with CIEDs, patients with *Staphylococcus aureus* bacteremia ended up with confirmed or suspected CIED infections in 54.6% of cases, compared with just 12.0% of patients who had bacteremia with gram-negative bacilli.³

Which bacteria cause most CIED infections?

The vast majority of CIED infections are caused by gram-positive bacteria.^{1,4} An Italian study of 1,204 patients with CIED infection reported that pathogens isolated from extracted leads were gram-positive bacteria in 92.5% of infections.⁴ Staph species are the most common pathogens. Coagulase-negative *Staphylococcus* species and *Staphylococcus aureus* accounted for 69% and 13.8% of all isolates, respectively. Of note, 33% of

coagulase-negative *Staphylococcus* isolates and 13% of *S. aureus* isolates were resistant to oxacillin in that study.⁴

Which initial diagnostic tests should be performed?

Patients should have two sets of blood cultures drawn from two separate sites prior to administration of antibiotics.¹ Current guidelines recommend against aspiration of a suspected infected pocket site because the sensitivity for identifying the causal pathogen is low while the risk of introducing infection to the generator pocket is substantial.¹ In the event of CIED removal, pocket tissue and lead tips should be sent for Gram stain and culture.¹

Do all patients require a transesophageal echocardiogram?

Guidelines recommend a transesophageal echocardiogram (TEE) if suspicion for CIED infection is high based on positive blood cultures, antibiotic initiation prior to culture collection, ongoing systemic illness, or other suggestive signs.^{1,2} Positive transthoracic echocardiogram findings (for example, a valve vegetation) do not obviate a TEE because of the possibility of other relevant complications (including endocarditis) for which TEE has a greater sensitivity.¹

What is the approach to antimicrobial therapy?

Since most infections involve *Staphylococcus* species, initial empiric antimicrobial therapy should cover both oxacillin-sensitive and oxacillin-resistant strains. Thus, intravenous vancomycin is an appropriate initial choice.¹ Culture and sensitivity results should then guide specific therapy decisions.¹ Table 1 (see p. 13) provides a summary of strategies for antimicrobial selection and duration.

Should all patients undergo complete device removal?

All patients with CIED infection require complete device removal, even if the infection is suspected to be confined to the generator pocket and blood cultures remain negative.² Patients with superficial or surgical site infections without CIED infection do not require complete device removal. Rather, those cases can be managed with a 7- to 10-day course of oral antimicrobials.¹

After device removal, what is the appropriate timing for installing a new device?

The decision to implant a replacement device is often made with input from infec-

tious disease and cardiac electrophysiology experts. The decision must consider both infection and device-related concerns. Importantly, repeat blood cultures must be negative, and any infection in the pocket site should be controlled prior to installing a new device.²

Should all patients with a CIED receive antimicrobial prophylaxis prior to invasive dental, urologic, or endoscopic procedures?

No. Merely having a CIED is not considered an indication for antimicrobial prophylaxis.²

Back to the case

Two sets of blood cultures are drawn, and vancomycin is started as empiric therapy. The culture results show coagulase-negative *Staphylococcus* species, and antimicrobial resistance testing shows oxacillin resistance.

TEE shows a vegetation on one of the leads but no vegetation on any of the heart valves. Cardiac electrophysiology is consulted and performs a percutaneous extraction of the entire device (generator and leads).

Starting on the day of extraction, the patient undergoes 2 weeks of intravenous antimicrobial therapy with vancomycin. The patient, his family, and the electrophysiology team discuss the patient's wishes,

indications, and potential burdens related to device replacement.

He ultimately decides to have a replacement device installed. An infectious disease specialist is consulted to help define appropriate timing of the new device installation procedure.

Bottom line

The patient clearly had a CIED infection that required TEE, extraction of his CIED, and prolonged antimicrobial therapy. **TH**

Dr. Davison is a primary care physician at Community Health Network in Indianapolis. Dr. Lockwood is a hospitalist at the Lexington (Ky.) VA Medical Center. Dr. Sweigart is a hospitalist at the University of Kentucky, Lexington, and the Lexington VA Medical Center.

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4. Bongioni MG, Tascini C, Tagliaferri E, et al. Microbiology of Cardiac Implantable Electronic Device Infections. *Europace*. 2012;14(9):1334-9.

Table 1. Duration of antimicrobial therapy for CIED infection

Infection		Therapy duration
Valve vegetation		Per ACC/AHA guidelines for endocarditis
Lead vegetation		
Uncomplicated	<i>S. aureus</i>	2-4 weeks (needs follow-up TEE if only 2 weeks)
	Non- <i>S. aureus</i>	2 weeks
Complicated (septic thrombosis, osteomyelitis)		4-6 weeks
Pocket infection (negative blood cultures)		10-14 days (after removal of device/leads)
Lead infection (negative blood cultures)		7-10 days (after removal of device/leads)

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Since most infections involve *Staphylococcus* species, initial empiric antimicrobial therapy should cover both oxacillin-sensitive and oxacillin-resistant strains. Thus, intravenous vancomycin is an appropriate initial choice.

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IN THE LITERATURE



ITL: Physician reviews of HM-centric research

BY SHADI MAYASY, MD; EILEEN BARRETT, MD, MPH; HOURIYA AYOUBIEH, MD; ALEXANDER RANKIN, MD; AND SARAH BURNS, DO, MS

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By Shadi Mayasy, MD

1 Rivaroxaban or aspirin for extended treatment of VTE

TITLE: Low-dose or full-dose rivaroxaban is superior to aspirin for long-term anticoagulation.

CLINICAL QUESTION: Is full or lower intensity rivaroxaban better for extended treatment of venous thromboembolism (VTE) as compared with aspirin?

BACKGROUND: Various medications are used for long-term anticoagulation therapy for VTE. However, the treatments available are commonly complex, expensive or require monitoring. With the development of direct oral anticoagulants (DOACs), optimal regimens, especially for long-term management of VTE, are unclear.

STUDY DESIGN: Multicenter, randomized, double-blinded phase III trial.

SETTING: 230 Medical centers worldwide in 20 countries.

SYNOPSIS: Of patients with a history of VTE who had undergone 6-12 months of initial anticoagulation therapy and in whom continuation of therapy was thought to be beneficial, 3,365 were enrolled. Patients were randomly assigned to daily high-dose rivaroxaban (20 mg) or daily low-dose rivaroxaban (10 mg) or aspirin (100 mg). After a median of 351 days, symptomatic recurrent VTE or unexplained death occurred in 17 of the 1,107 patients (1.5%) who were assigned to the high-dose group, in 13 of 1,127 patients (1.2%) who were assigned to the low-dose group, and in 50 of 1,131 patients (4.4%) who were assigned to aspirin. Bleeding rates were not significantly different between the three groups (2%-3%). The major limitation of this study is the short duration of follow-up and the lack of power to demonstrate noninferiority of the low-dose as compared with the high-dose regimen for rivaroxaban.

BOTTOM LINE: In patients with a history of VTE, in whom prolonged anticoagulation

could be beneficial, low or high-dose rivaroxaban is superior to aspirin in preventing recurrent VTE without increasing bleeding risk.

Citation: Weitz, JI, Lensing, MH, Prins, R et al. Rivaroxaban or aspirin for extended treatment of venous thromboembolism. *N Engl J Med.* 2017; 376:1211-22.

2 CCDSSs to prevent VTE

TITLE: Use of computerized clinical decision support systems decreases venous thromboembolic events in surgical patients.

CLINICAL QUESTION: Do computerized clinical decision support systems (CCDSSs) decrease the risk of venous thromboembolism (VTE) in surgical patients?

BACKGROUND: VTE remains the leading preventable cause of death in the hospital. Despite multiple tools that are available to stratify risk of VTE, they are not used uniformly or are used incorrectly. It is unclear whether CCDSSs help prevent VTE, compared with standard care.

STUDY DESIGN: Retrospective systematic review and meta-analysis.

SETTING: Of 188 studies initially screened, 11 studies were included.

