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NEW
PRESIDENT

The Hospitalist

VOLUME 21 No. 5 | MAY 2017

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Hospitalists prepare for MACRA, seek more changes

CMS issued final rules
in October, and some
changes were good
news for hospitalists.

By Kelly Tyrrell

"We heard you and will continue listening."
Those were the words that Andrew Slavitt,
then-acting administrator of the Centers for
Medicare & Medicaid Services, used in a
blog post on Oct. 14, 2016.¹ (Mr. Slavitt no
longer maintains that title since the new federal
administration took office on Jan. 20, 2017.)

Indeed, when it came to issuing its final
rules for the Medicare Access and CHIP
Reauthorization Act of 2015 (MACRA),
CMS appears to have considered the input
it received, including that from SHM and
other physician societies.²

And it seems they are still listening. Since
issuing the final rule, CMS has continued
to seek input from stakeholders. The SHM
and other groups are working to clarify and
pursue improvements to the bipartisan law.
Reporting under MACRA begins this year
and several changes that appeared in the final
rule already may make living with the law
less challenging for hospitalists.

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12 things pharmacists want hospitalists to know

From better communica-
tions to extra vigilance to
high-risk decisions, veteran
pharmacists outline areas
for improvement.

By Thomas R. Collins

It's hard to rank anything in hospi-
tal medicine much higher than
making sure patients receive the
medications they
need. When mistakes
happen, the care is
less than optimal,
and, in the worst cases,
there can be disastrous
consequences. Yet, the
pharmacy process —
involving interplay
between hospital-
ists and pharma-
cists — can some-
times be clunky and inefficient, even
in the age of electronic health records
(EHRs).

The Hospitalist surveyed a half-dozen
experts, who touched on the need for
extra vigilance, areas at high risk for
miscues, ways to refine communica-
tions and, ultimately, how to improve
the care of patients. The following are
tips and helpful hints for frontline
hospitalists caring for hospitalized
patients.

1 Avoid assumptions and shortcuts when reviewing a patient's home medication list.

"As the saying goes, 'garbage in,
garbage out.' This applies to complet-
ing a comprehensive medication
review for a patient at the time of

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Q&A

SHM MEMBER SPOTLIGHT

Nontraditional med
student hopes to bridge
common understanding
gaps in health care.

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HOSPITALIST MOVERS AND SHAKERS

An introduction to this year's high achievers in hospitalist medicine.

Andrew Auerbach, MD, MPH, SFHM, and **Vineet Arora, MD, MPP, MHM,** recently were elected to the new member



Dr. Auerbach



Dr. Arora

class of American Society for Clinical Investigation (ASCI) for 2017. Members must have "accomplished meritorious, original, creative, and independent investigations in the clinical or allied sciences of medicine and enjoy an unimpeachable moral standing in the medical profession."

Dr. Auerbach and Dr. Arora are just the third and fourth hospitalists to become ASCI members. Dr. Auerbach is the professor of medicine in residence and director of the research division of hospital medicine at the University of California, San Francisco. Dr. Arora is associate professor of medicine, assistant dean for scholarship and discovery, and director of graduate medical education's clinical learning environment innovation at the University of Chicago.

Mark V. Williams, MD, FACP, MHM, director of the University of Kentucky's Center for Health Services Research (CHSR), recently presented at the International Conference



Dr. Williams

of Hospital Medicine held in Taiwan.

Dr. Williams's presentation centered on the evolution of hospital medicine and the role hospitalists might play in the future.

Dr. Williams has been director of the CHSR since 2014, while simultaneously serving as chief of UK HealthCare's division of hospital medicine. He is the former president of the Society of Hospital Medicine.

Olevia M. Pitts, MD, SFHM, made history at Research Medical Center in Kansas City, becoming the first woman and the first person of color to be named the facility's chief medical officer.



Dr. Pitts

Dr. Pitts assumed her role at the 131-year-old RMC on Jan. 30.

Dr. Pitts previously served as Kansas City/Wichita region senior vice president for IPC Healthcare and medical director at Kindred Traditional Care Hospital. Prior to that, she was lead physician hospitalist with Midwest Hospitalist Specialists in Overland Park, Mo.

Greta Boynton, MD, SFHM, was promoted to the role of associate chief medical officer of Sound Physicians' northeast region. She was elevated from her position as regional medical director for Sound Physicians, a health care organization in 225 hospitals in 38 states.

Dr. Boynton will be charged with overseeing clinical operation of 13 programs, 120 providers, and a team of regional medical directors. She joined Sound Physicians in 2013 as chief hospitalist and divisional chief at Baystate Medical Center in Springfield, Mass.

BUSINESS MOVES

► **Sound Physicians**, Tacoma, Wash., added to its list of partners on March 1, when Eagle Hospital Medicine Practices, Atlanta, joined the Sound group's organization. Eagle's 150 providers in 16 hospitals across the United States raises Sound's resume to more than 2,500 providers.

Eagle will continue to run its own Locum Connections and Telemedicine divisions.

► **The Society of Hospital Medicine's Center for Quality Improvement** recently was recognized and honored by the Centers for Medicare & Medicaid Services for its patient-safety partnership with CMS. The two entities have maintained a relationship since August 2016.

SHM's Center for QI has participated in weekly CMS webinars to generate strategies intended to limit opioid use, including SHM's pilot RADEO – Reducing Adverse Drug Events Related to Opioids – program. In January 2017, CMS contacted SHM to provide best practices for patients receiving opioids and better use data to monitor those patients.

► **University of Iowa Health Care**, Iowa City, and **Van Buren County Hospital**, Keosauqua, Iowa, have created a partnership, allowing patients at VBCH access to UI hospitalists through a telemedicine connection. The relationship will allow VBCH patients to remain at their local hospital – located 90 minutes from Iowa City – while getting care and treatment advice from UI hospitalists through video-conferencing and a shared electronic health record.

With their VBCH provider bedside, patients meet face-to-virtual face with the UI hospitalist during twice-daily virtual rounding.

The Hospitalist

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Hospitalists are leaders in designing inpatient experience

By Diane Sliwka, MD, Patrick Kneeland, MD, Rob Hoffman, MD

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 affect patients' experience of care. This column highlights key takeaways from the SHM track of the upcoming 2017 Cleveland Clinic Patient Experience Empathy and Innovation Summit, May 22-24. Three hospitalist leaders describe their approach to leading the design of the inpatient experience.

What we say and do, and why

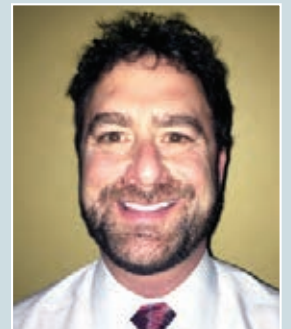
Like many forms of care improvement, we have found that health care providers and patients alike engage most proactively when they are directly involved in codesigning an approach or intervention for improving the experience of care. Here are some examples of how hospitalists can be effective leaders in cocreating the inpatient experience with patients and interdisciplinary colleagues.

Dr. Sliwka: Design principles and systems improvement. Inspiring and sustaining effective improvement in patient experience and the work experience of the care team warrants rethinking of how we design our leadership, goals, and engage-

ment of the people doing the work. Deliberate application of several principles has transformed improvement from being "another thing we have to do" to "the effective and engaging way we do things." Effective improvement design has included visibility walls, streamlined goals and targets, access to real-time data, dyad leadership, huddles, and executive leader rounding. Through these methods, we nurture a culture of support for – and problem solving by – the people doing the work.

Dr. Kneeland: User-centered design retreats. We have implemented experience cocreation through user-centered design workshops that bring together patient voices, nurses, physicians, case managers, social workers, and pharmacists from a specific inpatient unit. Over half- or full-day sessions, the interdisciplinary team follows a facilitated "design thinking" approach to brainstorm, prototype, and refine new ideas. The outputs are brought back to the unit for implementation and ongoing refinement. Not only do innovative ideas emerge for enhancing the experience of care for both patients and providers, but there is also a measurable impact on unit culture and interdisciplinary collaboration.

Dr. Hoffman: Partnering with patient and family advisers. Working in close partnership with patient and family advisers (PFAs), we redesigned and implemented interdisciplinary bedside rounding in a way that puts the patient and family at the center of the care team. A multidisciplinary group including physicians, advanced practice practitioners, case managers, pharmacists, and PFAs created daily "care team visits" that bring, at a minimum, the nurse, provider, and case manager to the bedside daily. Key concepts we learned from our PFAs include having the nurse initiate the visit, minimizing the number of participants, giving clear introductions



Dr. Sliwka is medical director of patient and provider experience at University of California, San Francisco, Health; Dr. Kneeland is medical director for patient and provider experience at University of Colorado, Aurora, Hospital; Dr. Hoffman is medical director for patient relations at University of Wisconsin-Madison, Health.

every time, and focusing explicitly on what is most important to the patient that day. Our PFAs also actively participated in our training sessions for nurses and providers. Their stories and feedback at these trainings motivated attendees and helped everyone understand "why" we bring our conversations to the bedside. We have seen significant improvements in provider and nurse satisfaction with collaboration and unit level decision making and trends toward improved patient satisfaction with communication and teamwork. **TH**

Hospitalist specialty code goes live: What 'C6' means for you

By Dea Robinson, FACMPE

The long wait for the introduction of the C6 hospitalist specialty code has ended. If you are a provider, hospital, or hospitalist administrator, this new specialty designation is important.

The Centers for Medicare & Medicaid Services tracks specialty utilization and compares providers across the country using codes attached to medical specialties, such as cardiology, emergency medicine, pediatrics, etc. Until the CMS designated hospital medicine as a unique specialty, hospitalists were grouped together with office-based internal medicine physicians and general practitioners. This lack of recognition of the hospitalist specialty created two issues.

The first is one of location. Hospitalists practice in hospitals and utilize codes that are hospital based, not office based. Yet hospitalists have been benchmarked against their primary care peers' utilization for many years.



This major milestone for hospital medicine demonstrates the continued growth and impact of the specialty.

—Dea Robinson, FACMPE

At this point in time, most if not all primary care physicians practice exclusively in the office, so comparison of CPT utilization looks unusual when benchmarked nationally. What appeared as a "spike" was actually normal utilization for a hospitalist; however, this coding anomaly can lead to pre- or postpayment audits.

The second issue is being able to benchmark utilization against one's peers. For the first time, hospitalist utilization will be considered unique, facilitating more accurate comparisons and fairer assessments of hospitalist performance.

Hospitalists can use the C6 specialty code

during initial enrollment or as an update, depending on the individual situation. Note that this is a designation for the individual, not the practice, organization, or billing company. The C6 specialty code was recognized as of April 1, 2017, on submitted claims. You may now change your designation and should avoid any disruption or denial of claims.

There are two places to designate the C6 specialty codes, depending on whether the provider is new to Medicare enrollment or is an existing provider:

► **Paper:** Initial enrollment in the Medicare program on form CMS-855I or CMS 8550 (<https://www.cms.gov/Medicare/>

CMS-Forms/CMS-Forms/CMS-Forms-List.html).

► **Electronically:** Utilizing the PECOS system, provider credentialing offices can update existing specialty codes to C6 (<https://pecos.cms.hhs.gov/PECOSWeb-Maintenance.htm>).

This major milestone for hospital medicine demonstrates the continued growth and impact of the specialty. Ensure your self-election in the PECOS system reflects "C6," your specialty as a hospitalist and your commitment to the hospital medicine movement.

For more information, visit www.hospitalmedicine.org/C6. **TH**

Dea Robinson is a member of SHM's Practice Management Committee, Cultural Competency Workgroup, and Physician Burnout Workgroup.

Reference

MLN Matters Number: MM9716 (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9716.pdf>)



Nontraditional med student hopes to bridge common understanding gaps in health care

SHM annual meeting inspires Ryan Gamlin with forward-looking programming.

By Felicia Steele

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

This month, *The Hospitalist* spotlights Ryan Gamlin, MD, a nontraditional student at the University of Cincinnati College of Medicine. Ryan was chosen to present his scientific abstract at SHM's annual meeting in 2016, and encourages medical students to utilize SHM's resources.

Question: Tell TH about your unique pathway to medical school. How did you become an SHM member?

After 10 years working for and consulting large health insurance companies, I was increasingly disillusioned with my work and the insurance industry and began feeling restless. When I considered possible avenues to help improve health and the health care delivery system, nothing held more intellectual or professional appeal than working on problems from the inside as a physician.

Many issues in our health care delivery and financing systems stem from lack of common understanding; physicians rarely speak the same language as administrators, who in turn do not speak the language of policy makers, etc. It's my goal to serve as something of an ideas translator for these disparate groups within U.S. health care – physicians, administrators, and

policy makers – helping them to make real progress, together, on the biggest challenges facing our health care system.

This effort to bridge these constituencies was my introduction to SHM. I was fortunate enough to be selected for the Health Innovations Scholars Program (HISP), an incredible quality improvement (QI) and leadership development program run by the hospital medicine group at University of Colorado. Conceived by Jeff Glasheen, MD, and now led by Read Pierce, MD, and Emily Gottenborg, MD, among many others, HISP brings eight medical students together to grow their QI toolkit and build leadership skills while providing the opportunity to design and run a meaningful QI project at the University of Colorado's Anschutz medical campus. Many involved with this program – and others within the hospital medicine group at the University of Colorado – are leaders within SHM. With their encouragement, I submitted an abstract based on our HISP project and had the good fortune to share our work as a podium presentation at Hospital Medicine 2016 in San Diego.

Q: Describe your experience at your first annual meeting. Why would you encourage medical students to attend?

Hospital Medicine 2016 inspired me. As someone interested in the intersection of clinical care and the care system itself, I was amazed at the depth and breadth of forward-looking programming and the amount of similarly-inclined people!

I wish that every medical student – irrespective of their intended specialty – could attend an SHM meeting to witness firsthand how a progressive, thriving professional soci-



After 10 years working for and consulting large health insurance companies, I was increasingly disillusioned with my work and the insurance industry and began feeling restless.

—Ryan Gamlin, MD

ety integrates members at all levels (student, resident, early-career faculty, and beyond) into their work of improving health care.

Q: As a medical student, why is SHM beneficial to your professional growth as a future physician?

I see SHM as a “big tent” professional society that values insights and expertise from all types of physicians, with tangible commitments to support them in the types of system-improving work that are important to me in my career. SHM's member resources and commitment to students' and residents' professional development are incomparable.

Q: What are the biggest opportunities you see for yourself and other future physicians in the changing health care landscape?

The days when a physician's job was limited to doctoring are over. Our generation of physicians must be great clinicians and work to heal a sick health care system. Now more than ever, physicians must be systems

thinkers, designers, and fixers, equipped with the tools of quality improvement, design thinking, finance, and health policy.