SYNOPSIS: Multiple studies relevant to the topic were reviewed; only studies that used an electronic medical record (EMR)-based tool to augment the rate of appropriate prophylaxis of VTE were included. Primary outcomes assessed were rate of appropriate prophylaxis for VTE and rate of VTE events. A total of 156,366 patients were analyzed, of which 104,241 (66%) received intervention with CCDSSs and 52,125 (33%) received standard care (physician judgment and discretion). The use of CCDSSs was associated with a significant increase in the rate of appropriate ordering of prophylaxis for VTE (odds ratio, 2.35; 95% confidence interval, 1.78-3.10; *P* less than .001) and a significant decrease in the risk of VTE events (risk ratio, 0.78; 95% CI, 0.72-0.85; *P* less than .001). The major

limitation of this study is that it did not evaluate the number of adverse events as a result of VTE prophylaxis, such as bleeding, which may have been significantly increased in the CCDSS group.

BOTTOM LINE: The use of CCDSSs increases the proportion of surgical patients who are prescribed adequate prophylaxis for VTE and correlates with a reduction in VTE events.

Citation: Borab, ZM, Lanni, MA, Tecce, MG et al. Use of computerized clinical decision support systems to prevent venous thromboembolism in surgical patients: A systematic review and meta-analysis. *JAMA Surg.* 2017. doi: 10.1001/jamasurg.2017.0131.

Dr. Mayasy is assistant professor in the department of hospital medicine at the University of New Mexico.

By Alexander Rankin, MD

3 Variation in physician spending and association with patient outcomes

TITLE: Variation in physician spending not associated with patient outcomes.

CLINICAL QUESTION: Is there a variation in spending between physicians in the same hospital, and does it have an effect on patient outcomes?

BACKGROUND: Not much is known about the presence of variations in individual physician spending within the same hospital, and it is not known if higher-spending physicians have better patient outcomes, compared with peers within the same institution.

STUDY DESIGN: Retrospective data analysis.

SETTING: National sample of hospitalized Medicare beneficiaries.

SYNOPSIS: Using National Medicare data over a 4-year period, the authors showed that there is wide variation in Part B spending across physicians (hospitalists and general internists) within the same acute care hospital. This inter-physician variation is larger than the difference in spending across hospitals. Higher spending was not associated with a reduction in 30-day mortality or 30-day readmission rates.

Most current health reform policies such as value-based purchasing and 30-day readmission penalties target hospitals as entities, but, based on this study, there may be a role for more physician-specific reform options. Because they found no significant difference in quality outcomes based on spending, the authors postulate that there may be an opportunity for individual high-spending physicians to decrease their health care utilization without compromising care quality.

The major limitation to this study is that it is a large-scale data analysis and may not capture some of the intricacies of individualized patient care.

BOTTOM LINE: Spending varies across physicians within the same hospital and is not associated with differences in mortality or readmissions outcomes.

Citation: Tsugawa, Y, Jha, AK, Newhouse, JP et al. Variation in Physician Spending and Association With Patient Outcomes. *JAMA Intern Med.* 2017. doi: 10.1001/jamainternmed.2017.0059.

4 Large-scale implementation of the I-PASS handover system

TITLE: Large-scale implementation of the I-PASS handover system at an academic medical center.

CLINICAL QUESTION: Is a system-wide I-PASS handover system able to be effectively implemented?

BACKGROUND: Handovers (also referred to as "handoffs") in patient care are ubiquitous and are increasing, especially in academic medicine. Errors in handovers are associated with poor patient outcomes. I-PASS (Illness Severity, Patient Summary, Action List, Situational Awareness, Synthesis by Receiver) is a handover system that is thought to improve efficiency and accuracy of handovers. However, generalized roll-out within a large academic hospital remains daunting.

STUDY DESIGN: Review of a single institution-wide operational change project.

SETTING: Academic medical center.

SYNOPSIS: The authors recount a 3-year system-wide I-PASS implementation at their 999-bed major academic medical center. Effectiveness was measured through surveys and direct observations. Postimplementation surveys demonstrated a generally positive response to the implementation and training processes. Direct observation over 8 months was used to assess adoption and adherence to the handover method, and results showed improvement across all aspects of the I-PASS model, although the synthesis component of the handover consistently scored lowest. The authors noted that this is an ongoing project and plan future studies to evaluate effect on quality and safety measures.

BOTTOM LINE: Implementing a system-wide handover change process is achievable but will need to be incorporated into organizational culture to ensure continued use.

Citation: Shahian, DM, McEachern, K, Rossi, L et al. Large-scale implementation of the I-PASS handover system at an academic medical center. *BMJ Qual Saf.*

2017. doi: 10.1136/bmjqs-2016006195.

Dr. Rankin is a hospitalist and director of the family medicine residency inpatient service at the University of New Mexico.

By Houriya Ayoubieh, MD

5 PEARL score for COPD exacerbations

TITLE: PEARL score predicts COPD readmissions.

CLINICAL QUESTION: Which prognostic score is best at predicting 90-day readmission and mortality for patients admitted with an acute exacerbation of chronic obstructive pulmonary disease (AECOPD)?

BACKGROUND: One-third of patients hospitalized for AECOPD are readmitted within 90 days. Previous prognostic tools (ADO, BODEX, CODEX, and DOSE) have been developed but remain suboptimal.

STUDY DESIGN: Prospective study with three separate cohorts: derivation, internal validation, and external validation.

SETTING: Six hospitals in the United Kingdom.

SYNOPSIS: In the study population, 2,417 patients were included and 936 were readmitted or died within 90 days of index admission. Patients with expected survival for less than 1 year for reasons other than COPD were excluded. The indices retained in the final PEARL score were previous admissions for AECOPD of 2 or more (2 points); extended medical research council (MRC) dyspnea score of 4, 5a, or 5b (1, 2, or 3 points); age of 80 or older (1 point); clinical diagnoses of right-sided heart failure (1 point) and/or left-sided heart failure on echocardiogram (1 point). Higher scores were associated with a shorter time to death or readmission. The performance of PEARL was superior to all alternative scoring systems. The major limitation to this study is that it did not differentiate between respiratory and other causes of readmission.

BOTTOM LINE: The PEARL score can be calculated for patients hospitalized for AECOPD to predict their 90-day readmission rate and/or mortality risk.

CITATION: Echevarria, C, Steer, J, Heslop-Marshall, K et al. The PEARL score predicts 90-day readmission or death after hospitalization for acute exacerbation of COPD. *Thorax*. 2017. doi: 10.1136/thoraxjnl-2016-209298.

6 C. difficile infection among U.S. ED patients

TITLE: *C. diff* infection common in emergency department patients, even without risk factors.

CLINICAL QUESTION: Should all emergency department (ED) patients with diarrhea, without vomiting, get tested for *Clostridium difficile*?

BACKGROUND: *C. difficile* infection has been described in low-risk patients in retrospective studies, but the prevalence in a prospective cohort has not been evaluated.

STUDY DESIGN: Prospective, observational study.

SETTING: Ten urban, university-affiliated

EDs in the United States between 2010 and 2013.

SYNOPSIS: In the study population, 422 patients met the inclusion of criteria of age older than 2, at least three diarrhea episodes in 24 hours, and absence of vomiting. The prevalence of *C. difficile* by stool culture and toxin assay was 10.2% (43/422; 95% CI, 7.7%-13.4%). The prevalence was 6.9% among patients without traditional risk factors defined as prior history of *C. difficile*, overnight health care stay, or antibiotic exposure in the last 3 months. The biggest limitation for this study is that the prevalence of *C. difficile* in the "low-risk" group may be overestimated given that factors such as use of antacids, history of inflammatory bowel disease, and immune suppression were not considered traditional risk factors. Also, 15 of the *C. difficile* samples were obtained via rectal swab, which is not standard of diagnosis.

BOTTOM LINE: The absence of traditional risk factors does not exclude the presence of *C. difficile* infection, which should be considered in ED patients with diarrhea and no vomiting.