Opportunities for meaningful improvement exist at every level, from care teams to health systems, the health care industry, and policy at every level. I would encourage those at any stage of their careers to find an area that they're excited about or interested in. Seek out information and mentors in that area at their institutions or within SHM, and just start working on something.

There is a tremendous amount of uncertainty in health care; reimbursement paradigms are changing, clinical expectations only grow, and the forces competing for every doctor's limited time seem unlimited. Uncertainty is uncomfortable, but it also means opportunity. I'm excited to see the commitment to leadership from SHM and so many of its members. It has never been more necessary. **TH**

Felicia Steele is SHM's communications coordinator.

NEWS & NOTES

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

By Brett Radler

SHM gives QI a new look

► SHM is proud to announce that its Center for Hospital Innovation & Improvement has a fresh look and name: SHM's Center for Quality Improvement. While the name may have changed, SHM's Center for QI will remain your partner in quality and patient safety.

“SHM's Center for QI provides a comprehensive set of resources and

programs to support hospitalists and other hospital clinicians as they work to improve quality and safety in their hospitals,” says Eric E. Howell, MD, MHM, senior physician adviser for SHM's Center for QI.

SHM's Center for QI's mentored implementation programs are deployed in hundreds of hospitals and have been recognized with the John M. Eisenberg Award. More recently, its opioid-safety program (RADEO) was recognized by the Centers for Medicare & Medicaid Services for its efforts to enhance patient safety.

Visit <http://www.hospitalmedicine.org/QI> to learn more about SHM's Center for QI and about opportunities for partnerships, solutions, and tools to address your QI needs.



PHM 2017 is coming! Book your ticket to Nashville today

► Pediatric Hospital Medicine (PHM) 2017 is the largest, leading educational event for health care professionals who specialize in the care of hospitalized children. This year's meeting will be held July 20-23 at the Omni Nashville in Tennessee. Attendees will have the opportunity to

network with colleagues from across the nation, learn from renowned faculty from throughout the discipline, and acquire skills, tools, and resources to directly benefit their patients and practice.

PHM 2017 has been designed to provide participants with tools to improve clinical skills and practice, address management issues, lead change and innovation within their institutions, and network with thought leaders to collaborate and learn about new innovations.

View the full meeting schedule, educational objectives, and more at www.peds2017.org. **TH**

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

Survey insights: Unwrapping the compensation package

When approached for advice regarding the evaluation of job offers after completion of training, specific day-to-day duties (shift length, teaching time, ICU coverage, and so on), and the overall gestalt of the interview experience, I find that location, lifestyle, and pay are the most consistent and common themes.

People often assume that pay is relatively straightforward, since it can be summarized in a number in the offer, whereas the other factors are harder to evaluate. However, it turns out pay is more complex. As a result, the last several State of Hospital Medicine reports have sought to evaluate compensation packages more thoroughly.



Dr. Anoff

In the 2014 report – derived from a 2014 survey and Medical Group Management Association results obtained through questionnaires focusing on provider compensation, production, and retirement benefits – SHM broke down compensation into base pay, production, and performance, which was further broken down into specific performance

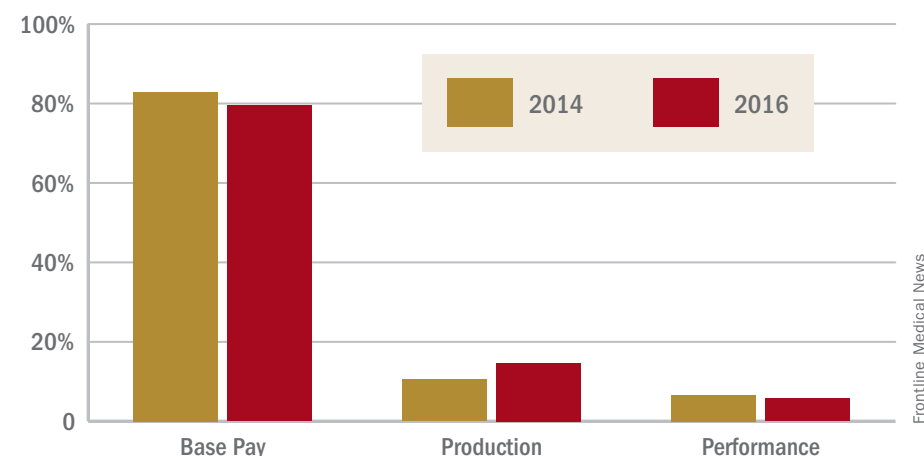
incentive measures. The SHM survey also looked at the overall annual value of benefits per full-time physician hospitalist, including retirement, federal and state payroll taxes, and employer contributions for health, life, disability, and other insurances (excluding malpractice). Finally, the survey looked at paid time off.

In 2016, the survey started including pay increases by years of experience, as well as CME dollars allotted per year per hospitalist. The goal was to gain deeper insight into the entire financial package, which is tied to a particular hospitalist job.

As far as the 2014 and 2016 SHM survey results, there are several interesting findings. Base pay makes up the majority of earnings for all types of hospitalists. In academic hospitalist groups, more of the total package of compensation comes from base pay, compared with nonacademic groups, where production and performance pay play a bigger role.

Of interest, despite the increased national attention on quality of care, productivity-based pay increased again (10.5%-14.7%), while performance-based pay (usually tied to quality and safety metrics) decreased (6.6%-5.7%) among groups serving adults. Consistent with prior trends for adults-

Breakdown of compensation among groups serving adults



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

only hospitalists, the Southern region of the country had the highest percentage of pay derived from productivity (18.8%), as well as of overall compensation in the 2016 report.

For hospitalists serving both adults and children, there was a smaller increase in pay derived from production (12.4%-13.2%), while pay derived from performance dropped more dramatically (8.9%-3.9%).

For hospitalists serving only children, the opposite occurred: Pay derived from production fell from 10.7% to 2.8%. While it is not yet clear why compensation, overall, is moving into closer alignment with productivity, rather than performance on quality and safety metrics, one hypothesis is that work relative value units used for calculating productivity are easier to tie to

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Filling the gap: Hospitalists & palliative care

There is now an important opportunity for hospitalists to lead prognosis and goals of care communication for their patients.

By Wendy G. Anderson, MD, MS

Most Americans diagnosed with serious illness will be hospitalized in their last months. During these hospitalizations, hospitalists direct their care.

For seriously ill patients, consultation with palliative care specialists has been shown to promote patient- and family-centered care, ensuring that care is consistent with patients' goals, values, and preferences. Yet, many hospitalized patients lack access to palliative care consultation, and specialists have identified key domains of primary palliative care that can be delivered by nonspecialists.

There is now an important opportunity for hospitalists to lead prognosis and goals of care communication for their patients. To succeed in this role, hospitalists need training and structural support that may not yet be available to them.

To fill this gap, SHM's Center for Quality Improvement partnered with The Hastings Center, a world-renowned bioethics research institution, to develop a resource room focused on hospitalists' role in providing high-quality communication about prognosis and goals of care. The resource room presents a Prognosis and Goals of Care Communication Pathway, which highlights key processes and maps them onto the daily workflows of hospitalist physicians.

The care pathway is grounded in palliative care communication research and the consensus guidance of *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life*. It was informed by a national stakeholder meeting of hospitalists, other hospital clinicians, patient and family advocates, bioethicists, social scientists, and other experts, who identified professional values of hospital medicine aligned with communication as part of good care for seriously ill patients.



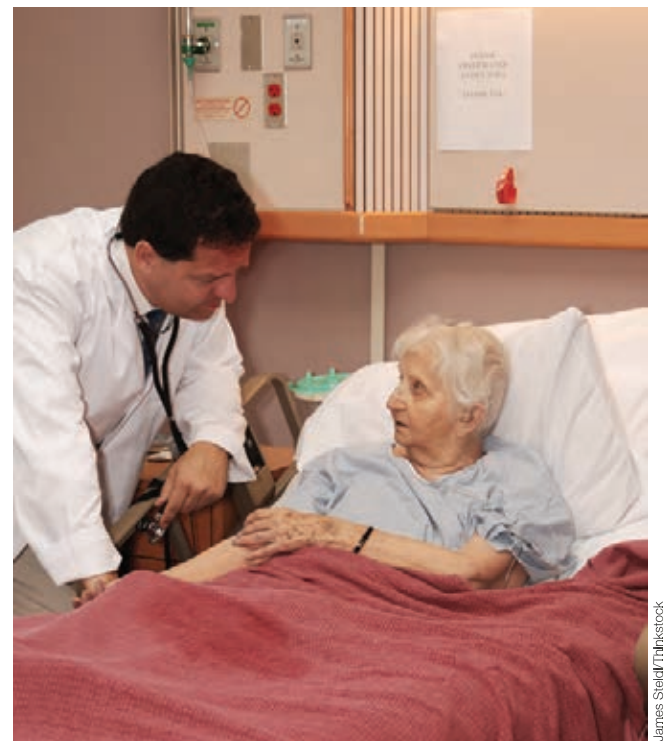
The care pathway ... was informed by a national stakeholder meeting of hospitalists, other hospital clinicians, patient and family advocates, bioethicists, social scientists, and other experts.

—Wendy G. Anderson, MD, MS

A collaborative interdisciplinary work group convened by SHM and including hospitalists, palliative medicine physicians, a bioethicist, and a palliative nursing specialist constructed the care pathway in terms of key processes occurring at admission, during hospitalization, and in discharge planning to support primary palliative care integration into normal workflow. The resource room also includes skills-building tools and resources for individual hospitals, teams, and institutions.

The work group will present a workshop on the care pathway at Hospital Medicine 2017: "Demystifying Difficult Decisions: Strategies and Skills to Equip Hospitalists for High-Quality Goals of Care Conversations with Seriously Ill Patients and Their Families." For more information on the resource room, visit www.hospitalmedicine.org/EOL. **TH**

Dr. Anderson is associate professor in residence in the division of hospital medicine at the University of California, San Francisco. She also serves as attending physician in the Palliative Care Program and codirector of the School of Nursing Interprofessional Palliative Care Training Program at UCSF.



James Steidl/Thinkstock

CONTINUED FROM PREVIOUS PAGE

an individual hospitalist than are quality and safety outcomes.

Looking specifically at items included amongst the performance metrics shows that there is a clear trend toward more emphasis on patient experience, which fits with the implementation of the Value-Based Purchasing Program and Episode Payment Models. Other common performance metrics include readmission rates, measures related to patient flow, and mortality rates. Measures of citizenship, examples of which may be participation in hospital committees and leadership of inpatient quality initiatives, remain common for many groups. Overall, core measures are receiving less focus, a trend that fits with the decrease in mandatory core measure reporting. Finally, there is a rapidly decreasing emphasis on performance measures related to utilization of

electronic health records.

Employee benefits, as previously defined, increased among hospitalists caring for adults only and those caring for adults and children, with a mean increase in both groups of \$5,000. The most generous benefits were typically seen at university-based academic medical centers. Amongst adult-only hospitalists, academic groups offer benefits worth \$8,000-\$9,000 more per year than in nonacademic groups. Lower benefits were common among practices in the Eastern region and in groups with four or fewer full-time hospitalists. The 2016 survey data on CME dollars revealed a median of \$3,000-\$4,000 per year, with higher amounts provided in nonacademic groups.

Paid time off (PTO) from work is an ongoing topic of interest on venues such as HMX forum, and, in the surveys, PTO remained fairly consistent among groups caring for adults only and those caring for

adults and children, with only 30%-40% of groups offering PTO. The number of PTO hours offered vary substantially, however, ranging from a mean of 126 hours up to 216.4 hours annually. Future analysis of PTO will benefit from a deeper understanding of how many hours equate to a shift.

Finally, the 2016 survey asked about automatic pay increases based strictly on overall experience or length of employment with the group. Roughly one-fifth to one-third of groups provided some sort of salary increase based on experience in 2015. This practice was more common in the Southern region and in nonteaching hospitals. These data raise the complex topic of seniority among hospitalists and how to define it. If seniority is not recognized in pay, how commonly are groups recognizing it in other ways, such as in preferences related to time on certain services, shift type, or vacation requests?

The expanded survey on hospitalist pay, in addition to the biannual comparison of prior data, will likely continue to add value in assessing and exploring the entire package of compensation. Additional topics of interest moving forward might include better understanding of parental leave, sick time, and the comparison between compensation packages for physician hospitalists and those for inpatient Nurse Practitioners and Physician Assistants. **TH**

Dr. Anoff is associate professor of clinical practice, division of hospital medicine, department of medicine, University of Colorado at Denver.

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QI enthusiast to QI leader

Bridging a love for teaching and for driving improvement.

By Claudia Stahl

Editor's Note: This new series highlights the professional pathways of quality improvement leaders. This month features the story of Jennifer Myers, director of quality and safety education at the University of Pennsylvania, Philadelphia.

Even as a junior physician, Jennifer Myers, MD, FHM, embraced the complexities of the hospital system and the opportunity to transform patient care. She was one of the first hospitalists to participate in and lead quality improvement (QI) work at the University of Pennsylvania Medical Center more than 10 years ago, where, “in that role, I got to know almost everyone in the hospital and got an up-close view of how the hospital works administratively,” she recalled.

The experience taught Dr. Myers how little she knew at that time about hospital operations, and she convinced hospital administrators that a mechanism was needed to prepare the next generation of leaders in QI and patient safety. In 2011,

with the support of a career development award from the Josiah Macy Jr. Foundation, Dr. Myers formulated a quality and patient safety curriculum for residents of Penn Medicine, as well as a more basic introductory program for medical students.

Today, Dr. Myers serves as director of quality and safety education in the Department of Medicine at the University of Pennsylvania, Philadelphia, and director of Penn's Center for Health Care Improvement in Patient Safety. These roles unite her interest in shaping the career development of faculty and fellows, and system science.

“You will always do your best in work that you are passionate about,” she said, advising others to do the same when choosing their career pathways. “Find others who are interested in – or frustrated by – the same things that you are, and work with them as you begin to shape your projects. If it's the opioid epidemic, partner with someone in the hospital with an interest in making informed prescribing decisions. If it's working with residents in quality, find a chief

resident to help you develop an educational pathway or elective.”

Dr. Myers says that hospitalists who function at the intersection of the ICU, the ER, and inpatient care are naturally suited for leadership positions in quality and patient safety, “but, if you are a hospitalist aspiring to be a chief quality or medical officer or (someone) who wants to know the field more deeply, I recommend getting advanced training.”

Hospitalists now have multiple educational opportunities in QI to choose from, but that was not the case 7 years ago when SHM leaders invited Dr. Myers to develop and lead the Quality and Safety Educators Academy (QSEA). The 2.5-day program trains medical educators to develop curricula that incorporate quality improvement and safety principles into their local institutions. “We give them the core quality and safety



Dr. Myers

knowledge but also the skills to develop and assess curricula,” Dr. Myers said. “The program also focuses on professional development and community building.”