CITATION: Abrahamian, FM, Talan, DA, Krishnadasan, A et al. *Clostridium difficile* infection among U.S. emergency department patients with diarrhea and no vomiting. *Ann Emerg Med*. 2017. doi: 10.1016/j.annemergmed.2016.12.013.

Dr. Ayoubieh is assistant professor in the division of hospital medicine at the University of New Mexico.

By Eileen Barrett, MD, MPH

7 Association between concurrent use of prescription opiates and benzos

TITLE: Short periods of concurrent benzodiazepine and opioid use increase overdose risk.

CLINICAL QUESTION: What is the impact of concurrent benzodiazepine use in chronic versus intermittent opioid use on risk for opioid overdose?

BACKGROUND: Previous studies have described the increased risk of fatal opioid overdose with benzodiazepine coprescription but have not quantified the difference in risk for overdose from intermittent versus chronic opioid use.

STUDY DESIGN: Retrospective study.

SETTING: Private insurance administrative claims in the United States.

SYNOPSIS: In 315,428 privately insured adults younger than 65 without malignancy who filled at least one opioid prescription between 2001 and 2013, concurrent benzodiazepine use doubled (increasing from 9% to 17%) and was associated with an increased risk for hospitalization for opioid overdose (1.16% versus 2.42%; odds ratio, 2.14; *P* less than .001). The risk was increased in both chronic opioid users versus nonusers (5.36% versus 3.13%; OR, 1.8; 95% CI, 1.67-1.96; *P* less than .001) and in intermittent opioid users as compared with nonusers (1.45% versus 1.02%; OR, 1.42; 95% CI, 1.33-1.51; *P* less than .001).

These results are similar to prior studies performed in other patient populations but add to those by including short periods of coprescription between opioid and benzodiazepine prescriptions (including a single day of overlap). Limitations of this study include that it included only patients who were seen in the ED or hospital.

BOTTOM LINE: There may be no safe duration of opioid use in patients who are also taking benzodiazepines.

CITATION: Sun, EC, Dixit, A, Humphreys, K et al. Association between concurrent use of prescription opioids and benzodiazepines and overdose: Retrospective analysis. *BMJ*. 2017;356(760):1-7.

8 Effect of frailty on HF readmissions

TITLE: Frailty is an independent risk factor for short-term mortality in older patients hospitalized with acute decompensated heart failure.

CLINICAL QUESTION: What is the effect of frailty on 30-day mortality in non-severely disabled older patients with acute decompensated heart failure?

BACKGROUND: Existing research highlights the worsened short-term prognosis in older patients with acute decompensated heart failure but has not examined if frailty is a specific independent risk factor for 30-day mortality in those without severe functional dependence.

STUDY DESIGN: Retrospective secondary analysis of a prospective observational multicenter cohort study.

SETTING: Three Spanish EDs.

SYNOPSIS: In 465 patients age 65 years and older with acute decompensated heart failure who did not have an ST-segment elevation myocardial infarction, severe functional dependence, or dementia, 36.3% were categorized as frail on a validated performance status scoring system. Frail patients had a higher 30-day mortality rate than did nonfrail patients (13.0% versus 4.1% in nonfrail patients). Frailty was independently associated with a 30-day mortality (HR, 2.5; *P* = .047).

The major limitations of this study are that the researchers did not report how many patients were discharged versus admitted from the ED and they did not stratify short-term mortality attributable to frailty by degree of medical comorbidity.

BOTTOM LINE: Frailty is common in older patients with acute decompensated heart failure and is also an independent risk factor for short-term mortality.

CITATION: Martin-Sanchez, FJ, Rodriguez-Adrada, E, Mueller, C et al. The effect of frailty on 30-day mortality risk in older patients with acute heart failure attended in the emergency department. *Acad Em Med*. 2017;24(3):298-307.

Dr. Barrett is assistant professor in the division of hospital medicine at the University of New Mexico.

By Sarah Burns, DO, MS

9 Effect of inpatient rehab vs. home-based program for TKA

TITLE: Inpatient rehabilitation does not improve mobility after total knee arthroplasty versus a monitored home-based program.

CLINICAL QUESTION: Does initial treatment in an inpatient rehabilitation facility offer greater improvements in mobility when added to a monitored home-based program after undergoing total knee arthroplasty?

BACKGROUND: Total knee arthroplasty (TKA) is common, and postsurgical care varies. No randomized controlled trials have compared inpatient rehabilitation to monitored home-based programs.


STUDY DESIGN: Multicenter, two intervention groups in parallel, randomized, controlled trial with a third observational group.

SETTING: Two high-volume arthroplasty hospitals in Sydney, Australia from July 2012 to December 2015.

SYNOPSIS: Of patients who underwent unilateral TKA, 165 were randomized to inpatient rehabilitation, followed by a home-based program vs. a home-based program only. A separate observation group (patients who chose home-based program) was included in the analysis of primary outcome. Primary outcome was functional mobility at 26 weeks as measured by walking distance via the 6-minute walk test. All 165 patients were included in an intention-to-treat analysis. The primary outcome was no different among the two randomized groups (adjusted mean difference with imputation, -1.01; 95% CI, -25.56 to 23.55). The per protocol analysis of the primary outcome yielded similar results; nonadherent patients were excluded from the per protocol analysis so the sample size was smaller. There were no between-group differences in the primary outcome when the home-based program was compared with the observation group. Secondary outcomes included patient reported and observer assessed outcomes in function and quality of life. The most significant limitation was that these results are generalizable only to patients considered appropriate for discharge home.

BOTTOM LINE: In total knee arthroplasty patients appropriate for discharge home, inpatient rehabilitation followed by a home-based program did not improve mobility as compared with a monitored home-based program alone.

CITATION: Buhagiar, MA, Naylor, JM, Harris, IA et al. Effect of inpatient rehabilitation vs. a monitored home-based program on mobility in patients with total knee arthroplasty, the HIHO randomized clinical trial. *JAMA*. 2017;317(10):1037-46.

Dr. Burns is assistant professor in the division of hospital medicine at the University of New Mexico. 

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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.

Corticosteroid therapy in Kawasaki disease

CLINICAL QUESTION

What is the efficacy of corticosteroid therapy in Kawasaki disease?

BACKGROUND

First described in 1967 in Japan, Kawasaki disease (KD), or mucocutaneous lymph node syndrome, is an acute systemic vasculitis of unclear etiology that primarily affects infants and children. Of significant clinical concern, 30%-50% of untreated patients develop acute coronary artery dilatation, and about one-fourth progress to serious coronary artery abnormalities (CAA) such as aneurysm and ectasia.^{1,2} These patients have a higher risk of long-term complications, such as coronary artery thrombus, myocardial infarction, and sudden death.³ KD is typically treated with a combination of intravenous immunoglobulin (IVIG) and aspirin, which reduces the risk of CAA.¹ However, more than 20% of cases are resistant to this conventional therapy and have higher risk of CAA than nonresistant patients.⁴ Corticosteroids have been suggested as therapy in KD, as the anti-inflammatory effect is useful

for many other vasculitides, but studies to date have had conflicting results. This study was performed to comprehensively evaluate the effect of corticosteroids in KD as initial or rescue therapy (after failure to respond to IVIG).

STUDY DESIGN

Systematic review and meta-analysis.

SYNOPSIS

The population of interest was children diagnosed with KD. The intervention of interest was treatment with adjunctive corticosteroids either as initial or rescue therapy. Comparisons were made between the corticosteroids group and the conventional therapy (IVIG) group. Outcome measurements included the incidence of CAA (primary outcome), duration until defervescence, and adverse events. IVIG resistance was defined as persistent or recurrent fever lasting (or relapsed within) 24-48 hours after the initial IVIG treatment.

A total of 681 articles were initially retrieved, and after exclusions, 16 comparative studies were enrolled for meta-analysis. In these studies, a total of 2,746 cases were involved, with 861 in the corticosteroid group and 1,885 in the IVIG group. Ten

studies used corticosteroids as initial treatment (comparing this plus IVIG versus IVIG therapy alone), and six used steroids as rescue treatment after initial IVIG failure (comparing corticosteroids with additional IVIG therapy). Four studies enrolled patients with KD who were predicted to have high risk of IVIG resistance, based on published scoring systems. All patients in the studies received oral aspirin.