While education is important, Dr. Myers says that a willingness to take risks is a greater predictor of success in QI. “It's a very experiential field where you learn by doing. What you have done, and are willing to do, is more important than the training that you've had. Can you lead an initiative? Do you communicate well with people and teams? Can you articulate the value equation?”

She also advises hospitalists to find multiple mentors in quality work. “We talk a lot about that at QSEA,” Dr. Myers said. “It's important to have the perspectives of people inside and outside of your institution. That's also where the SHM network is helpful. Mentorship is a pillar of [many activities] at the annual meeting ... and [at] programs like the Academic Hospitalist Academy and QSEA.” **TH**

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

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SHM receives Eisenberg Award as part of I-PASS Study Group

Award recognized contributions to improving patient safety

By Brett Radler

The Society of Hospital Medicine is part of a patient safety research group that received the prestigious 2016 John M. Eisenberg Award for Innovation in Patient Safety and Quality presented annually by The Joint Commission and the National Quality Forum, two leading organizations that set standards in patient care as part of the I-PASS Study Group.

I-PASS comprises a suite of educational materials and interventions dedicated to improving patient safety by reducing miscommunication during patient handoffs that can lead to harmful medical errors. The team in SHM's Center for Quality Improve-

ment has been instrumental in supporting the I-PASS Study Group, which represents more than 50 hospitals from across North America.

"The Eisenberg Award for Innovation represents the highest patient safety and quality award in the country, and we are honored to be recognized for our role in this important program," said Jenna Goldstein, director of SHM's Center for Quality Improvement. "Our team's participation in developing and sustaining the SHM I-PASS mentored implementation demonstrates our commitment to ensure safe and high-quality care for hospitalized patients."

SHM previously won the 2011 Eisen-

berg Award at the national level for its mentored implementation program model. Through its mentored implementation framework and project management, SHM has supported the I-PASS program across the country at 32 hospitals of varying types, including pediatric and adult hospitals, academic medical centers, and community-based hospitals. SHM has offered both an I-PASS mentored implementation program, in which a physician mentor coaches hospital team members on evidence-based best practices in process improvement and culture change for safe patient handoffs, and an implementation guide, which contains strategies and tools needed to lead the quality improvement

effort in the hospital.

In a large multicenter study published in the *New England Journal of Medicine*, implementation of I-PASS was associated with a 30% reduction in medical errors that harm patients. An estimated 80% of the most serious medical errors can be linked to communication failures, particularly during patient handoffs.

In addition to its work with I-PASS, SHM's Center for Quality Improvement plays a prominent role in developing tools that empower clinicians to lead quality improvement efforts in their institutions. **TH**

Brett Radler is SHM's communications specialist.

NEWS & NOTES

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

By Brett Radler

Benchmark your HMG appropriately with the State of Hospital Medicine Report

► The *State of Hospital Medicine Report* continues to be the best source of detail regarding the configuration and operation of hospital medicine groups. The biennial report provides current data on hospitalist compensation and production, in addition to cutting-edge knowledge covering practice demographics, staffing levels, turnover, staff growth, compensation methods, and financial support for solid, evidence-based management decisions.

"We've used data from the report to hold more informed discussions with the group that provides our note-coding services and to determine how to benchmark our nocturnists' workloads and pay," said Andrew White, MD, SFHM, director of the Hospital Medicine Service at the University of Washington in Seattle. "The results are broken into region and academic practice type, which gives me the confidence that I'm looking at results from groups like mine, rather than comparing to the country-wide average."

The report is designed for hospital medicine leaders (both physician leaders and nonphysician practice administrators and executives), as well as frontline hospitalists, nurse practitioners, physician assistants, pediatricians, and internal and family medicine physicians.

In addition to the print version, the 2016 *State of Hospital Medicine Report* is also available in an enhanced, fully searchable digital version. To order your copy in either print or digital, visit www.hospitalmedicine.org/survey.

Learn how to drive change as a leader in hospital medicine

► A successful hospitalist program requires strong leadership from the floor to the C-suite. SHM's Leadership Academy prepares clinical and academic leaders with vital skills that, traditionally, are not taught in medical school or typical residency programs. This year's meeting will be held Oct. 23-26 at the JW Marriott Camelback Inn in Scottsdale, Ariz.



New for Leadership Academy 2017, Strategic Essentials (formerly Leadership Foundations), Influential Management, and Mastering Teamwork will be available to all attendees, regardless of previous attendance. SHM provides recommendations for interested registrants so they can determine which course fits them best in their leadership journey.

Take the **Strategic Essentials** course to evaluate your personal leadership strengths and weaknesses, understand key hospital drivers, and more.

If you are looking to learn skills needed to drive culture change through specific leadership behaviors as well as financial storytelling, then **Leadership: Influential Management** would be a great course for you.

The third course, **Leadership: Mastering Teamwork**, will help attendees learn to critically assess program growth opportunities, lead and motivate teams, and design effective communication strategies. Learn more at www.shmleadershipacademy.org.

Stay ahead of the MACRA curve with SHM

► The Medicare Access and CHIP Reauthorization Act (MACRA) put into motion the new Quality Payment Program, which replaces past pay-for-performance programs, such as the Physician Quality Reporting System and physician value-based modifier. The new program has many complicated requirements, and hospitalists will be impacted.

The first year of the program has flexible participation, yet hospitalists need to do at least one thing (report one quality measure, attest to one improvement activity) in the program in order to avoid a 4% penalty to Medicare payments. 2017 is the first reporting year, so now is the time for providers to familiarize themselves with the requirements.

To support hospitalists who are looking for hospital medicine-specific ways to participate and avoid penalties, SHM hosted a webinar that is now available at www.macroforhm.org under "Resources." SHM's policy staff broke down the program requirements and went into detail on ways in which hospitalists can and should participate in the new program. Updates and other resources are also available at www.macroforhm.org.

Looking to be a speaker at Hospital Medicine 2018?

► The Society of Hospital Medicine reminds you to submit your workshop proposal for the 2018 Annual Meeting to be held April 8-11, 2018, at the Orlando World Center Marriott. Workshops should involve topics in 1 of 10 categories: clinical, career development, research, academic, patient experience/communication, perioperative, information technology, practice management, quality and patient safety, and evidence-based medicine/high-value care. Each workshop should last 90 minutes.

Proposals that are the most likely to be accepted will be innovative as well as highly interactive, utilizing small groups and limiting didactic/lecture content. Workshops previously presented at national or regional meetings will be considered. Four faculty members from each workshop that is accepted will receive 50% off their annual meeting registration, although workshops may include a maximum of six additional facilitators.

The submission deadline is Friday, May 12, 2017 at 8:00 a.m. EST. Visit www.hospitalmedicine2018.org for more information. **TH**

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



12 things pharmacists want hospitalists to know

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admission to the hospital, to ensure the patient is started on the right medications,” said Lisa Kroon, PharmD, chair of the department of clinical pharmacy at the University of California, San Francisco.

Even though EHRs are becoming more connected, they don’t provide all the details. Just because a medication is on the medication list doesn’t mean patients are actually taking it. They also might be taking it differently than prescribed, Dr. Kroon said. Patients and caregivers should be asked what medications they’re actually taking, as well as the strength of the tablet, how many at a time and how often, and at what time of the day they are taking them.

The EHR “is often more of a record of which medications have been ordered by a provider at some point,” she notes.

Doug Humber, PharmD, clinical professor of pharmacy at the University of California, San Diego, said hospitalists should be sure to ask patients about over-the-counter drugs, herbals, and nutraceuticals.

“Some of those medications may interact with prescribed medication in the hospital,” he said. “The most complete data that we have on a patient’s medication list coming in clearly sets [us] up for success, in terms of making medication therapy safer for the patients while they’re here.”

Dr. Kroon encourages hospitalists to conduct a complete medication review, which helps determine what should be continued at discharge.

“Sometimes, not all medications a patient was taking at home need to be restarted, such as vitamins or supplements, so avoid just entering, ‘Restart all home meds,’” she said.

2 Pay close attention to adjustments based on liver and kidney function.

“A hospitalist may take a more hands-off approach and just make the assumption that their medications are dose adjusted

appropriately, and I think that might be a bad assumption. [Don’t assume] that things are just automatically going to be adjusted,” Dr. Humber said.

Mohamed Jalloh, PharmD, a pharmacist and a spokesman for the American Pharmacists Association, concurs. He said that most mistakes are related to “kidney [or] liver adjustments.”

That said, hospitalists also need to be cognizant of adjustments for reasons that aren’t kidney or liver related.

“It is well known that patients with renal and hepatic disease often require dosage adjustments for optimal therapeutic response, but patients with other characteristics and conditions also may require dosage adjustments due to variations in pharmacokinetics and pharmacodynamics,” said Erika Thomas, MBA, RPh, a pharmacist and director of the Inpatient Care Practitioners section of the American Society of Health-System Pharmacists. “Patients who are obese, elderly, neonatal, pediatric, and those with other comorbidities also may require dosage adjustment.”

Drug-drug interactions might call for unique dosage adjustments, too, she adds.

3 Carefully choose drug-information sources.

Dr. Jalloh said that one of the roots of inappropriate dosing is simply “a lack of time and money to look at credible resources.” Free drug-information apps might not have the extensive information needed to make all the right decisions, such as adjustments for organ function, he said. More comprehensive apps are expensive, he admits, and sometimes even those apps contain gaps.

“Hospitalists can contact drug-information centers that answer complex clinical questions about drugs if they do not have the time to explore themselves,” he said.

Creighton University, Omaha, Neb., for



“As the saying goes, ‘garbage in, garbage out.’ This applies to completing a comprehensive medication review for a patient at the time of admission to the hospital, to ensure the patient is started on the right medications.”

—Lisa Kroon, PharmD

example, has such a center that has been nationally recognized.

Carefully review patients’ medications when they transfer from different levels of care.

Certain medications are started in the ICU that may not need to be continued on the non-ICU floor or at discharge, said MacKenzie Clark, PharmD, program pharmacist at the University of San Francisco. One example is quetiapine, which is used in the ICU for delirium.

“Unfortunately, we are seeing patients erroneously continued on this [medication]

on the floor. Some are even discharged on this [med],” Clark said, adding that a specific order set can be developed that has a 72-hour automatic stop date for all orders for quetiapine when used specifically for delirium.

“[The order set] can help reduce the chance that it be continued unnecessarily when a patient transfers out of the ICU,” she explains.

Another class of medication that is often initiated in the ICU is proton-pump inhibitors for stress ulcer prophylaxis. Continuing these on the floor or at discharge, Clark said, should be carefully considered to avoid unnecessary use and potential adverse effects.

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—Doug Humber, PharmD

“It is well known that patients with renal and hepatic disease often require dosage adjustments for optimal therapeutic response, but patients with other characteristics and conditions also may require dosage adjustments due to variations in pharmacokinetics and pharmacodynamics.”

—Erika Thomas, MBA, RPh

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5 Seek opportunities to change from intravenous to oral medications – it could mean big savings.

Intravenous medications usually are more expensive than oral formulations. They also increase the risk of infection. Those are two good reasons to switch patients from IV to oral (PO) as early as possible.

“We find that physicians often don’t know how much drugs cost,” said Marilyn Stebbins, PharmD, vice chair of clinical innovation at University of California, San Francisco.

A common example, she said, is IV acetaminophen, the cost of which skyrocketed in 2014. Institutions can save significant dollars by limiting use of IV acetaminophen outside the perioperative area to patients unable to tolerate oral medications. For patients who are candidates for IV acetaminophen, consider setting an automatic expiration of the order at 24 hours.

Hospitalists can help reduce the drug budget by supporting IV-to-PO programs, in which pharmacists can automatically change an IV medication to PO formulation after verifying a patient is able to tolerate orals.

6 Consider a patient’s health insurance coverage when prescribing a drug at discharge.

“Don’t start the fancy drug that the patient can’t continue at home,” said Ian Jenkins, MD, SFHM, a hospitalist and health sciences clinical professor at the University of California, San Diego, and member of the UCSD pharmacy and therapeutics committee. “New anticoagulants are a great example. We run outpatient claims against their insurance before starting anything, as a policy to avoid this.”

7 Tell the pharmacist what you’re thinking.

Dr. Jenkins uses a case of sepsis as an example:

“If you make it clear that’s what’s happening, you can get a stat loading-dose infused and meet [The Joint Commission] goals for management and improve care, rather than

just routine antibiotic starts,” he said.

Another example is anticoagulants:

“Why are you starting the anticoagulant? Recommendations could differ if it’s for acute PE [pulmonary embolism] versus just bridging, which pharmacists these days might catch as overtreatment,” he said. “Keep [the pharmacy] posted about upcoming changes, so they can do discharge planning and anticipate things like glucose management changes with steroid dose fluctuations.”

8 Beware chronic medications that are not on the hospital formulary.

Your hospital likely has a formulary for chronic medications, such as ACE inhibitors, angiotensin receptor blockers, and statins, which might be different than what the patient was taking at home. So, changes might need to be made, Dr. Clark said.

“Pharmacists can assist in this,” she said. “Often, a ‘therapeutic interchange program’ can be established whereby a pharmacist can automatically change the medication to a therapeutically equivalent one and ensure the appropriate dose conversion.”

At discharge, the reverse process is required.

“Be sure you are not discharging the patient on the hospital formulary drug [e.g., ramipril] when they already have lisinopril in their medicine cabinet at home,” Dr. Clark said. “This can lead to confusion by the patient about which medication to take and result in unintended duplicate drug therapy or worse. A patient may not take either medication because they aren’t sure just what to take.”

9 Don’t hesitate to rely on pharmacists’ expertise.

“To ensure that patients enter and leave the hospital on the right medications and [that they are] taken at the right dose and time, do not forget to enlist your pharmacists to provide support during care transitions,” Dr. Stebbins said.

Dr. Humber said pharmacists are “uniquely qualified” to be medication experts in a facility, and that “kind of experience and that type of expertise to the care



of the hospitalized patient is paramount.”

Dr. Thomas said that pharmacists can save hospitalists time.

“Check with your pharmacist on available decision-support tools, available infusion devices, institutional medication-related protocols, and medications within a drug class.”

Additionally, encourage pharmacists to join you for rounds, if they’re not already doing so. Dr. Humber also said hospitalists should consider more one-on-one communications, noting that it’s always better to chat “face to face than it is over the phone or with a text message. Things can certainly get misinterpreted.”

10 Consider asking a pharmacist for advice on how to administer complicated regimens.

“Drugs can be administered in a variety of ways, including nasogastric, sublingual, oral, rectal, IV infusion, epidural, intra-arterial, topical, extracorporeal, and intrathecal,” Dr. Thomas said. “Not all drug formulations can be administered by all routes for a variety of reasons. Pharmacists can assist in determining the safest and most effective route of administration for drug formulations.”