Overall, this meta-analysis found that adding corticosteroid therapy was associated with a relative risk reduction of 58% in CAA (odds ratio, 0.424; 95% confidence interval, 0.270-0.665; P less than .001). Further analysis showed that, the longer the duration of illness prior to corticosteroids, the less of a treatment effect was noticed. The studies using steroids as initial adjunctive therapy had duration of illness 4.7 days prior to treatment, and showed an advantage, compared with IVIG alone, while studies using steroids as rescue therapy had a longer duration of illness prior to steroid therapy (7.2 days), and did not show significant benefit, compared with additional IVIG. In analyzing patients predicted to be at high risk of IVIG resistance at baseline, addition of corti-

costeroids with IVIG as initial therapy showed a significantly lower risk of CAA development (relative risk reduction of 76%) versus IVIG alone (OR, 0.240; 95% CI, 0.123-0.467; P less than .001). As a secondary outcome, the use of adjunctive corticosteroid therapy was associated with a quicker resolution of fever, compared with IVIG alone (0.66 days vs. 2.18 days). There was no significant difference in adverse events between the two groups.

Although this is the most comprehensive study of corticosteroids in KD, there are some limitations. High-risk patients were found to receive the greatest benefit, but the predictive ability of published scoring systems have not been optimized or generalized to all populations. Most of the studies included in this review were conducted in Japan, so it is uncertain if the results are applicable to other regions. Also, the selection of corticosteroids and treatment regimens were not consistent between studies.

BOTTOM LINE

This study suggests that corticosteroids combined with IVIG as initial therapy for KD showed a more protective effect against CAA, compared with conventional IVIG therapy, and the efficacy was more pronounced in the high-risk patient group. **TH**

CITATION

Chen, S, Dong, Y, Kiuchi, MG et al. Coronary Artery Complication in Kawasaki Disease and the Importance of Early Intervention: A Systematic Review and Meta-analysis. *JAMA Pediatr.* 2016;170(12):1156-63.

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“Now begins the work of an ABP sub-board on pediatric hospital medicine, which I chair, to establish the criteria that would allow one to sit for board certification and to define the core content specific to this field, which will provide the basis for the certifying exam,” said Daniel Rauch, MD, FHM, associate director of pediatrics at Elmhurst Hospital Center, Queens, N.Y. Although passing the exam is a necessary requirement for achieving board certification in the subspecialty, qualifying to sit for the exam will be possible through an experiential or practice pathway the first three times the exam is offered – in 2019, 2021, and 2023.

Eventually, starting in 2025, pediatric hospitalists will need to complete a fellowship of 2 years or more if they wish to sit for the exam and become board certified in the field. But, for the next 7 years, hospitalists in current practice will be able to qualify based on their work experience. Maintenance of certification requirements likely will be similar to those in other subspecialties, and doctors certified in pediatric hospital medicine won’t be required to maintain general pediatric certification, Dr. Rauch said.

Formal eligibility criteria have not been set, but likely will include working half-time overall in pediatric-related activities, and quarter-time in clinical practice in pediatric hospital medicine for 4 years prior to qualifying for the exam. How the hours might break down between clinical and other hospital responsibilities and between pediatric or adult patients, still needs to be determined, Dr. Rauch said. He added that the experiential pathway is likely to be defined broadly, with latitude for determinations based on percentages of time worked, rather than absolute number of hours worked. Local pediatric institutions will be granted latitude to determine how that “plays out” in real world situations, he said, “and an ABP credentialing committee will be available to hear appeals for people who have complicated life circumstances.”

The Society of Hospital Medicine (SHM) didn’t have any formal role in developing subspecialty certification, although it includes members who work in pediatrics and led the development of Pediatric Hospital Medicine Core Competencies,² a cornerstone of the field’s development, said Ricardo Quinonez, MD, FAAP, FHM, past chair of the AAP’s Section on Hospital Medicine and chief of the division of pediatric hospital medicine at Texas Children’s Hospital, Baylor College of Medicine, Houston.

“I was part of a committee that explored these issues. We were an independent group of hospitalists who decided that board certification was a good way to advance the field,” Dr. Quinonez said. “We’ve seen what subspecialty certification has done, for example, for pediatric emergency medicine and pediatric critical care medicine – advancing them tremendously from a research standpoint and helping to develop a distinct body of knowledge reflecting increased severity of illness in hospitalized children.”

Discrepancy between practicing hospitalists, fellowships

An estimated 4,000 pediatric hospitalists now practice in the United States, and 2,100 of those belong to the American Academy of Pediatrics’ Section on Hospital Medicine. There are 40 pediatric hospital medicine fellowship programs listed on the website of AAP’s Section on Hospital Medicine (<http://phmfellows.org/phm-programs>), although formal training assessment criteria will be needed for the American College of Graduate Medical Education to recognize programs that qualify their fellows to sit for the PHM exam. A wide gap is anticipated between the demand for pediatric hospitalists and currently available fellowship training slots to generate new



Dr. Chang



Dr. Alverson



Dr. Quinonez

candidates for board certification, although Dr. Rauch projects that fellowship slots will double in coming years.

“My message to the field is that, historically, board certification has been the launching point for further development of the field,” Dr. Rauch said. “It leads to standardization of who is a subspecialist. Right now, who is a pediatric hospitalist is subject to wide variation. We need to standardize training and to create for this field the same distinction and stature as other medical subspecialties,” he said, noting that subspecialty status also has ramifications for academic settings, and for career advancement and career satisfaction for the individuals who choose to pursue it.

“I know there has been some hue and cry about this in the field, but in most cases, certification will not change a pediatric hospitalist’s ability to obtain a job,” he said. “Already, you can’t become a division leader at a children’s hospital without additional training. This isn’t going to change that reality. But for people who don’t want to follow an academic career path, there will never be enough board-certified or fellowship-trained pediatric hospitalists to fill all of the pediatric positions in all the hospitals in the country. Community hospitals aren’t going to say: We won’t hire you unless you are board certified.”

Is the fellowship good for the field?

The subspecialty development process clearly is moving forward. Those in favor believe it will increase scholarship, research, and recognition for the subspecialty by the public for its specialized body of knowledge. But not everyone in the field agrees. Last fall *The Hospitalist* published³ an opinion piece questioning the need for fellowship-based board certification in pediatric hospital medicine. The author recommended instead retaining the current voluntary approach to fellowships and establishing a pediatric “focused practice”

incorporated into residency training, much as the American Board of Internal Medicine and the American Board of Family Medicine have done for hospitalists in adult medicine.

Weijen Chang, MD, SFHM, chief of the division of pediatric hospital medicine at Baystate Children’s Hospital in Springfield, Mass., wrote an introduction for that article. He wonders if board certification will eventually become necessary to continue seeing pediatric patients in the hospital. “This process leaves that question to local hospitals as the decision makers. But we can’t know what your local hospital credentialing committee will do,” he said.

“Will it lead to uncertainty among those currently in residency programs? If you are a pediatric resident and you want to become a board-certified pediatric hospitalist, you’ll need at least 2 years more of training. Is that going to deter qualified individuals?” Dr. Chang asked. “The people this decision will impact the most are med-peds doctors – who complete a combined internal medicine and pediatrics residency – and part-timers. They may find themselves in a difficult position if the number of hours don’t add up for them to sit for the boards. For the most part, we’ll have to wait and see for answers to these questions.”

Brian Alverson, MD, FAAP, current chair of the AAP’s Section on Hospital Medicine and associate professor of pediatrics at Brown University, Providence, R.I., says he can see both sides of the debate.

“I think for the field of pediatric hospital medicine, as far as advancing our knowledge and the care of children in the hospital, this is a very good thing,” he said. “It will push academic children’s hospitals that don’t have a division of hospital medicine to invest in one. All of the really sick children are in the hospital, and if we’re going to attend to those children at their most vulnerable time, we need to address the existing knowledge gap in pediatric hospital medicine.”

But, at the same time, there is a significant opportunity cost for doing 2 more years of fellowship training, Dr. Alverson said.

“We don’t know how much the board certification test will improve actual care,” he noted. “Does it truly identify higher quality doctors, or just doctors who are good at taking multiple choice exams? There are a number of people in pediatrics who do a lot of different things in their jobs, and it’s important that they not lose their ability to practice in the field. Two-thirds of our work force is in community hospitals, not academic medical centers. They work hard to provide the backbone of hospital care for young patients, and many of them are unlikely to ever do a fellowship.”

Nonetheless, Dr. Alverson believes pediatric hospitalists needn’t worry. “You still have plenty of time to figure out what’s going to happen in your hospital,” he said. **TH**

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NEW MEMBERS CONTINUED FROM PAGE 1

plugging in and working, doing our shifts, somewhere in that 8- to 10-year range, we might get a little bored, tired, worn out,” Dr. Thompson said. “I believe, if we have the community and professional home to keep us engaged, that helps us see the value in what we’re doing every day. It helps us continue to grow, so we don’t hit that wall.”

Given Dr. Thompson’s involvement both with her chapter and the society’s chapter support committee, she will likely continue that effort to make sure SHM’s board sees the value of encouraging and partnering with local chapters. She will also work with SHM president Ron Greeno, MD, FCCP, MHM, on policy issues, as her background in public health has aligned her interests on health care reform and other headwinds facing the specialty.

“I went in to do my masters in public health with the idea that I wanted to build the skill set so that I could be more analytical in how I approach our problem solving, our discovery in the hospital setting,” she said. “It really speaks to a part of me that has always been interested in finding ways to prevent illness and moving beyond that reactivity that we have in medicine into a prevention-based [approach].”

Dr. Thompson noted that her background in perioperative medicine helps her work as part of a team because it “entirely relies on collaboration and coordination of care, which is pretty much the basis of what we do in the hospital any day.”

Dr. Rehm, who serves as a pediatric hospitalist at the Monroe Carell Jr. Children’s Hospital at Vanderbilt, said she will also bring a teamwork-focused perspective to the SHM board.

She could be expected to view everything through the lens of inpatient pediatrics, but that’s not her style.

“I think we have so many similarities and so many things that [pediatric and adult hospitalists] can partner to do together,” she said. “We all are involved in, for example, medication reconciliation or discharge-management planning or postacute care follow-up. There’s a lot of synergy, and I think we can learn so much from each other.”

Dr. Rehm, who chairs SHM’s Pediatrics Committee and the 2017 Pediatric Hospital Medicine meeting, pointed out that working well with others is a natural skill set for hospitalists.

“Collaboration is probably my biggest skill set and that of



Dr. Rehm

many hospital medicine providers,” she said. “I think I do that in my job here at Vanderbilt in thinking about complicated patients that require multiple subspecialists and in bringing together people to figure out the question at hand. That is definitely my leadership style.”

If Dr. Rehm has one goal on the board, it is to become a little bit more like Dr. Thompson and focus on chapter development for pediatric hospitalists.

“I’m really interested in engaging with members to better understand the struggles on the front line so that we can make sure that, as an organization, we’re offering a brand of things that our membership needs,” she said. “So, I’m really looking forward to becoming more involved in the chapter engagement and development. The Nashville chapter is getting reengaged now, and I’m excited to be involved.”

To prepare for her debut board meeting in Las Vegas, Dr. Rehm attended SHM board meetings at the group’s Philadelphia headquarters over the past 2 years.

“I’ve been lucky enough to attend the fall board meeting in Philadelphia and observe the board in action, and I think that has helped me get to know some of the current board members and to have a little bit of a vision of what the meetings will be like,” she said. **TH**



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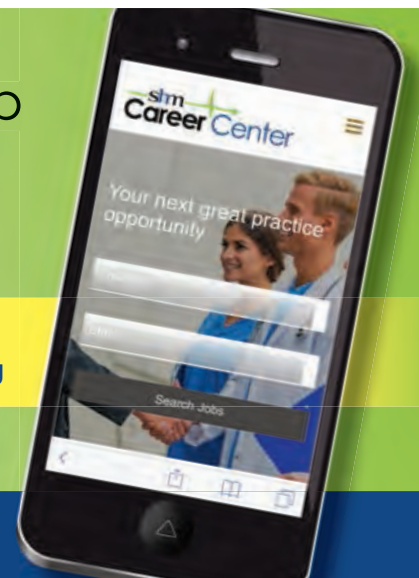
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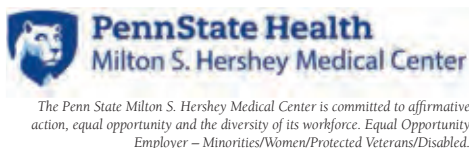
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Our largest facility has 514 beds and is a premier tertiary referral hospital, while our community facilities include 152-bed, 150-bed and 100-bed hospitals. We are also home to the only state-accredited Level II trauma center in Brevard and Indian River Counties.

At Health First Medical Group, we provide our patients with outstanding services and state-of-the-art care provided by internists and supported by a wide array of specialists. All service lines are represented with the exception of transplant surgery.

When you join our team, you can expect a very competitive base salary plus bonus plan, full benefits offered to the physician and family, CME, retirement benefits, sign-on bonus, relocation allowance and much more.

Our location is just a few miles from beautiful beaches, close to major airports, shopping and all Florida attractions. Brevard County is known for excellent public and private schools along with great housing locations/options.

To learn more about our opportunity, please email your CV to **HFMG Senior Provider Recruiter, Mary Weerts, at: Mary.Weerts@Health-First.org or call 321-725-4500, ext 7607 to discuss the details.**

Health First
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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 Lauer, CMMC Physician Recruitment
300 Main Street, Lewiston, ME 04240
email: LauerJu@cmhc.org
call: 800/445-7431 fax: 207/755-5854

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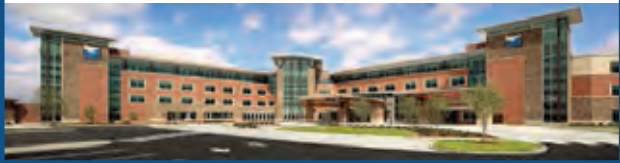
HOSPITALISTS & NOCTURNISTS

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



Division of Hospital Medicine of Cooper University Hospital Board Certified/Eligible Internal Medicine and Family Medicine Hospitalists and Nocturnists

The Division of Hospital Medicine of Cooper University Hospital seeks motivated physicians to join a dynamic team of 80 physicians and 20 nurse practitioners at more than ten locations in Southern New Jersey.

Highlights:

- Full-time or part-time Hospitalist positions
- Day or night shifts available
- Flexible scheduling
- Teaching opportunities with residents and medical students
- Emphasis on patient experience, quality and safety
- Average encounter number of 14-18/day
- Secure employment with low physician turnover
- Potential for career advancement in administrative, quality or educational roles

Cooper University Hospital is a 635 bed teaching hospital. We are the only tertiary care center and the first Advanced Certified Comprehensive Stroke Center in Southern New Jersey. We employ more than 900 physicians and 325 trainees in all medical and surgical specialties. Cooper University Hospital has its own on-campus medical school, the Cooper Medical School of Rowan University. The Cooper Health System maintains multiple partnerships with local and national institutions, including the MD Anderson Cancer Center.