11 Not all patients need broad-spectrum antibiotics for a prolonged period of time.

According to the Centers for Disease Control and Prevention, 20%-50% of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or inappropriate, Dr. Kroon said.

“Specifying the dose, duration, and indication for all courses of antibiotics helps

promote the appropriate use of antibiotics,” she noted.

Pharmacists play a large role in antibiotic dosing based on therapeutic levels, such as with vancomycin or on organ function, as with renal dose adjustments; and in identifying drug-drug interactions that occur frequently with antibiotics, such as with the separation of quinolones from many supplements.

12 For orders of medication, a complete and legible signature is required.

With new computerized physician order entry ordering, it seems intuitive that what a physician orders is what they want, Dr. Kroon said. But, if medication orders are not completely clear, errors can arise at steps in the medication-management process, such as when a pharmacist verifies and approves the medication order or at medication administration by a nurse. To avoid errors, she suggests that every medication order have the drug name, dose, route, and frequency. She also suggested that all “PRN” – as needed – orders need an indication and additional specificity if there are multiple medications.

For pain medications, an example might be: “Tylenol 1,000 mg PO q8h prn mild pain; Norco 5-325mg, 1 tab PO q4h prn moderate pain; oxycodone 5 mg PO q4h prn severe pain.” This, Dr. Kroon explains, allows nurses to know when a specific medication should be administered to a patient. “Writing complete orders alleviates unnecessary paging to the ordering providers and ensures the timely administration of medications to patients,” she said. **TH**



“Hospitalists can contact drug-information centers that answer complex clinical questions about drugs if they do not have the time to explore themselves.”

—Mohamed Jalloh, PharmD



“Don’t start the fancy drug that the patient can’t continue at home. New anticoagulants are a great example. We run outpatient claims against their insurance before starting anything, as a policy to avoid this.”

—Ian Jenkins, MD, SFHM

Hospitalists prepare for MACRA, seek more changes

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“We think this will all end up fine, but we’re still working on it,” said Ron Greeno, MD, FCCP, MHM, founding member of SHM and chair of SHM’s Public Policy Committee (PPC). “They’re very receptive to the feedback we give them.” Dr. Greeno met with CMS in January 2017 to continue advocating on behalf of the hospitalist community.

For instance, 13 specialty measures were required under the final rule in order for hospitalists to begin reporting under the Quality category of the Merit-Based Incentive Payment System (MIPS), one of two pathways to reimbursement available to all physicians under MACRA’s Quality Payment Program. However, of these, Dr. Greeno said that just seven are relevant to the hospitalist practice. The CMS now requires six reported measures in the Quality category, reduced from the initial nine.³

The measures include:

- Heart failure: ACE inhibitor/angiotensin receptor blocker for left ventricular systolic dysfunction
- Heart failure: Beta-blocker for LVSD
- Stroke: DC on antithrombotic therapy

though all physicians will see a 0.5 percent fee increase between now and 2019.

Additionally, just for this year, physicians can choose to report for either a full or partial year (90 days). They will not be subject to the penalty and may be eligible for a positive payment adjustment. However, those who submit nothing are subject to a negative 4% adjustment penalty.

This gives hospitalists the opportunity to decide “how much to dip your toe in this year,” said Suparna Dutta, MD, a hospitalist at Rush Medical College in Chicago and a PPC member. “You can go all in and submit data in all categories, with the potential for a large positive payment adjustment no matter how you perform, or you can submit just one piece of data and avoid any negative adjustment. It gives you the chance to get feedback on your performance from CMS and play around with how to best integrate MACRA measurement and reporting into your practice.”

Additionally, CMS took steps to make MACRA easier on small and rural physician practices. The final rule exempts physicians who bill \$30,000 or less in Medicare Part B or 100 or fewer Medicare patients, up from



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—Ron Greeno, MD, FCCP, MHM

a composite score. However, this is not yet well defined, and the option is not available in 2017. The CMS said that it will continue to seek feedback on the structure and implementation of virtual groups in future years.¹

Hospitalists may find themselves presented with another option for performance measurement, Dr. Greeno said. The SHM has asked CMS to consider allowing hospitalists to align with their hospital facility instead of being measured separately.

“Hospitalists are in the unique position of working at only one acute care hospital, for the most part, and we actually floated this idea around years ago, to give hospitalists the option for all their quality metrics —

2017, the other option is the Alternative Payment Models (APMs) pathway, which moves away from the pay-for-performance, semi-fee-for-service structure of MIPS and, instead, follows the rules established by the models themselves, which include select qualified accountable care organizations and patient-centered medical homes.⁷ Participating physicians are eligible for a 5% incentive payment in 2019. Many health experts say that it’s clear CMS would like to ultimately steer most physicians from MIPS to APMs.

However, very few — if any — hospitalists will find themselves on an APM track. This is, in part, because models considered APMs



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—Suparna Dutta, MD

- Advance Care Plan
- Prevention of catheter-related bloodstream infection: CVC (central venous catheter) Insertion Protocol
- Documentation of current medications
- Appropriate treatment of methicillin-susceptible *Staphylococcus aureus* bacteremia

“Of the seven available, not all will be reportable because hospitalist practices have a lot of variation, both in their practices and in their patient mix,” Dr. Greeno said. “Most hospitalists will only be able to successfully report on four measures, but we are seeking clarification on what they call a validation test and how that will function.”

In the final rule, CMS said that it will perform that “validation test” to evaluate physicians who cannot report the minimum number of measures to ensure they are not penalized for it.

In addition to Quality, the other reporting categories under the umbrella of MIPS include Advancing Care Information, Cost, and Improvement Activities. For 2017, CMS gave physicians the option to “pick your pace.”⁴ As long as doctors report just one quality measure, one improvement activity, or the required advancing care information measures (most hospitalists will be exempt from this category), they will avoid a penalty.^{1,5} Cost will not be included for 2017, the first performance year for MIPS. This year’s reporting will be used to determine payments in 2019,

the previous \$10,000 threshold.¹

Mr. Slavitt “was very concerned about small practices and raised the threshold from \$10,000 to \$30,000 in Medicare revenue a year,” said Robert Berenson, MD, FACP, institute fellow of the Health Policy Center at the Urban Institute and former member of the Medicare Payment Advisory Committee.

However, this is unlikely to apply to the majority of — if any — hospitalists, Dr. Dutta said. “By virtue of being a hospitalist, you are seeing all comers to your institution. We don’t really have the choice to see fewer Medicare patients, to be honest, and, [for] most hospitalists — whether employed by a hospital or contracting — one of the main reasons we are in place is to help the hospital and take the patients nobody else will take.”

The CMS has also allotted \$20 million each year for 5 years to support training and education for practices of 15 providers or fewer, for rural providers, and for those working in geographic health professional shortage areas.^{1,6} According to CMS, as of December 2016, experienced organizations (regional health collaboratives, quality improvement organizations, and others) began receiving funds to help these practices choose appropriate quality measures, train in improvement techniques, select the right health information technology, and more.

Under MACRA, small practices (10 clinicians or fewer) may also join “virtual groups” in order to combine their MIPS reporting into

not as a standalone physician group — to be judged on hospital performance metrics,” he said, adding, “It would be easier if we could do this for everybody, but not all hospitalist groups that work for hospitals may want to do that.”

Dr. Dutta said that this would be “a great and efficient option,” especially since hospitalists oversee the bulk of quality improvement activities in their hospitals.

“Hospital-level data would be a reflection of what we’re involved in, as the bulk of hospitalists not only provide clinical care but also participate in a multitude of hospital activities,” she said, such as “helping to develop and promote practices around high-value care, to serving on groups like safe transitions in care. It’s hospitalists who are usually the hospital leaders around quality improvement.”

This includes coming up with ways to work with pharmacists at patient admission and on medication reconciliation upon discharge, as well as providing input on clinical protocols, such as what should be done when someone falls or when potassium is high, Dr. Dutta said.

“Performance should be tied to the performance of the hospital. It moves in the right direction to force more collaboration and a joint fate,” Dr. Berenson added.

Alternative payment models

While MIPS is the pathway most physicians expect to find themselves on in

require the use of Certified Electronic Health Record Technology (CEHRT) and must present “more than nominal risk” to providers.

“Right now, the only alternative payment model where hospitalists can directly take risk is BPCI [Bundled Payments for Care Improvement], but it does not qualify as an APM,” Dr. Greeno said.

It will also be difficult because CMS requires patient and payer thresholds under APMs that hospitalists simply are not poised to meet. In 2019, this means 25% of Medicare payments must come from an Advanced APM in 2017, or 20% of providers’ Medicare patients must be seen through an Advanced APM.⁸

Advanced APMs are those with which, at least in 2019 and 2020, providers face the risk of losing the lesser of 8% of their revenue or repaying CMS up to 3% of their total Medicare expenditures, if expenditures are higher than expected.^{8,9}

“It is going to be very difficult for hospitalists to qualify for APMs because we’re not in the position to hit the thresholds,” said Dr. Dutta.

However, SHM has urged CMS to consider other BPCI models for qualification as APMs, and Dr. Greeno said that CMS is currently looking into developing bundles that may be appropriate for hospitalists. For instance, Dr. Dutta said, “What we do often in medicine is chronic disease management,

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and the time is coming to get into chronic disease bundles, such as [those for] management of heart failure or kidney disease.”

In December, SHM submitted a letter to PTAC (the Physician-Focused Payment Model Technical Advisory Committee) to show support for a model created by the American College of Surgeons, called ACS-Brandeis, which they hope will be considered as an Advanced Alternative Payment Model. In the proposal that ACS submitted, the authors noted, “The core model is focused on procedure episodes but can easily be expanded to include acute and chronic conditions.”

The SHM notes in its letter that, while the initial proposal is intended for surgical patients, the term-based nature of surgical care provides a platform for expanding the model more broadly to hospitalists and other specialties.

Some skepticism remains

Even if BPCI or other models are accepted as APMs, hospitalists may still be challenged to meet the required payment or patient thresholds, Dr. Greeno said. Additionally, Dr. Berenson is skeptical of bundled payments, particularly for hospitalists.


“Are hospitalists the right organization to be held accountable for the total cost of care for 90 days of spending, any more than oncologists under Oncology Care Models

should be accountable for the total cost of cancer where some patients are getting palliative care and that’s not a driver of health care costs?” he asked. “I could see that as problematic for hospitalists.”

While he believes there are many positive aspects to MACRA, in general, Dr. Berenson considers it bad policy. While he does not want to see the Sustainable Growth Rate return, he believes many physicians would have seen reimbursement reductions sooner without MACRA (under the prior quality measurement programs) and that the law provides some perverse incentives.

For one thing, the Quality Payment Program is budget neutral, which means that, for every winner, there is also a loser. Before CMS expanded exemptions for smaller and rural practices, Dr. Berenson said that some larger groups – which are often better equipped to pursue APMs – were planning to stay in MIPS because they figured they were more likely to be the winners when compared with smaller physician practices. And MIPS comes with a 9% payment boost by 2022 (or 9% penalty), plus the possibility of an extra bonus for top performers, compared with the 5% incentive of APMs that same year.⁷

“There were literally groups saying they were going to go for the MIPS pathway because it’s a bigger upside,” Dr. Berenson said. “When CMS said it was exempting those [smaller, rural] groups, the [larger] groups



“We heard you and will continue listening.”
—Andrew Slavitt, then-acting administrator of the Centers for Medicare & Medicaid Services, used in a blog post on Oct. 14, 2016.¹ (Mr. Slavitt no longer maintains that title since the new federal administration took office on Jan. 20, 2017.)

turned around and said [that the smaller, rural groups] were the downside. ... That kind of game theory is bad public policy.”

Dr. Berenson also believes MACRA will be detrimental to some small and independent practices. Others may decide not to bill Medicare altogether, though that is not an option open to most hospitalists who care to stay in practice. It could, however, drive more hospitalists to consolidate or to become employees of their hospitals.¹⁰

“I don’t think there is any doubt this is going to drive consolidation,” Dr. Greeno said, citing numbers released by CMS that show an inverse relationship between practice size and the negative impact of MACRA.¹¹ “I think it’s going to be pretty tough unless you’re big enough to commit the resources you need to do it right.”

At TeamHealth, where Dr. Greeno is senior adviser of medical affairs, he said that they have invested in information technology compliance, developed systems and trained providers to ensure the creation of favorable metrics for the organization and built the infrastructure to gather, report, and validate data. These are steps that may be out of reach for most smaller practices.

As Dr. Greeno said, no one expected this to be easy. “You’re trying to get doctors to change the way they practice. Anybody who has ever worked with doctors knows that’s not an easy thing to do,” he said. “CMS is changing things to create enough incentive so the pain of not changing becomes greater than the pain of changing.”

While hospitalists may bear more of the pressure than other physician specialties, by virtue of their role in improving the quality of care in hospitals, they were born from reform efforts of the past, Dr. Greeno adds.

“If there had never been an attempt to change the way that physicians were paid, hospitalists wouldn’t exist,” he said. “We were created by physician groups who took capitated payments from HMOs, who had to find more efficient ways to treat patients in the hospital or go out of business.”

“Hospitalists are a delivery system reform and people look to us to lead. We can create a tremendous amount of value for whom ever we work for,” Dr. Greeno said.

This is also why SHM continues to work with CMS to advocate for all its members.

Dr. Greeno is in Washington at least once a month, participating in critical meetings and helping to guide decisions.

“The Public Policy Committee has to get into the weeds and get involved in advocating for measures that truly get at the work we do and push back on metrics and categories that do not relate to the care we are delivering for our patients,” said Dr. Dutta. “The group worked hard to push back on having to comply with Meaningful Use standards for hospitalists, and now we’re exempt from that category. CMS does listen. It sometimes just takes a while.” **TH**

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Mr. Slavitt “was very concerned about small practices and raised the threshold from \$10,000 to \$30,000 in Medicare revenue a year.”

—Robert Berenson, MD, FACP

IN THE LITERATURE



ITL: Physician reviews of HM-centric research

BY ANAR MASHRUWALA, MD, FACP, MARGARET TSIEN, MD, AGNES LIBOT, MD, FAAP, AMY KIM, MD, TIFFANY WHITE, MD, AND PAULA MARFIA, MD,

Division of Hospital Medicine, Department of Medicine, Loyola University Chicago, Maywood, Ill.

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By Margaret Tsien, MD, FAAP

1 Comparison of risk scoring systems for patients presenting with upper gastrointestinal bleeding

CLINICAL QUESTION: What are the accuracy and clinical utility of risk scoring systems in the assessment of patients with upper gastrointestinal bleeding?

BACKGROUND: There are several pre- and postendoscopy risk scores to predict clinically relevant outcomes such as transfusion, mortality, endoscopy treatment, surgery, and length of hospital stay for upper GI bleeding. The accuracy and applicability of these risk scores has not been well established.

STUDY DESIGN: International multicenter prospective study.

SETTING: Six large hospitals in Europe, North America, Asia, and Oceania.

SYNOPSIS: This is a prospective study comparing three pre-endoscopy scoring systems (Rockall, AIMS65, Glasgow Blatchford) and two postendoscopy scoring systems (PNED, full Rockall) in 3,012 patients with upper GI bleeding over six hospitals. It examined clinically relevant outcomes: intervention (transfusion, endoscopy, interventional radiology, surgery), mortality, rebleeding, and length of hospital stay.

The Glasgow Blatchford risk score was the most accurate at predicting the need for hospitalization and death across all hospitals, compared with the other scoring systems. It was determined that a Glasgow Blatchford score of less than 1 is an optimal threshold for outpatient management, with a 98.6% sensitivity in identifying those who would not require intervention or die. The utility of these scores to direct management in high-risk patients is limited and needs further studies. No scoring system predicted rebleeding or length of hospital stay.

A weakness of the study is that patients who bled while already inpatients were excluded.

BOTTOM LINE: The Glasgow Blatchford risk score can help direct care of very low risk patients (score, less than 1) with upper GI bleeding toward outpatient management.

CITATION: Stanley AJ, Laine L, Dalton HR, et al. "Comparison of risk scoring systems for patients presenting with upper gastrointestinal bleeding: International multicenter prospective study." *BMJ*. 2017 Jan 4;356:i6432.

2 Patient-to-intensivist ratios can influence patient mortality

CLINICAL QUESTION: Is there variation in patient-to-intensivist ratios (PIR) across ICUs, and does that ratio affect hospital mortality?

BACKGROUND: Most studies show that intensivists improve ICU patient outcomes. With increasing ICU patients but stable intensivist staffing, patient-to-intensivist ratios are increasing. It is unclear if that rising ratio is adversely affecting patient mortality.

STUDY DESIGN: Multicenter retrospective cohort analysis.

SETTING: ICUs in the United Kingdom from 2010 to 2013.

SYNOPSIS: In 94 ICUs, 49,686 adults were examined. The PIR was defined as the total number of patients cared for by an intensivist during daytime hours. However, PIR was also calculated using nine variations of the definition, which took into account new admissions and severity of illness, among other factors. A multivariable mixed-effect logistic regression was used to assess the association of PIR and mortality.

The median PIR was 8.5 but varied substantially – PIRs were often larger. The association between PIR and mortality was

U shaped. There was a decrease in mortality as the PIR reached 7.5, after which the mortality increased again. The higher mortality with very low PIRs could reflect a volume-outcome relationship. Less patients could mean less experience, different levels of ancillary staff, and so on.

This study did not take into account the possible differences in the multidisciplinary makeup of the ICU teams that would affect the intensivist's level of responsibility.

BOTTOM LINE: There seems to be an optimal PIR for mortality, though that optimal number would likely depend on the ancillary staff, level of trainees, and patient acuity.

CITATION: Gershengorn HB, Harrison DA, Garland A, et al. "Association of intensive care unit patient-to-intensivist ratios with hospital mortality." *JAMA Intern Med*. 2017 Mar 1;177(3):388-96.

Dr. Tsien is assistant professor in the division of hospital medicine, Loyola University Chicago, Maywood, Ill.

By Agnes Libot, MD

3 Risks are reduced when angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers are held before noncardiac surgery

CLINICAL QUESTION: Is withholding angiotensin-converting enzyme inhibitors (ACEI) or angiotensin II receptor blockers (ARBs) prior to noncardiac surgery associated with a lower risk of a 30-day composite outcome of all-cause death, myocardial injury after noncardiac surgery, and stroke when compared with continuing them on the day of surgery?

BACKGROUND: The current American College of Cardiology/American Heart Association guidelines recommend continuing ACEI and ARBs for noncardiac surgery. However, many clinicians, including anesthesiologists, withhold these medications to prevent intraoperative hypotension. Because of the lack of strong evidence regarding clinical outcomes, the decision to withhold ACEI and ARBs prior to noncardiac surgery is currently dictated by physician preference and local policy.

STUDY DESIGN: Prospective cohort study.

SETTING: Analysis sample from the VISION study (Vascular Events in Noncardiac Surgery Patients Cohort Evaluation), which included 12 centers in eight countries.

SYNOPSIS: A sample analysis was performed on 14,687 patients from the VISION study, who were at least 45 years old and undergoing noncardiac surgery and who required

an overnight hospital admission. A total of 4,802 patients were taking ACEI/ARBs at baseline, and, for 1,245 (25.9%) of those patients, ACEI/ARBs were withheld at least 24 hours before surgery. Using multivariable regression models, the authors found that patients for whom ACEI/ARBs were withheld were less likely to suffer from the primary composite outcome of 30-day all-cause death, myocardial injury after noncardiac surgery, and stroke (12% vs 12.9%; adjusted relative risk, 0.82; 95% confidence interval, 0.7-0.96; $P = .01$). Withholding ACEI/ARBs prior to surgery was also associated with less risk of clinically important intraoperative hypotension, while the risk of postoperative hypotension was similar between the two groups.

Given that this was an observational study, analysis is limited because of the inability to account for every potential confounding factor.

BOTTOM LINE: The study suggests a lower risk of postoperative death, stroke, and myocardial injury in patients for whom ACEI/ARBs were withheld prior to noncardiac surgery. A large randomized trial is needed to confirm the findings suggested by this analysis.

CITATION: Roshanov PS, Rochwerf B, Patel A, et al. Withholding versus continuing angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers before noncardiac surgery." *Anesthesiology*. 2017 Jan;126(1):16-27.

Dr. Libot is assistant professor in the division of hospital medicine, Loyola University Chicago, Maywood, Ill.

By Amy Kim, MD

4 Guideline for reversal of antithrombotics in intracranial hemorrhage

CLINICAL QUESTION: What is the current guideline for reversal of antithrombotics in intracranial hemorrhage (ICH)?

BACKGROUND: Antithrombotics are used to treat or decrease the risk of thromboembolic events, and the use is expected to rise in the future because of an aging population and conditions such as atrial fibrillation. Patients on antithrombotics who experience spontaneous ICH have a higher risk of death or poor outcome, compared with those who are not. Rapid reversal of coagulopathy may help to improve outcomes.

STUDY DESIGN: A 13-person, multi-institutional, international committee with expertise in relevant medical fields reviewed a total of 488 articles to develop guidelines

CONTINUED ON FOLLOWING PAGE

and treatment recommendations.

SYNOPSIS: The committee developed guidelines for the reversal of antithrombotics after reviewing a total of 488 articles up through November 2015. The quality of evidence and treatment recommendations were drafted based on the GRADE system, as follows:

- **Vitamin K antagonists:** If international normalized ratio is greater than or equal to 1.4, administer vitamin K 10 mg IV, plus 3-4 factor prothrombin complex concentrate (PCC) or fresh frozen plasma.
- **Direct factor Xa inhibitors:** activated charcoal within 2 hr of ingestion, activated PCC or 4 factor PCC.
- **Direct thrombin inhibitors – Dabigatran:** activated charcoal within 2 hr of ingestion and Idarucizumab. Consider hemodialysis. **Other DTIs:** activated PCC or 4 factor PCC.
- **Unfractionated heparin:** protamine IV.
- **Low-molecular-weight heparins – Enoxaparin:** protamine IV, dose based on time of enoxaparin administration. **Dalteparin/nadroparin/tinzaparin:** protamine IV or recombinant factor (rF)VIIa.
- **Danaparoid:** rFVIIa.
- **Pentasaccharides:** activated PCC.
- **Thrombolytic agents:** cryoprecipitate 10 units or antifibrinolytics.
- **Antiplatelet agents:** desmopressin 0.4 mcg or platelet transfusion in neurosurgical procedure.

BOTTOM LINE: This is a statement of the guideline for reversal of antithrombotics in intracranial hemorrhage from the Neurocritical Care Society and the Society of Critical Care Medicine.

CITATION: Frontera J, Lewin JJ, Rabinstein AA, et al. "Guideline for reversal of antithrombotics in intracranial hemorrhage: a statement for healthcare professionals from the Neurocritical Care Society and Society of Critical Care Medicine." *Neurocrit Care*. 2016 Feb;24(1):6-46.

5 Use of second-generation antidepressants in older adults is associated with increased hospitalization with hyponatremia

CLINICAL QUESTION: Is there an increased risk of hyponatremia for older patients who are taking a second-generation antidepressant?

BACKGROUND: Mood and anxiety disorders affect about one in eight older adults, and second-generation antidepressants are frequently recommended for treatment. A potential adverse effect of these agents is hyponatremia, which can lead to serious sequelae. The aim of this study was to investigate the 30-day risk for hospitalization with hyponatremia in older adults who were newly started on a second-generation antidepressant.

STUDY DESIGN: A retrospective population-based cohort study of older adults from

2003 to 2012 using linked health care databases.

SETTING: Ontario, Canada.

SYNOPSIS: Multiple databases were utilized to obtain vital statistics and demographic information, diagnoses, prescriptions, and serum sodium measurements to establish a cohort population. One group of 172,552 was newly prescribed a second-generation antidepressant. A second control group of 297,501 was established in which patients were not prescribed antidepressants. Greedy matching was used to match each user to a nonuser based on similar characteristics of age, sex, evidence of mood disorder, chronic kidney disease, congestive heart failure, or diuretic use. After matching, 138,246 patients remained in each group and were nearly identical for all 100 measured characteristics. The primary outcome was that, compared with nonuse, second-generation antidepressant use was associated with higher 30-day risk of hospitalization with hyponatremia (relative risk, 5.46; 95% CI, 4.32-6.91). The secondary outcome showed that, compared with non-use, second-generation antidepressant use was associated with higher 30-day risk for hospitalization with concomitant hyponatremia and delirium (RR, 4.00; 95% CI, 1.74 - 9.16). Additionally, tests for specificity and temporality were employed.

SHORT TAKES

FDA issues important safety precautions for use of implantable infusions pumps in MRI

Serious adverse events, including patient injury and death, have been reported with the use of implantable infusion pumps in the MRI environment. The Food and Drug Administration has issued a safety communication for patients, caregivers, health care providers, and MRI technologists, outlining safety precautions and recommendations.

CITATION: "Implantable Infusion Pumps in the Magnetic Resonance (MR) Environment: FDA Safety Communication – Important Safety Precautions." FDA.gov. 2017 Jan 11. www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm536526.htm.

BOTTOM LINE: A robust association between second-generation antidepressant use and hospitalization with hyponatremia was determined in the large population-based cohort study.

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CITATION: Gandhi S, Shariff SZ, Al-Jaishi A, et al. "Second-generation antidepressants and hyponatremia risk: a population-based cohort study of older adults." *Am J Kidney Dis.* 2017 Jan;69(1):87-96.

Dr. Kim is clinical assistant professor in the division of hospital medicine, Loyola University Chicago, Maywood, Ill.

By Tiffany White, MD

6 Bezlotoxumab for prevention of recurrent *Clostridium difficile* infection

CLINICAL QUESTION: Does administration of monoclonal antibodies to *C. difficile* toxins A and B, in addition to standard-of-care antibiotics, prevent recurrent infection?

BACKGROUND: Currently, no therapy has been approved to prevent recurrent *C. difficile* infection. A new approach to the prevention of recurrent *C. difficile* infection is the administration of monoclonal antibodies against *C. difficile* toxins (in addition to antibiotic therapy) as a form of passive immunity. Actoxumab and bezlotoxumab are fully human monoclonal antibodies that bind and neutralize *C. difficile* toxins A and B, respectively. In humans, the level of circulating antibodies against toxin A or toxin B has been correlated with protection against primary and recurrent *C. difficile* infection.

STUDY DESIGN: Two (MODIFY [MK-6072 and MK-3415A in Participants Receiving Antibiotic Therapy for *Clostridium Difficile* Infection] I and MODIFY II) double-blind, randomized, placebo-controlled, phase III trials.

SETTING: 322 sites (~68% inpatient) in 30 countries from Nov. 1, 2011, through May 22, 2015.

SYNOPSIS: Trials pooled data from 2,174 adults who were receiving oral standard-of-care antibiotics for primary or recurrent *C. difficile* infections. Participants received an infusion of either bezlotoxumab, actoxumab plus bezlotoxumab, or placebo for MODIFY II; actoxumab alone was also given in MODIFY I. The primary endpoint was recurrent infection within 12 weeks.

The rate of recurrent *C. difficile* infection was significantly lower with bezlotoxumab alone than with placebo (MODIFY I: 17% vs. 28%; 95% CI, -15.9 to -4.3; *P* less than .001; MODIFY II: 16% vs. 26%; 95% CI, -15.5 to -4.3; *P* less than .001) and was significantly lower with actoxumab plus bezlotoxumab than with placebo (MODIFY I: 16% vs. 28%; 95% CI, -17.4 to -5.9; *P* less than .001; MODIFY II: 15% vs. 26%; 95% CI, -16.4 to -5.1; *P* less than .001).

The serious adverse events were similar with most groups, the exception being actoxumab alone. Given the higher rate of recurrent infection and deaths in the actoxumab group from interim analysis, the enrollment was discontinued in MODIFY I.

Investigators did admit that safety assessments were limited because of the relatively small number of patients who received bezlotoxumab, making it difficult to detect potentially serious but low-frequency toxic effects.

BOTTOM LINE: In patients receiving oral standard-of-care antibiotics for primary or recurrent *C. difficile* infection, a single intravenous infusion of bezlotoxumab was associated with a significantly lower rate of recurrent infection than placebo and had a safety profile similar to that of placebo.

CITATION: Wilcox MH, Gerding DN, Poxton IR, et al. "Bezlotoxumab for prevention of recurrent *Clostridium difficile* infection." *N Engl J Med.* 2017 Jan 26;376(4):305-17.

7 Decision pathway for periprocedural management of anticoagulation in patients with nonvalvular atrial fibrillation

CLINICAL QUESTION: This work group synthesized available data to address whether and when anticoagulant therapy should be interrupted, whether and how anticoagulant bridging with a parenteral agent should be performed, and when and how anticoagulant therapy should be restarted for those who require temporary interruption.

BACKGROUND: Atrial fibrillation is the most common sustained arrhythmia worldwide. Antithrombotic therapy, with a strong preference to oral anticoagulant (vitamin K antagonists [VKA] or Direct oral anticoagulant [DOAC]) over antiplatelet, is recommended for patients with high thrombotic risk. Temporary interruption is frequently necessary to mitigate bleed risk with surgical or invasive procedures. Although several factors go into the decision to interrupt anticoagulation, practice varies widely.

STUDY DESIGN: Data review and commentary.

SETTING: Veterans' Affairs Hospitals.