Employment Eligibility:

Must be Board Certified/Eligible in Internal or Family Medicine

Contact Information:

Lauren Simon, Administrative Supervisor, 856-342-3150
Simon-Lauren@cooperhealth.edu www.cooperhealth.org

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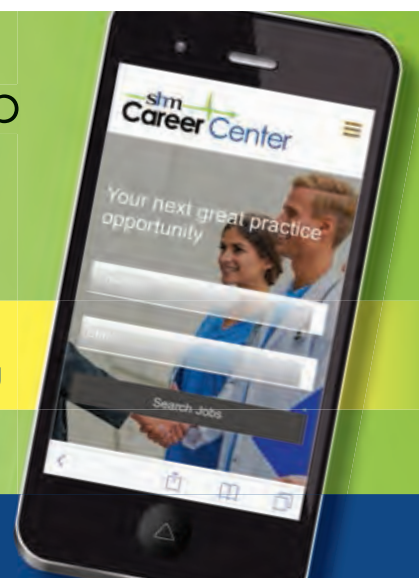
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At TeamHealth, our purpose is to perfect physicians' ability to practice medicine, every day, in everything we do. Our philosophy is as simple as our goal is singular: we believe better experiences for physicians lead to better outcomes—for patients, hospital partners, and physicians alike.

To learn more about this position or other Hospital Medicine opportunities, contact **Jennie Paschal** at **954.835.2845** or physicianjobs@teamhealth.com, or visit teamhealth.com.

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 of the Hospitalist service for the Network. This individual will serve as the clinical lead for the service and will work closely with physicians, Site Medical Directors, AP leadership and Staff to assure consistently 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 physicians and 7 hospitals, providing care in eastern Pennsylvania and western NJ. We employ more than 450 physician and 200 advanced practitioners. St. Luke's currently has more than 180 physicians enrolled in internship, residency and fellowship programs and is a regional campus for the Temple/St. Luke's School of Medicine. Visit www.sluhn.org

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Hospitalist or Nocturnist Montgomery County, PA

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

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University of Pittsburgh

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

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

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

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

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OHIO

St. Rita's Professional Services, LLC has 10 openings for a Hospitalist in Lima, Ohio.

Responsibilities: Supervise medical activities in intensive care & stepdown units; Daily rounds on all patients in units; Screen admissions, transfers & discharges to the units; Oversee the Quality Improvement/Performance Improvement program established for the service; Collaborate w/ Critical Care Nursing Director & clinical managers to achieve results; Develop hospital-based consulting practice to allow 24 hour critical care coverage. Schedule: 7 days/7 days off – 12 hr shifts. At least 182 shifts per yr.

Must have: MD Degree or DO (foreign equiv. accepted); Unrestricted Ohio Medical License; appropriate credentials to qualify for privileges at St. Rita's Medical Center; unrestricted DEA registration; & graduate of accredited Internal Medicine or Family Medicine Residency Program.

Email resumes: cljones@mercy.com (No Calls).



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Successful candidates will have the following education and experience:

- Graduate of four-year U.S. Medical School or equivalent
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- Board Certified in IM or FP
- Clinical experience in IM or FP
- Board eligible or board certified in IM or FP

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NOCTURNIST and Staff Opportunities

Earn More, Work Less, Enjoy Work-Life Balance

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The Opportunity:

Nocturnist and staff positions: We are seeking BC/BE IM or FM physicians to work in a team environment with NP and PA providers.

Nocturnists are supported by physician and NP/PA swing shift staff, **full-time hours are reduced and compensation is highly incented.** We also offer:

- The opportunity to expand your professional interests in areas such as our nationally recognized Palliative Care team and award-winning Quality Improvement initiatives.
- Encouragement of innovation and career growth at all stages starting with mentoring for early hospitalists, and progressing to leadership training and opportunities.
- The only Hospital Medicine Fellowship in northern New England with active roles in fellow, resident and medical student education.



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Hospitalist/Nocturnist Opportunities

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

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

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

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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.

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HOSPITALIST OPPORTUNITY Southwest Ohio

UC Health Hospitalist Group at West Chester Hospital seeking a board certified/prepared Internal Medicine or Family Medicine physician to join our growing Hospitalist group. West Chester Hospital is a community hospital, located just north of Cincinnati OH, with academic affiliation to the University of Cincinnati Health System.

Seeking candidates for a dedicated nocturnist position, 7p to 7a. Position is supported by 24hr Critical Care Services. The contractual obligation is for 12 shifts per month with opportunities/ incentives for additional shifts if desired.

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CONTACT: Dr. Brad Evans, Director
UC Health Hospitalist Group
513-298-7325
evansb7@ucmail.uc.edu



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.

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- Excellent benefits, including malpractice, moving expenses



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.sluhn.org.

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Hospitalists

Minnesota and Wisconsin

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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 our residency program.
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- 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.
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Hospitalist

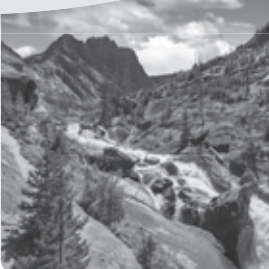
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HOSPITALISTS

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Kansas City and Region

Saint Luke's Hospital, based in Kansas City, Missouri is a 600 bed tertiary/teaching hospital searching for hospitalists to join a well established 66 physician hospitalist group providing inpatient coverage to 6 Saint Luke's Health System hospitals and 2 independent hospitals in beautiful communities within an hour's drive of Kansas City. The hospitalist program has seen consistent growth over its 12 year history and has one of the highest physician retention rates in the region.

Saint Luke's Health System is a not-for-profit, locally owned health system consisting of 10 area hospitals and is a past Malcolm Baldrige Award winner. It is the leader in patient satisfaction and ranked nationally as one of the top health systems in the U.S.

Ideal candidates will be BC/BE and have a high degree of training and expertise in inpatient hospital work as well as excellent communication skills. The schedule is designed around patient centered care and provides for a wonderful work and life balance. Recently added is an e-Hospitalist component providing an added level of support.

Kansas City community offers nationally ranked schools, museums, beautiful lakes and outdoor hiking/biking trails, golf courses and is known as the "City of Fountains". It also offers professional sports, theatre, jazz, world-class BBQ and most recently the Kauffman Center for the Performing Arts, a state of the art cultural icon.

Saint Luke's has an extremely competitive employment package that includes guaranteed salary, bonus based on productivity with fabulous benefits (i.e. malpractice insurance, retirement, insurance, vacation, CME, etc). All inquiries are confidential.

Contact: Mick Allison, System Director of Physician Recruitment and Retention, Saint Luke's Health System, Phone: 816-502-8865, E-mail: mallison@saint-lukes.org

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Highlights:

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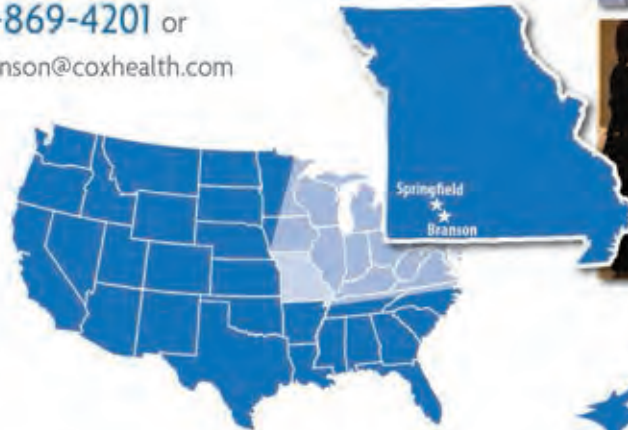
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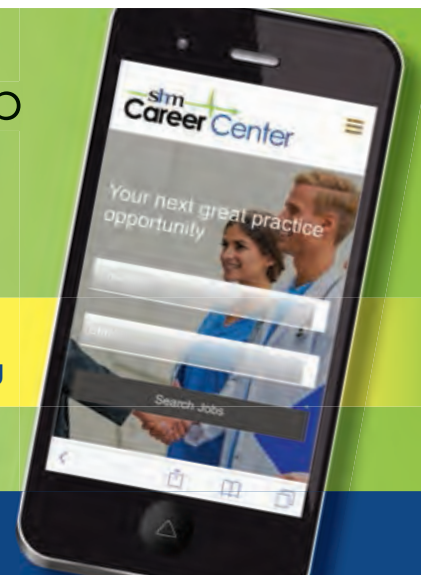
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Hospitalist burnout

The causes of burnout for different subspecialties are very similar

Some things I've been thinking about:

- Physician well-being, morale, and burnout seem to be getting more attention in both the medical and the lay press.
- Leaders from 10 prestigious health systems and the CEO of the American Medical Association wrote a March 2017 post in the Health Affairs Blog titled "Physician Burnout is a Public Health Crisis: A Message To Our Fellow Health Care CEOs."
- I'm now regularly hearing and reading mention of the "Quadruple Aim." The "Triple Aim," first described in 2008, is the pursuit of excellence in 1) patient experience – quality of care and patient satisfaction; 2) population health; and 3) cost reduction. The November/December 2014 Annals of Family Medicine included an article recommending "that the Triple Aim be expanded to a Quadruple Aim by adding the goal of improving the work life of health care providers, including clinicians and staff."¹
- The CEO at a community hospital near me chose to make addressing physician burnout one of his top priorities and tied success in the effort to his own compensation bonus.
- In the course of my consulting work, I've noticed a meaningful increase in the number of our colleagues who seem deeply unhappy with their work and/or burned out. The "Hospitalist Morale Index" may be a worthwhile way for a group to conduct an assessment.²
- I'm concerned that many other hospital care givers, including RNs and social workers, are experiencing levels of distress and/or burnout that might be similar to that of physicians. From where I sit, they seem to be getting less attention, and I can't tell if that is just because I'm not as immersed in their world or if it reflects reality. It's pretty disappointing if it's the latter.

For the most part, I think the causes of hospitalist distress and burnout are very similar to those of doctors in other specialties, and interventions to address the problem can be similar across specialties. Yet, each specialty probably differs in ways that are important to keep in mind.

In the September 2015 edition of this column, I shared my opinion that EHRs cause stress for hospitalists, only in part because they're difficult to use. The bigger issue is that EHR adoption often leads doctors in most other specialties to take a step back from direct care in the hospital, leaving the hospitalists to manage much of the documentation and ordering that might have been done by other doctors previously. At my hospital, our terrific rheumatologists stopped providing hospital care altogether since their low volume of hospital work didn't justify the effort required to learn to use the EHR.

Hospitalists also bear a huge burden related to observation status. Doctors in most other specialties rarely face complex decisions

regarding whether observation is the right choice and are not so often the target of related patient/family frustration and anger.

Those seeking to address hospitalist burnout and well-being specifically should keep in mind these uniquely hospitalist issues. I think of them as a chronic disease to manage and mitigate, since "curing" them (making them go away entirely) is probably impossible for the foreseeable future.

What to do?

An Internet search on physician burnout, or other terms related to well-being, will yield more articles with advice to address the problem than you'll ever have time to read. Trying to read all of them would likely lead to burnout! I think interventions can be divided into two broad categories: organizational efforts and personal efforts.

Like the 10 CEOs mentioned above, health care leaders should acknowledge physician distress and burnout as a meaningful issue that can impede organizational performance and that investments to address it can have a meaningful return on investment. The Health Affairs Blog post listed 11 things the CEOs committed to doing. It's a list anyone working on this issue should review.

Doctors at The Mayo Clinic have published a great deal of research on physician burnout. In the March 7, 2017, JAMA, (summarized in a YouTube video) they describe several worthwhile organizational changes, as well as some personal strategies.³ They wrote about their experiences with interventions such as a deliberate curriculum to train doctors in self-care (self-reflection, mindfulness, etc.) in a series of

one-hour lectures over several months.⁴ In November 2016, they published a meta-analysis of interventions to address burnout.⁵

In total, all of the worthwhile recommendations to address burnout leave me feeling like they're a lot of work, and any individual intervention may not be as helpful as hoped, so the best way to approach this is with a collection of interventions. In many ways, it is similar to the problem of readmissions: There is a lot of research out there, it's hard to prove that any single intervention really works, and success lies in implementing a broad set of interventions. And success doesn't equate to eliminating readmissions, only reducing them.

Coda: Is a sabbatical uniquely valuable for hospitalists?

I think a sabbatical might be a good idea for hospitalists. It also seems practical for other doctors, such as radiologists, anesthesiologists, and ED doctors, who don't have 1:1 continuity relationships with patients. However, it is problematic for primary care doctors and specialists who need to maintain continuity relationships with patients and referring doctors that could be disrupted by a lengthy absence.

I'm not sure a sabbatical would reduce burnout much on its own, but, if properly structured, it seems very likely to reduce staffing turnover, and the sabbatical could be spent in ways that help rejuvenate interest and satisfaction in our work rather than simply taking a long vacation to travel and play golf, etc. It should probably be at least 3 months and better if it lasts a year.



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

A common arrangement is that a doctor becomes eligible for the sabbatical after 10 years and is paid half of her usual compensation while away. I'd like to see more hospitalist groups do this. **TH**

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Finding your path in hospital medicine



Dr. Epstein is executive vice president & chief medical officer at PreferredOne and adjunct assistant professor of medicine at the University of Minnesota, Minneapolis. He also serves as Board Secretary of SHM.

Several times a year, I'm privileged to step away from my role as chief medical officer of a health insurance company and return to a previous role I cherish – teaching.

This isn't the clinical teaching that I used to do as a hospital medicine attending or palliative medicine consultant. These are mostly 4th-year medical students who have 90 minutes or so set aside during their primary care rotation to learn about "the business of medicine."

I always begin by telling them that, when I went to medical school, "I always intended to become a health insurance executive – NOT!" (If I get a few laughs, I know the time will fly by.) I share the history of my improbable career arc and how I wound up doing something I didn't even know existed when I was their age. And, I still try to impart some pearls of wisdom in case they remember any of this discussion as they embark on their own personal and professional journeys, knowing that, at this stage in their young careers, they will be almost totally immersed in their clinical training.

I find myself being asked by an increasing number of mid- and even late-career physicians, "What did you have to do to get that job?" Sadly, what most of them are really saying is: "I need to find something else to do. I just don't think I can do this for the rest of my working life." As a practicing physician until only a few years ago, I completely empathize. The

increased pace and productivity demands of medicine; the additional component of being measured on quality, safety, and patient experience; and the negative aspects of working in (for?) an electronic medical records system have all been cited as reasons for the increasing trend of provider burnout. So – preferably before you ever reach that point – allow me to share some of my personal "career pearls" that I share with those medical students.

1. Do what you love

Sounds simple, but too many of us make the expedient choice or the one expected of us. Work is hard enough without being able to find some joy and meaning every day in what you do. Every job has aspects that must be tolerated, but if you don't find a greater purpose in practicing medicine, then find a way to get it back – or think about doing something else.

2. When opportunity knocks, be prepared to answer the door

For me, I enjoyed caring for patients one at a time, perhaps 15 or so during any particular day. Being a hospitalist is important and fulfilling work. But, my experience as a hospitalist enabled me to recognize the "quality chasms" that existed in my hospital and across the "system," namely lost opportunities to provide better end-of-life care and to better coordinate care within the hospital and across the care continuum. A new mission evolved for me: to do whatever I could to improve the safety, quality, and efficiency of the care we provided and to make the hospital a better place to work. I taught myself the clinical skills to practice palliative medicine, and I attended courses that helped me prepare to become a service line medical director in hopes of starting a program at my hospital. I also took on the role of medical director of care management at my hospital, which in a sense allowed me to help take care of several hundred patients at a time – the beginning of my transition to population health.

3. Be a lifelong learner

When these opportunities arose, I was prepared for the challenges, thanks to training opportunities I actively sought out and thanks to the support of my mentors and my medical group to attend leadership training, such as SHM's Leadership Academy. No matter what your role in your group or at your hospital, gaining these valuable skills outside of the usual medical training will help position you for new opportunities that can only help you create a more sustainable career. And, although I never went back to school to earn another advanced degree such as an MBA or MHA, additional formal education is something to consider. You can never have too many tools in your toolkit.