SYNOPSIS: For the assessment of procedural bleed risk, the guideline provides bleeding risks levels: 1) no clinically important bleed risk, 2) low procedural bleed risk, 3) uncertain procedural bleed risk, or 4) intermediate/high procedural bleed risk.

For the assessment of patient-related bleed risk, consider the HAS-BLED (Hypertension, Abnormal Renal and Liver Function, Stroke-Bleeding, Labile INRs,

Elderly, Drugs or Alcohol) score: bleeding in the preceding 3 months, bleeding with a similar procedure or prior bridging, abnormalities of platelet function, concomitant use of antiplatelet therapy, and/or supratherapeutic international normalized ratio.

Vitamin K Antagonists:

- Do not interrupt for no clinically important or low bleed risk AND absence of patient-related bleed risk factor(s).
- Interrupt for procedures with intermediate or high bleed risk OR procedures with uncertain bleed risk and the presence of patient-related bleed risk factor(s).
- Consider interruption for procedure with no clinically important or low bleed risk AND the presence of patient-related bleed risk factor(s) OR procedures with uncertain bleed risk AND the absence of patient-related bleed risk factor(s).

Direct Oral Anticoagulants:

Can interrupt therapy for all bleed risks; duration based on creatinine clearance.

A procedure performed at the trough level may allow reinitiation the evening of or the day after the procedure with 1 or fewer dose(s) missed.

BOTTOM LINE: VKAs should be held based on surgical and patient bleed risk factors. Guidelines provide tools to calculate and consider. DOACs can always be held, preferably at trough times to minimize interruptions and for durations based on creatinine clearance.

CITATION: Doherty JU, Gluckman TJ, Hucker WJ, et al. "2017 ACC Expert consensus decision pathway for periprocedural management of anticoagulation in patients with nonvalvular atrial fibrillation." *J Am Coll Cardiol.* 2017 Feb 21;69(7):871-98.

Dr. White is an instructor in the Division of Hospital Medicine, Loyola University Chicago.

By Paula Marfia, MD

8 Emergency department census impacts hospital admission rates

CLINICAL QUESTION: Does emergency department patient census impact the disposition decisions of emergency room physicians?

BACKGROUND: Studies of ED utilization have focused on the influence of increases in usage on patient outcomes and mortality but not on the effect on hospital admission rates. Additionally, the emergency department is a growing area of scrutiny when it comes to reducing the costs of medical care because of it being a "gatekeeper" to hospital admissions. Some patients may be more likely to be admitted in times of high ED census when they require more time and resources to discharge safely.

STUDY DESIGN: Retrospective observational study.

SETTING: Academic tertiary care center with a level I trauma center.

SYNOPSIS: Data from the electronic health records of 49,487 patients were included in the study. With a multivariate model regression, waiting room census and physician load census were evaluated for effect on admission rates. As waiting room

SHORT TAKES

Efficacy of ketorolac is similar at all the most commonly administered doses

A randomized, double-blind trial of IV ketorolac dosing found similar analgesic efficacy in patients aged 18-65 years with moderate to severe pain at the commonly ordered doses of 10 mg, 15 mg, and 30 mg with no increase in adverse effects.

CITATION: Motov S, Yasavolian M, Likourezos A, et al. "Comparison of intravenous ketorolac at three single-dose regimens for treating acute pain in the emergency department: A randomized controlled trial." *Ann Emerg Med.* 2016 Dec 16. doi: org/10.1016/j.annemergmed.2016.10.014.

Viruses are common cause of nonventilated, hospital-acquired pneumonia

Retrospective analysis demonstrates that viruses are common etiology for nonventilated hospital-acquired pneumonia (NVHAP), as common as bacterial organisms. Clinicians should consider testing for viral etiologies in NVHAP in an effort to improve antibiotic stewardship.

CITATION: Shorr AF, Zilberberg MD, Micek ST, Kollef MH. "Viruses are prevalent in non-ventilated hospital-acquired pneumonia." *Respir Med.* 2017;122:76-80.

census increased, patients were 1.011 times more likely to be admitted (95% CI, 1.001-1.020). Similarly, as physician load census increased, patients were 1.010 times more likely to be admitted (95% CI, 1.002-1.019). Although these intervals appear modest, when translated into percentages, the impact is more easily understood. With a zero waiting room and physician load census, patients had a 35.3% chance of admission but, at the highest volume of physician load of 16 and waiting room of 12, chance of admission was 40.1%.

This study is limited by the use of odds ratios to report its results, which are more difficult to interpret into practice. Additionally, this study cannot prove causality, though it may make ED physicians more aware of a possible influence on their admission decisions when census is high.

BOTTOM LINE: ED census, measured as waiting room census as well as physician load census, was positively associated with increased likelihood of hospital admission.

CITATION: Gorski JK, Batt RJ, Otles E, et al. "The impact of emergency department census on the decision to admit." *Acad Emerg Med.* 2017 Jan;24(1):13-21.

Dr. Marfia is assistant professor in the Division of Hospital Medicine, Loyola University Chicago, Maywood, Ill.

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- Elimination of urine culture screenings prior to elective joint arthroplasty

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KEY
CLINICAL
QUESTION

Procalcitonin guidance improves antibiotic stewardship

Use of the procalcitonin assay has been shown to reduce antibiotic utilization without an increase in adverse outcomes.

By Bryan J Huang, MD, FHM, and Gregory B Seymann, MD, SFHM

KEY POINTS

- Elevated procalcitonin levels suggest the presence of bacterial infection.
- In patients presenting with acute respiratory illness, procalcitonin levels can be used to guide the decision to initiate or withhold antibiotics, improving antibiotic stewardship.
- Sequential monitoring of procalcitonin levels may help guide duration of antibiotic therapy.
- There is potential but less conclusive evidence for procalcitonin usage in the broader population of ICU patients with sepsis.

The case

A 72-year-old male with COPD presents to the emergency department with increased dyspnea and cough. He is afebrile, and oxygen saturation is 87% on room air. WBC count is 9.5 with a normal differential, and chest x-ray is read by the radiologist as atelectasis versus early consolidation in the left lower lobe. Should antibiotics be initiated?



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Background

The problem: Antibiotic overuse

With the increasing prevalence of antibiotic resistance in our nation's hospitals, the need for robust antibiotic stewardship programs has continued to rise in importance. In 2016, the Centers for Disease Control and Prevention reported a fatal case of septic shock due to a carbapenem-resistant strain of *Klebsiella* resistant to all tested antibiotics.¹ This case received much media coverage; moreover, this patient represented only 1 of the approximately 23,000 patients infected with antibiotic-resistant bacteria in the United States who die each year. Although various approaches to curbing antibiotic resistance are being pursued, judicious antibiotic use is central to success. Current evidence suggests that up to 30% of antibiotics are not optimally prescribed,² leaving a significant opportunity for improvement.

Lower respiratory infections account for a substantial proportion of antibiotic utilization in the United States. In a recent study, acute respiratory conditions generated 221 antibiotic prescriptions per 1,000 population, but only half of these were deemed appropriate.² The inability to reliably discern viral from bacterial etiology is a driver of excess antibiotic use.

The procalcitonin assay has been touted as a possible solution to this problem. Multiple studies have evaluated its utility as a tool to help discriminate between bacterial infection and viral or noninfectious etiologies.

What is procalcitonin?

Thyroidal C cells convert the prohormone procalcitonin to calcitonin, which is stored in secretory granules for release in response to fluctuations in calcium levels via a classical neuroendocrine feedback loop. Alternatively, procalcitonin can be synthesized in nonthyroidal parenchymal cells, and high levels of proinflammatory mediators secreted in response to bacterial endotoxin drive increased procalcitonin production. Interestingly, interferon gamma, up-regulated in viral infections, reduces procalcitonin production. Nonthyroidal parenchymal cells lack mechanisms for efficient conversion of procalcitonin to calcitonin and do not contain secretory granules to facilitate its regulated release. Hence bacterial infections correlate with higher serum procalcitonin levels.³

Evidence

Can procalcitonin guide antibiotic therapy in patients with acute respiratory illness while reducing antibiotic utilization?

The ability of procalcitonin to selectively identify bacterial infection makes it a potentially promising tool to advance the antibiotic stewardship agenda. Multiple randomized controlled trials have explored the use of procalcitonin-guided antibiotic therapy for treatment of lower respiratory tract infections such as acute bronchitis, exacerbations of chronic obstructive pulmonary disease, and pneumonia. Each

study discussed below was done in Switzerland, involved the same key investigator (Mirjam Christ-Crain, MD, PhD), and shared a similar design in which a threshold for low procalcitonin values (less than 0.1 mcg/L) and high procalcitonin values (greater than 0.25 mcg/L) was prespecified. Antibiotic therapy was strongly discouraged for patients with low procalcitonin and encouraged for those with high procalcitonin; antibiotics were not recommended for patients with intermediate values, but the treating physician was allowed ultimate discretion (Figure 1). All studies compared a procalcitonin-guided treatment group to a standard-care group, in which antibiotics were prescribed by the treating physician based on established clinical guidelines.

In a study focusing on outpatients presenting to their primary care physicians with acute respiratory tract infection, 53 primary care physicians in Switzerland recruited 458 patients. There was no significant difference in time to symptom resolution, as determined by patient report during an interview 14 days after initial presentation; however, 97% of patients in the standard-care group received antibiotics, compared with 25% in the procalcitonin-guided group. Equal numbers of patients (30% in each group) reported persistent symptoms at 28-day follow-up. Among the cohort of patients with upper respiratory infections or acute bronchitis, procalcitonin guidance reduced antibiotic prescriptions by 80%.⁴

In a blinded, single-center, randomized, controlled trial of 226 patients presenting to a university hospital with a COPD exacerbation severe enough to require a change in the baseline medication regimen, procalcitonin-guided therapy allowed for an absolute reduction of antibiotic use by 32% without an impact on outcomes. Rates of clinical improvement, ICU utilization, recurrent exacerbations, hospital length of stay, and mortality did not differ between the groups.⁵

Another study by Dr. Christ-Crain looked at whether procalcitonin could be used to determine duration of antibiotic therapy in hospitalized pneumonia patients. In a similarly designed randomized, nonblinded trial with two arms, a procalcitonin group (n = 151) and a standard-care group (n = 151), procalcitonin levels were checked at 4, 6, and 8 days, with similar cutoffs regarding levels for which antibiotics were encouraged or discouraged. Antibiotic treatment duration was reduced from a median of 12

days in the standard-care group to 5 days in the procalcitonin group (P less than .001). There was no difference in the success rate of treatment, readmission rate, or death rate between the two groups.⁶

These initial studies were limited by their relatively small size and narrow scope. The ProHOSP study was the first large, multicenter study to address the utility of procalcitonin-guided antibiotic therapy. Design was similar, although the decision to treat with antibiotics was more rigorously controlled by the centralized study personnel. The study enrolled 1,359 patients in the emergency departments of six Swiss tertiary-care hospitals. Most patients had pneumonia, but 17% had COPD exacerbation and 11% had acute bronchitis. No difference in death, ICU admission, readmission, or disease-specific complications was noted. Antibiotic exposure was reduced by 34.8% in the procalcitonin group, with a mean of 8.7 days versus 5.7 days on antibiotics.⁷

In combination, the studies above support the use of procalcitonin to guide decisions about antibiotic use in patients with lower respiratory tract infections; antibiotic use can be significantly reduced without adverse outcomes. Further, sequential monitoring of procalcitonin levels may help guide duration of antibiotic therapy. These



Dr. Huang

Is there evidence for using procalcitonin to guide treatment in the broader population of ICU patients?

While there is good evidence for using procalcitonin to guide antibiotic use in patients with acute respiratory illness, the evidence for using procalcitonin in the broader cohort of critically ill patients with sepsis is less well established.



Dr. Seymann

The most promising results were reported by the Stop Antibiotics on Procalcitonin Guidance Study (SAPS). Published in July 2016, this was a prospective, multicenter, randomized, controlled, open-label study of patients admitted to the ICU (not limited to respiratory illness) in the Netherlands. A total of 1,575 patients were assigned to the procalcitonin-guided group or the standard-of-care group. In the procalcitonin-guided group, procalcitonin levels were checked daily, and physicians were given nonbinding advice to discontinue antibiotics if procalcitonin levels decreased by greater than 80% from peak levels or to below 0.5 mcg/L.

Patients received an average of 7.5 daily defined antibiotic doses in the procalcitonin-guided group versus 9.3 daily defined doses in the standard-of-care group (P less than .0001). The median duration of antibiotic treatment in the procalcitonin arm

Earlier trials regarding the procalcitonin assay in the critical care setting similarly showed some promise but also concerns. One trial reported a 25% reduction in antibiotic exposure and noninferiority of 28-day mortality, but there was a nonsignificant 3.8% absolute increase in mortality at 60 days.¹⁰ Another trial reported similar survival in the procalcitonin group but more side effects and longer ICU stays.¹¹

Ultimately, while the SAPS trial supports the potential use of procalcitonin in critically ill patients, these patients likely have complex sepsis physiology that requires clinicians to consider a number of clinical factors when making antibiotic decisions.

Back to the case

The case illustrates a common emergency department presentation where clinical and radiographic features are not convincing for bacterial infection. This patient has an acute respiratory illness, but is afebrile and lacks leukocytosis with left shift, and x-rays are indeterminate for pneumonia. The differential diagnosis also includes COPD exacerbation, viral infection, or noninfectious triggers of dyspnea.

In this scenario, obtaining procalcitonin levels is useful in the decision to initiate or withhold antibiotic treatment. An elevated procalcitonin level suggests a bacterial infection and would favor initiation of antibiot-

ics for pneumonia. A low procalcitonin level makes a bacterial infection less likely, and a clinician may consider withholding antibiotics and consider alternative etiologies for the patient's presentation.

Bottom line

Procalcitonin can be safely used to guide the decision to initiate antibiotics in patients presenting with acute respiratory illness. Use of the procalcitonin assay has been shown to reduce antibiotic utilization without an increase in adverse outcomes. There is potential but less conclusive evidence for procalcitonin usage in the broader population of ICU patients with sepsis. **TH**

Dr. Huang and Dr. Seymann are in the division of hospital medicine, University of California, San Diego.

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FIGURE 1. Procalcitonin treatment algorithm

Procalcitonin level (mcg/L)	Likelihood of bacterial infection	Antibiotic treatment
less than 0.1	Absent	Strongly discouraged
0.1–0.25	Unlikely	Discouraged
0.25–0.5	Possible	Encouraged
greater than 0.5	Present	Strongly encouraged

studies all had fairly high rates of follow-up and the ProHOSP study, in particular, had a large, representative sample and a rigorous methodology to standardize antibiotic prescription in the control group.

Limitations include the possible impact of the Hawthorne effect, as physicians knew their antibiotic usage patterns were being monitored, which may impact generalizability of the findings to a real-world setting. Similarly, it is difficult to control for a spillover effect as providers exposed to the procalcitonin-guided algorithm became more comfortable with a restrictive prescribing approach. The costs of the additional procalcitonin assay must be weighed against the benefits. Incidence and cost of other adverse effects of antibiotic use (rates of *Clostridium difficile*, renal insufficiency, urticarial drug eruptions, etc.) were not addressed. The rapid assay currently has limited availability in the United States, though that is changing. Finally, recent additional studies (unrelated to procalcitonin) have suggested shorter antibiotic treatment durations for patients with pneumonia.⁸

was 5 days versus 7 days in the control group (P less than .0001). Mortality at 28 days was 20% in the procalcitonin group and 25% in the control group ($P = .0122$). At 1 year, mortality was 36% in the procalcitonin group and 43% in the control group ($P = .0188$). The authors hypothesized that the unexpected decrease in mortality in the procalcitonin group may have been due to earlier consideration of alternative illness etiologies in patients with a low procalcitonin level or decreased antibiotic side effects.⁹

While the SAPS trial supports decreased antibiotic usage in ICU patients with the use of the procalcitonin assay, there are some important limitations. First, the trial was done in the Netherlands, where baseline antibiotic usage was comparatively low. Second, daily procalcitonin level monitoring was not continued for patients transferred out of the ICU while still on antibiotics. Further, guidelines for antibiotic discontinuation were nonbinding, and in many cases physicians did not stop antibiotics based on procalcitonin guidelines suggested by the study authors.



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Battling biases with the 5 Rs of cultural humility

By Aziz Ansari, Do, Fhm

How do we, as hospitalists, win the hearts and minds of patients, families, and care team members whom we do not know? What are the obstacles that we face when encountering patients and gaining the trust needed to improve patient care and patient experience?

With these questions in mind, the Cultural Humility Work Group, part of SHM's Practice Management Committee, set out to develop a simple, universal framework to provide a foundation for strengthening communication skills and raising awareness of the basic tenets of cultural humility. According to Tervalon and Murray-García, cultural humility is defined as a "process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners. It requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care, and it is a process that requires humility to develop and maintain mutually respectful and dynamic

partnerships with communities" (Tervalon, M., Murray-García, J. "Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education." *J Health Care Poor Underserved*. 1998;9[2]:117-25).

To begin, the work group set out to identify where the root of communication breakdowns lies. As we pulled the literature review together, the Sabin and Greenwald study (2011) reverberated with us. It concluded that a physician's implicit (or unconscious) attitudes and stereotypes are associated with treatment recommendations. Unconscious biases became the focal point of our project given the realization that treatment is being affected without many physicians even knowing it (*Am J Public Health*. 2012 May;102[5]:988-95).

How do we win this battle? The first step is to simply be aware that everyone is a victim of unconscious biases. Once we come to this (often uncomfortable) realization, we must make a conscious effort to change our mindset and make conscious decisions to not allow these biases to manifest.

Practicing cultural humility is extremely important in this process. It puts every-

one on the same platform because there is no "minority," "majority," or "ethnicity" associated with it. It takes away the need to know everything about a certain culture and encourages us to approach every patient encounter acknowledging that we will humble ourselves, learn what is important to the patient, and leave having learned something from the interaction.



Dr. Ansari

The work group developed "The 5 Rs of Cultural Humility" as a simple tool for hospitalists to incorporate into their practice. The first four Rs (Reflection, Respect, Regard, and Relevance) are extrinsically focused, while the 5th R (Resiliency) is intrinsic. Our theory posits that, if you attain the first 4 Rs in every interaction, these will serve to build on and develop your own personal resiliency. Here are the 5 Rs:

- **Reflection** – Hospitalists will approach every encounter with humility and understanding that there is always something to learn from everyone.
- **Respect** – Hospitalists will treat every person with the utmost respect and strive to preserve dignity at all times.
- **Regard** – Hospitalists will hold every person in their highest regard while being aware of and not allowing unconscious biases to interfere in any interactions.
- **Relevance** – Hospitalists will expect

cultural humility to be relevant to the patient and apply this practice to every encounter.

- **Resiliency** – Hospitalists will embody the practice of cultural humility to enhance personal resilience and globally focused compassion.

The content will be available as a downloadable pocket card that can be easily referenced on rounds and shared with colleagues. Our hope is to achieve heightened awareness of effective interaction. In addition to the definitions of each of the Rs, the card will feature questions to ask yourself before, during, and after every interaction to aid in attaining cultural humility.

The card will be printed and disseminated at Hospital Medicine 2017, and the 5 Rs will be discussed in a few sessions: "Making 'Everything We Say and Do' a Positive Patient Experience" in the Practice Management track on Thursday, May 4, and during a 20-minute "MEDtalk" in Product Theater 1 on May 3, at 10:15 a.m.

Keep on the lookout for future blog posts, where you'll read about the 5 Rs in action through vignettes and a deeper dive into each aspect.

For more information and the downloadable pocket card, visit www.hospitalmedicine.org/5Rs. **TM**

Dr. Ansari is associate professor and associate division director of hospital medicine at Loyola University Medical Center, Maywood, Ill., and serves on SHM's Cultural Humility Work Group.

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The Online Toolkit presents a Prognosis and Goals of Care Communication Pathway, which highlights key processes and suggests opportunities to integrate these into the daily workflows of hospitalist physicians to improve their skills to provide the best care for the seriously ill patient.

—Wendy Anderson, MD, MS

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ADDITIONAL READING

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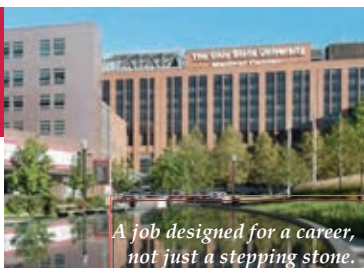
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The University of Texas Southwestern Medical Center, Department of Internal Medicine, Division of Hospital Medicine-University Hospitals, is seeking physicians to join a thriving academic hospital medicine program at the new William J Clements University Hospital. This state of the art facility is the flagship of UT Southwestern's clinical and educational programs in dynamic and cosmopolitan Dallas, Texas. Applicants must have an M.D. degree, or equivalent, from an approved LCME medical school and satisfactory completion of an Internal Medicine residency program from an ACGME accredited program. Level of appointment will be commensurate with experience. Candidate must be eligible for Texas medical licensure and be board certified in Internal Medicine.

Hospitalists will play a vital role in teaching medical students and house officers, as well as serving on non-teaching inpatient services. It is the intent of the Department of Internal Medicine that faculty in Hospital Medicine will set the standard for scholarship in patient care.

Both day and nocturnist interest welcomed.

Highlights of the position include

- Salaries which are competitive with private hospitalist groups in Dallas and exceed academic programs elsewhere
- Faculty appointment at a top 20 medical school and research center that is home to 5 Nobel Prize winners
- Relocation allowance
- 403 (b), 457 and state-matched retirement accounts
- Incentive bonus payments
- Team based approach with individual dedicated support
- Dedicated advanced practice providers, pharmacists and discharge planners

Qualified applicants should submit a cover letter, curriculum vitae, three (3) letters of reference, and a summary of professional goals to:

Jonathan Weissler, M.D.
c/o Larry Hughes
UT Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, TX 75390-9175
larry.hughes@utsouthwestern.edu

UTSouthwestern
Medical Center



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.

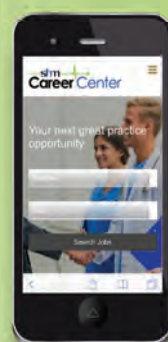
Interested candidates should submit their curriculum vitae, a brief letter outlining their interests and the names of three references to:

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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We are "Cape-able" at Cape Fear Valley Health System
Join One of the Oldest and
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We are seeking BE/BC Internal Medicine or Family Medicine providers for growth to a well-established Hospitalist Program. Staff positions and dual teaching opportunities are available in our newest residency program. Physician leadership with team leads and sub specialty support is available.

Our competitive benefits and compensation package includes:

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- Nocturnist Opportunities available
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- Relocation Package
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- Health, Dental, 403b and 457b match

Fayetteville is a vibrant, cosmopolitan Southern Community in North Carolina. We are one hour from Raleigh, an easy drive east to the beaches, and west to the mountains. Fayetteville offers big city amenities, low cost of living, regional airport making the location a plus!

Please Contact Cynthia Edelman, Physician Recruiter for more details at (910) 615-1888 or cedelman@capefearvalley.com



HOSPITALISTS & NOCTURNISTS

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

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

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



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HOSPITALIST

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

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

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



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

Successful candidates require the following:

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

For further consideration, please send your CV to:

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



Nocturnist Hospitalist Opportunity Hendersonville, NC (Near Asheville!)

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

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

No Recruitment or Placement Firm Inquiries.
No Visa sponsorship.

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

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.slhn.org

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



MOUNT AUBURN HOSPITAL

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

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

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

NOCTURNIST



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physicianrecruiter@billingsclinic.org
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Self Medical Group

Hospitalist & Nocturnist Beautiful Greenwood, SC

Based in Greenwood, SC, Self Medical Group is multi-practice, multi-specialty group is seeking a BE/BC Hospitalist and BE/BC Nocturnist for an expanding practice. Self Regional Healthcare is a 300 bed non-for-profit, DNV accredited facility providing a wide range of specialty services to our surrounding communities.

- Work a 7on/7off, 12 hour schedule with no call
- Excellent work-life balance with comfortable patient volumes
- Intensivist provides majority ICU care
- EPIC EMR 2018
- Competitive salary package and benefits including sign on bonus and student loan repayment
- Self Regional, a nine-time Gallup Great Workplace Award recipient (2008-2016)

About Greenwood, S.C.:

Just an hour from Columbia and Greenville, Greenwood, or as it is called the "Emerald City," offers a temperate climate, year-round golf and recreation and lakeside living at pristine Lake Greenwood. It is also home to the S.C. Festival of Flowers, a celebration of flora that features larger-than-life size topiaries during the month of June.

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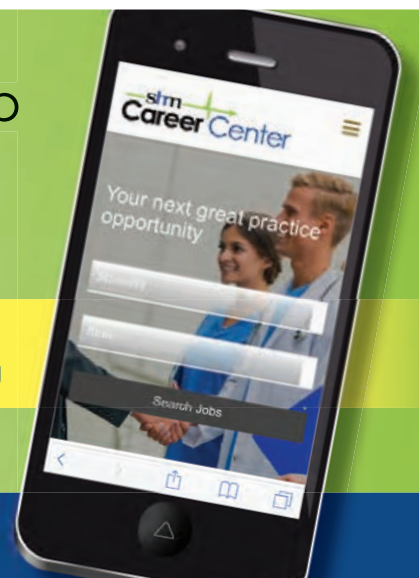
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- Flexible 7 days on/7 days off schedule
- Closed ICU
- Intensivists in-house
- Nocturnist coverage
- Extensive specialty backup



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

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- Full-time or part-time Hospitalist positions
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Employment Eligibility:

Must be Board Certified/Eligible in Internal or Family Medicine.

Contact: Navneet K Sharma, MD

Phone: 2676645742

E-mail: tricountyhospitalists@gmail.com

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Qualified candidates should submit a letter of interest and CV to Sr. In-House Physician Recruiter, Kendra Hall, kbhall@ghs.org, 800-772-6987.



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Highlights of the position:

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Joan Humphries | Manager, Physician Recruitment

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Hospitalists

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ACADEMIC NOCTURNIST HOSPITALIST

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

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

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

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

For additional information, please contact:

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



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



Bassett Healthcare Network
A.O. Fox Hospital

HOSPITALIST

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

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

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

EOE

For confidential consideration, please contact:

Debra Ferrari, Manager, Medical Staff Recruitment
Bassett Healthcare Network
phone: 607-547-6982; fax: 607-547-3651 or email:
debra.ferrari@bassett.org
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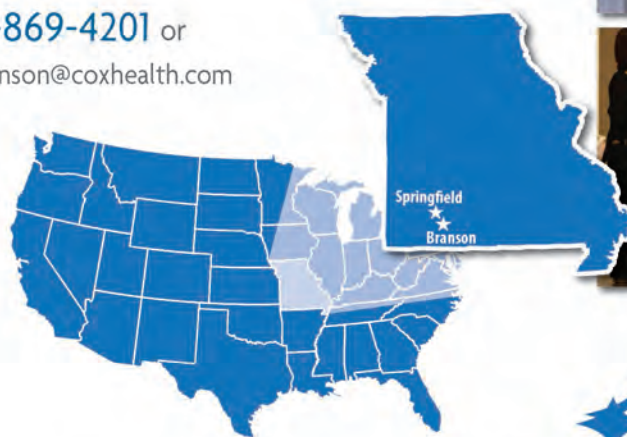
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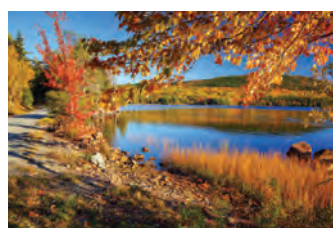
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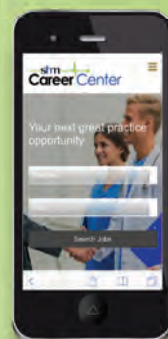
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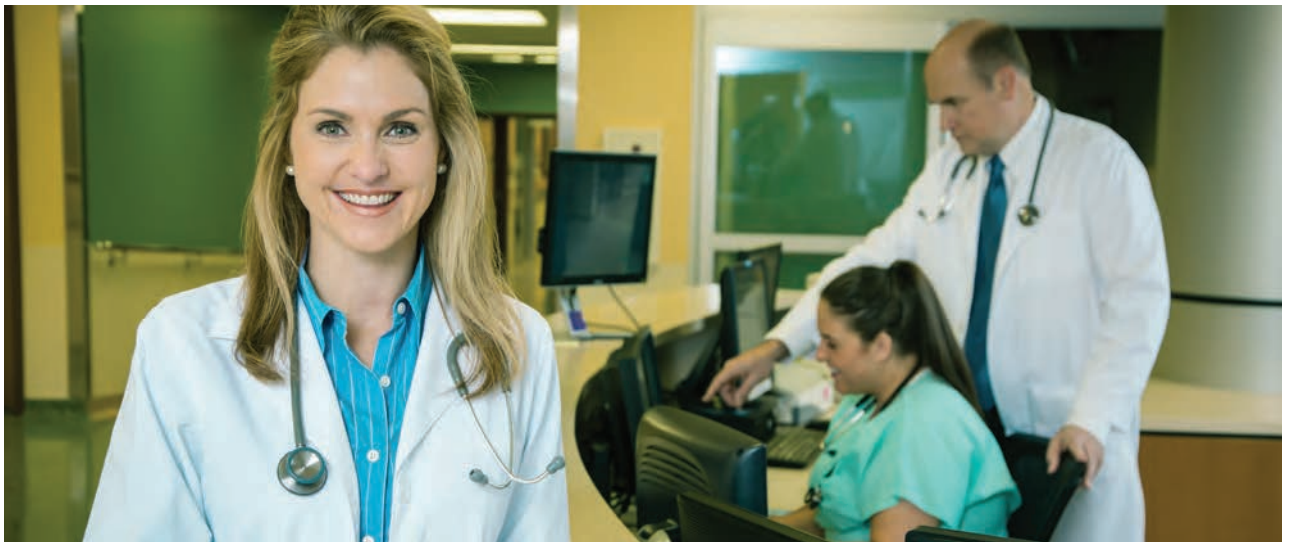
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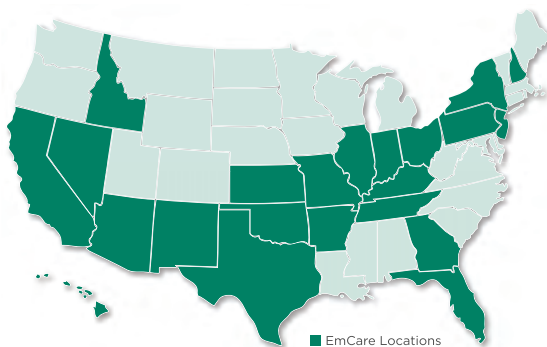
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Hospitalists: Leading health care innovation

I have never witnessed a health care movement quite like hospital medicine.