4. Diversify!

It's good advice from your financial adviser, and it's good advice for your career. I'm not suggesting you take on a side job as a lawyer or a carpenter, but you might want to think about becoming an expert in a related field like perioperative medicine, primary palliative care, or postacute care. Or consider developing a niche as a sought-after leader for hospital-based committees, such as Quality or P&T. Or maybe consider clinical research, even if you're not at an academic medical center. The point I'm making – and I know this may seem controversial – is that practicing medicine 100% of the time is probably no longer a sustainable plan for the entire 30- to 40-year span of your postgraduate career. Find an area that you can develop into protected, paid time apart from providing direct clinical care.

5. If you are thinking of changing jobs or even careers, run toward something – not away from something else

When I was first recruited to be a medical director at another health plan, I struggled mightily as to whether leaving full-time practice was an opportunity or a foolish, dead-end career move. Ultimately, I made my decision not to avoid night call or working every other weekend; I did it because I felt I had made a difference in the hospital where I had worked for 15 years and was ready to take on a new challenge by learning the business side of health care. It provided me the opportunity to positively impact the care of not just several hundred patients but for as many as two million! My current position now allows me to have even greater influence in pursuing my personal mission to improve the quality, safety, and affordability of health care.

6. Seek balance in life

Again, sounds trite, but think about it. Most health care professionals, especially physicians, have spent most of their adult lives focused on a single goal – and that often comes at a great cost, both financially and personally. (By the way, I say "seek" because, at this point in my career, I doubt any of us ever really find balance.) The best you can hope for is to be wise enough to know that, amongst all the balls we are juggling, there are a few that you just can't let drop without possibly breaking without repair.

As I conclude my talks, I tell those young medical students to practice resiliency; the only constant is change. Remain inquisitive, open yourself to whatever life may bring and enjoy the ride. With a specialty as dynamic and diverse as hospital medicine, you never know where it will take you. **TH**



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The role of NPs and PAs in hospital medicine programs



Dr. Scheurer (top) is a hospitalist and chief quality officer at the Medical University of South Carolina in Charleston. She is physician editor of *The Hospitalist*. Ms. Cardin is a nurse practitioner in the Section of Hospital Medicine at the University of Chicago and is chair of SHM's NP/PA Committee.

Background and growth

Hospitalist nurse practitioner (NP) and physician assistant (PA) providers have been a growing and evolving part of the inpatient medical workforce, seemingly since the inception of hospital medicine. Given the growth of these disciplines within hospital medicine, at this juncture it is helpful to look at this journey, to see what roles these providers have been serving, and to consider newer and novel trends in how NPs and PAs are being weaved into hospital medicine programs.

The drivers for growth in this provider population are not unlike those of physician hospitalists. The same milieu that provided inroads for physicians in hospital-based care have led the way for increased use of NP/PA providers. An aging physician workforce, residency work hour reforms, increasing complexity of patients and systems on the inpatient side, and the recognition that caring for inpatients is a specialty vastly different from the role of internist in primary care have all impacted the numbers of NPs and PAs in this arena.

A quick review of older articles gives a very interesting snapshot of the utilization of NP/PA providers in hospital medicine in past years. The titles alone reflect the uncertainty at the time in how best to utilize NP/PA providers in hospital medicine:

- 2007 *Today's Hospitalist* article: "Midlevels make a rocky entrance into hospital medicine."¹
- 2009 *ACP Hospitalist* article: "When hiring midlevels, proceed with caution."²

The numbers at the time tell a similar story. In the Society of Hospital Medicine survey in 2007-2008, about 29% and 21% of hospital medicine practices utilized NPs and PAs, respectively. However, by 2014 about 50% of Veterans Affairs inpatient medical services deployed NP/PA providers, and most recent data from SHM reveal that about 63% of groups use these advanced practice providers (APPs), with higher numbers in pediatric programs. Clearly, there is evolving growth and enthusiasm for NP/PAs in hospital medicine.

Program models

Determining how best to use NP/PAs in hospital medicine programs has had a similar evolution. Reviewing past articles addressing these issues, one can see that there has been clear migration; initially NP/PAs were primarily hired to assist with late-afternoon admission surges, with about 60% of the APP workload being utilized to admit in 2007. Their role has continued to grow and change, much as hospitalist practices have; current program models consist of a few major types.

The first model is the classic paired rounding or "dyad" model. This is where a physician and an APP split a panel of patients. The APP then cares for his/her

panel of patients, and the physician does the same for his/her panel of patients. The physician and the APP may then "run the list together" and the physician may then see most or all of the APP's patients and bill for them when medical complexity demands. This allows for a higher volume of patients to be seen and billed, at a lower overall cost; it also provides for backup/support/redundancy for both team members when the patient acuity gets high.

Another model is use of an NP/PA in an observation unit or with lower acuity observation patients. The majority of the management of the patients is completed and billed by the APP, with the physician available for backup. The program has to account for some reimbursement or compensation for the physician oversight time, but it is a very efficient use of APPs.

The third major deployment of APPs is with admissions. Many groups use APPs to admit into the late afternoon and evening, getting patients "tucked in," including starting diagnostic work-ups and treatment plans. The physician hospitalist then evaluates the patient the next day and often bills for the admission. This model works in situations where the patient work-up is dependent on lab testing, imaging, or other diagnostic testing to understand and plan for the "arc" of the hospitalization; or in situations where the diagnosis is clear, but the patient needs time with treatment to determine response. The downside of this model is long-term job satisfaction for the APP.

Another area where APPs have made strong inroads is that of comanagement services. The NP or PA develops a long-term relationship with a surgical comanagement team, and is often highly engaged and extremely appreciated for managing chronic conditions such as hypertension and diabetes. The NP/PA usually bills independently for these encounters.

APPs are also used in cross coverage and triage roles, allowing the day teams to focus on their primary patients. In a triage role, they can interface with the emergency department, providing a semi-neutral "mediator" for patient disposition.

On the more novel end of the spectrum, there is growth in more independent roles for APP hospitalists. Some groups are having success at using the paired rounding or dyad model but having the physician see the patient every third day. This is most successful where there is strong onboarding and deep clarity for when to contact the backup physician.³

Critical access hospitals are also having success in deploying APPs in a very independent role, staffing these hospitals at night. Smaller, rural hospitals with aging medical staff have learned to maximize the scope of practice of their APPs to remain viable and provide care for inpatients. The use of telemedicine has been implemented

to allow for remote physician backup.

Ongoing barriers

There are many barriers to maximizing the scope of practice and efficiency of APPs in hospital medicine. They range from the "macro" to the "micro."

On the larger stage, Medicare requires that home care orders be signed by an attending physician, which can be difficult to accomplish. Other payers may have somewhat arcane statutes that limit billing practices, and state practice limitations vary widely. Although 22 states now allow for independent practice for NPs, other states may have a very restrictive practice environment. A hospital's medical bylaws can also restrict the day-to-day practice of APPs, and those bylaws are emblematic of a more constant barrier to APP practice, that of medical staff culture.

If there are physicians on the staff who fear that utilization of NP/PA providers will lead to a decay in the quality of care, or who feel threatened by the use of APPs, that can create a local stopgap to maximizing utilization of APPs. In addition, hospitalist physicians and leaders may lack knowledge of APP practice. APPs take more time to successfully onboard than physicians; without clear expectations or road maps to accomplish this onboarding, leaders may feel that APP integration doesn't work.

Other barriers are the lack of standardized rigor in graduate education programs. This results in variation in the quality of NP/PA providers at graduation. Knowledge gaps may be perceived as incompetence, rather than just a lack of experience. There is a certificate for added qualification in hospital medicine for PA providers, and there is an acute care focus for NPs in training; however, there is no standardized licensure to ensure hospital medicine competency.

Another barrier for some programs is financial; physicians may not want to give up their RVUs to an NP/PA provider.

Summary and future

In summary, the role of PA/NP in hospital medicine has continued to grow and evolve, to meet the needs of the industry. This includes an increase in the scope and independence of APPs, including the use of telehealth for required oversight. As a specialty, it is imperative that we continue to research APP model effectiveness, embrace innovative delivery models, and support effective onboarding and career development opportunities for our NP/PA providers. **TH**

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