As I begin my year as SHM president, I continue to be energized by the opportunity to be part of an organization that has such a positive impact on our nation's health care system. From the beginning of my medical career to now, never have I witnessed a health care movement quite like hospital medicine.

Even when I first arrived in Southern California as a pulmonary/critical-care physician in 1987, there were groups of physicians who had taken financial risk on populations of managed-care patients and were paid using an "alternative payment model" called capitation. One of the innovations they had utilized since the early 1980s to successfully manage their risk – and their patients' – was to have dedicated inpatient physicians caring for their hospitalized patients 24/7, while most of their primary care partners managed the group's patients in the outpatient setting.

of these policies will result in groups of providers being pushed away from fee-for-service payment toward alternative payment models that involve higher levels of risk and opportunity. If we, as providers, are going to be successful in managing our "at risk" populations, we are going to have to be as innovative as our managed-care forefathers. If we are not, we, as a society, are not going to be able to afford to deliver high-quality care to our nation's sickest citizens.

At the center of much of this innovation will be hospitalists. After all, by its very nature, our model is a delivery system reform. The drive to deliver more efficient quality care is in the very DNA of our specialty.

As decisions are made, they will have a significant impact on our patients and our careers. It will continue to be a priority for SHM to make sure that the voice of hospital medicine is heard loud and clear. We

groups. These local chapters and these interest groups will fuel new ideas that will continue to improve our specialty and the effectiveness of the society to speak for hospital medicine with a strong voice.

Of course, SHM will continue to be the only organization that was created to represent our nation's hospitalists and will be totally committed to providing our members with clinical and administrative education, dedicated publications, leadership training, research opportunities, and advocacy. I look forward to serving you and helping you get the most from your SHM experience. Together, we will continue to move the hospital medicine movement forward, shaping our health care system and improving patient care. **TH**



Dr. Greeno is the incoming president of the Society of Hospital Medicine and senior adviser for medical affairs at TeamHealth.

In our attempts to further connect our members with others who share similar interests and focuses, we will be rolling out a new structure of special interest groups. These local chapters and these interest groups will fuel new ideas that will continue to improve our specialty and the effectiveness of the society to speak for hospital medicine with a strong voice.

These inpatient specialists were, without a doubt, the first hospitalists, even though the creation of the name came many years after the model was first used. By the early 1990s, more and more groups (including mine) in pockets around the country started delivering care using this model. By the second half of the decade, we had a name, an emerging national identity, and even a medical society to bring us together and represent us and the issues we care about. As our health care system continues to change, there is no specialty as well positioned as hospital medicine to evolve with it.

This year will see a continued reshaping of our delivery system, driven by emerging federal policy like the Medicare Access and CHIP Reauthorization Act (MACRA). All of this policy is designed to create a health care system that delivers high-quality care in a much more cost-effective way. Many

will continue to ask our members to ensure that the hospital medicine community has a prominent place in these conversations. Those who step up in this effort will lead us as we insist on having a prominent seat at the table and as new models of care emerge and new incentives are created for the provider community. We will continue to strive to make sure that our patients get the care they deserve and that we continue to help build a sustainable health care delivery system.

This year, you will also see a focused effort to strengthen SHM's system of state and local chapters. The vitality of these local organizations is important to our efforts to effectively serve our members by engaging them with their colleagues at the local level. In our attempts to further connect our members with others who share similar interests and focuses, we will be rolling out a new structure of special interest

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The growth of telehospitalist programs.



Dr. Scheurer is a hospitalist and chief quality officer at the Medical University of South Carolina in Charleston. She is physician editor of *The Hospitalist*. Email her at scheured@musc.edu.

Within hospital medicine, there has been a recent increase in programs that provide virtual or telehealth hospitalists, primarily to hospitals that are small, remote, and/or understaffed. According to a 2013 Cisco health care customer experience report, the number of telehealth consumers will likely markedly increase to at least 7 million by 2018.¹

Since telehospitalist programs are still relatively new, there are many questions about why and how they exist and how they are (and can be) funded. Questions also remain about some limitations of telehospitalist programs for both the “givers” and the “receivers” of the services. I tackle some of these questions in this article.

What is a telehospitalist?

A telehospitalist is a hospitalist who provides remote services to patients and providers in need of such services. These services can range from initial encounters, follow-up encounters, post-acute care visits, home visits, consultations, and emergency care.

What are the drivers of telehospitalist programs?

One primary driver of telehealth (and specifically telehospitalist) programs is an ongoing shortage of hospitalists, especially in remote areas and critical access hospitals where coverage issues are especially prominent at night and/or on weekends. In many hospitals, there is also a growing unwillingness on the part of physicians to be routinely on call at night. Although working on call used to be on par with being a physician, many younger-generation physicians are less willing to blur “work and life.” This increases the need for dedicated night coverage in many hospitals.

Another driver for some programs (especially at tertiary care medical centers) is a desire to more thoroughly assess patients prior to transfer to their respective centers (the alternative being a phone conversation with the transferring center about the patient’s status). There is also a growing desire to keep patients local if possible, which is usually better for the patient and the family and can decrease the total cost of their care.

Another catalyst to telehospitalist program growth is the growing cultural comfort level with two-way video interactions, such as Skype and FaceTime. Since videoconferencing has permeated most of our professional and personal lives, telehealth seems familiar and comfortable for both providers and patients. In a recent consumer survey, three out of every four consumers responded that they are very comfortable communicating with providers via technology, as opposed to seeing them in person.¹

Another driver for some programs is financial. Depending on the way the program is structured, it can be not only financially feasible but financially beneficial, especially if

the program can consolidate coverage across multiple sites (more on this later).

One other driver for some health care systems is the need to cover areas with on-site nurse practitioners and physician assistants. Using a telehospitalist makes it easier to get appropriate and required oversight for this coverage model across time and space.

What are the advantages of being a telehospitalist?

Some of the career advantages of being a telehospitalist include the shift flexibility and convenience. This work allows a hospitalist to serve a shift from anywhere in the world and from the convenience of their home. Some telehospitalists can easily work local night shifts when they live many time zones away (and therefore, don’t actually have to work a night shift). Many programs are designed to have a single hospitalist cover many hospitals over a wide geography, which would be logistically impossible to do in person. This is especially appealing for multihospital systems that cannot afford to have a hospitalist on site at each location.

The earning potential can also be appealing, depending on the number of shifts a hospitalist is willing to work.

What are the limitations of being a telehospitalist?

There are limits to what a telehospitalist can perform, many of which depend on the manner in which the program and the technology are arranged. Telehealth can vary from a cart-based videoconferencing system that is transported into a patient’s room to an independent robot that travels throughout sites. The primary limitation is the need to rely on someone in the patient’s room to act as virtual hands. This usually falls to the bedside nurse and requires a good working relationship and patience on their part. The bedside nurses have to “buy into” the program in advance and may need to have scripting for how to explain the process to the patients.

Another major challenge is interacting with different electronic health record systems. Becoming agile with a single EHR is challenging enough, but maneuvering several of them in a single shift can be extremely trying. Telehospitalists can also be challenged by technology glitches or failures that need troubleshooting both on their end and on-site. Although these problems are rare, there will always be a concern that the patient will not get his or her needs met if the technology fails.

How does the financing work?

Although this is a rapidly changing landscape, telehospitalists are not currently able to generate much revenue from professional billing. Unlike in-person visits, Medicare will not reimburse professional fees for telehospitalist visits. Although each payer is unique,

most other (nonMedicare) payers are also not willing to reimburse for televisits. This may change in the future, however, as Medicare does pay for virtual specialty services such as telestroke. In addition, many states have enacted telemedicine parity laws, which require private payers to pay for all health care services equally, regardless of modality (audio, video, or in person).

For now, the financial case for employing telehospitalists for most programs has to be made using benefits other than the generation of professional fees. For telehospitalist programs that can cover several sites, the cost is substantially less than employing individual on-site hospitalists to do low-volume work. Telehospitalist programs are also, likely, less costly than is locum tenens staffing. For programs that evaluate the need for transfers, a case can be made that keeping a patient in a smaller, low-cost venue, rather than transferring them to a larger, higher-cost venue, can also reduce overall cost for a health care system.

What about licensing and credentialing?

Telehospitalists can be hindered by the need to have a license in several states and to be credentialed in several systems. This can be cumbersome, time-consuming, and expensive. To ease the multistate licensing burden, the Interstate Medical Licensure Compact has been established.² This is an accelerated licensure process for eligible physicians that improves license portability across states. There are currently 18 states that participate, and the number continues to increase.

For credentialing, most hospitals require initial credentialing and full recredentialing every 2 years. Maintaining credentials at several sites can be extremely time consuming. To ease this burden, some hospitals with telehealth programs have adopted “credentialing by proxy,” which means that one hospital will accept the credentialing process of another facility.

What next?

In summary, there has been and will likely continue to be explosive growth of telehospitalist programs and providers for all the reasons outlined above. Although some barriers to efficient and effective practice do exist, many of those barriers are being overcome quite rapidly. I expect this growth to continue for the betterment of hospitalists, our patients, and the systems in which we work. **TH**

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1. Cisco. (2013 March 4). Cisco Study Reveals 74 Percent of Consumers Open to Virtual Doctor Visit. *Cisco: The Network*. Retrieved from <https://newsroom.cisco.com/press-release-content?type=webcontent&articleId=1148539>.
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On 15 years: Celebrating a nocturnist's career longevity



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

"Nocturnist years are like dog years. So really we're celebrating you for 105 years of service!"

Shawn Lee, MD, a day-shift hospitalist at Overlake Medical Center in Bellevue, Wash. (where I work), said this about our colleague, Arash Nadershahi, MD, on the occasion of his 15th anniversary as a nocturnist with our group. Every hospitalist group should be so lucky to have someone like Arash among them, whether working nights or days.

When Arash joined our group the job simply entailed turning on the pager at 9

ten 10-hour night shifts and two 6-hour evening shifts (5-11 p.m.) per month. I like to think this has contributed to longevity for our nocturnists. One left last year after working nights for 10 years, and another just started his 9th year in the group.

The three nocturnists can work any schedule they like as long as one of them is on duty each night. For more than 10 years they've worked 7 consecutive night shifts followed by 14 off (that is sometimes

The longest-tenured nocturnist?

At 15 years of full-time work as a nocturnist, Arash may be one of the longest-tenured doctors in this role nationally. (I would love to hear about others who've been at it longer.) I like to think that our "pay 'em the same and work 'em less" approach may be a meaningful contributor to his longevity in the role, but I'm convinced his personal attributes are also a big factor.

He seems to have pulled off a really good work-life balance. He is serious about his work, but has never pursued working extra shifts or moonlighting at another practice. Instead he takes full advantage of all of his



Dr. Nadershahi seems to have pulled off a really good work-life balance. He is serious about his work, but has never pursued working extra shifts or moonlighting at another practice. Instead he takes full advantage of all of his time off and immerses himself in family and personal interests such as racing vintage motorcycles and constantly tinkering with cars.

p.m. and coming in to the hospital only when the need arose. Some nights meant only answering some "cross-cover" calls from home, while other nights started with one or more patients needing admission right at the start of the shift.

As the months went by, patient volume climbed rapidly and Arash, as well as the nocturnists who joined us subsequently, began arriving at the hospital no later than the 9:00 p.m. shift start and staying in-house until 7 a.m. We never had a meeting or contentious conversation to make it official that the night shift changed to in-house all night instead of call-from-home. It just evolved that way to meet the need.

We all value Arash's steady demeanor, excellent clinical skills, and good relationships with ED staff and nurses as well as patients. And for many years he and our other two nocturnists have covered all night shifts, including filling in when one of them is unexpectedly out for the birth of a child, illness, or other reason. The day doctors have never been called upon to work night shifts to cover an unexpected nocturnist absence.

Configuring the nocturnist position

A full-time nocturnist in our group works

interrupted by an evening shift). To my way of thinking, though, they're essentially devoting 9 days to the practice for every seven consecutive shifts. The days before they start their rotation and after they complete it are spent preparing/recovering by adjusting their sleep, so aren't really days of R&R.

For this work their compensation is very similar to that of full-time day shift doctors. The idea is that their compensation premium for working nights comes in the form of less work rather than more money; they work fewer and shorter shifts than their daytime counterparts. And we discourage moonlighting during all those days off. We want to provide the conditions for a healthy lifestyle to offset night work.

On a regular basis, I talk with hospitalist groups lamenting their inability to find nocturnists willing to work the same number of hours and shifts as their day doctors, for little or no additional compensation. That is an exceptionally tough position to recruit to. Our goal has been for a day position and night position to be equally attractive to most candidates. Judging by how quickly we replaced a departing nocturnist last year, and our day doctors regularly talking about the merits of switching to night work, we may have gotten close to the goal.

time off and immerses himself in family and personal interests such as racing vintage motorcycles and constantly tinkering with cars.

His interests and creativity find their way into our workplace. For a while the day-shift doctors would arrive to find our office full of motorcycle parts in various stages of assembly. Many of his doodles and drawings and witty writings are taped to the walls and cabinets. A few years ago he started writing haikus and before long everyone in the group joined in. This even led to one of our docs hosting a really fun party at which every guest wrote haikus and all had to guess the author of each one.

Other groups can't count on finding someone as valuable as Arash, but they'll have the best chance of it if they think carefully about how the nocturnist role is configured. **TH**



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