HM17 is the Super Bowl of hospital medicine. It’s the only meeting dedicated to hospitalists, designed by hospitalists, and focused purely on issues important to hospitalists. This year, the Society of Hospital Medicine returns to Las Vegas, May 1-4, at Mandalay Bay Resort and Casino, with expectations of record-setting crowds and a comprehensive array of educational and networking opportunities. Inside, 7 pages of insights into what’s new this year, keynote speakers, and must-see sessions.
Dr. Nelson responds: Thanks for your message, Marci. It seems clear you’ve thought a lot about NPs and PAs in hospitalist practices and have arrived at conclusions that differ from what I wrote. Your voice and views are welcome. If you publish articles that show a positive finding yet allow and highlight opinion not backed by research, I would likely also be offended for taking their study and turning it into a “story.” EDUCATE yourselves. There are numerous studies out there showing care by APPs is cost effective, efficient, and with excellent care outcomes. There is a national group, APPex (Advanced Practice Provider Executives), that can give you all the studies you need.

I am a working hospitalist NP and appreciate my physician colleagues and have their respect. This “John” person obviously doesn’t respect APPs and to publish him is just disheartening. This publication could have and should have done better. You have one APP on your editorial advisory board — it appears you need more.

Correction

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

LETTERS TO THE EDITOR

Disappointment in article on NP, PA roles in HM groups

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

All,

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

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

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

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

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

From staff reports

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

The letter of recognition from Paul McGann, MD, Jean Moody-Williams, RN, MPP, and Dennis Wagner, MPA, of McGann, MD, Jean Moody-Williams, RN, MPP, and Dennis Wagner, MPA, of

the CMS, to Jenna Goldstein, MA, director of SHM’s Center for QI, and Kevin Vuernick, MPA, senior project manager, noted: “Over the last several years, our team has been privileged to partner with you and the Society of Hospital Medicine on the work of quality improvement and patient safety. Without relationships like these, the results in the reduction of patient harm we have seen at a national scale, saving 87,000 lives and nearly $20 billion in cost savings, would never have been possible.”

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

In August 2016, CMS’ Hospital Improvement Innovation Networks contacted SHM to participate in their weekly Partnership for Patients (PfP) Pacing Event webinar to present strategies for reducing opioid use and preventing adverse drug events, including SHM’s Mentored Implementation pilot program on Reducing Adverse Drug Events Related to Opioids (RADEO).

SHM’s contribution to this webinar was twofold: Thomas W. Frederickson, MD, the lead author of the RADEO guide and one of two program mentors, spoke about the development of the RADEO program and its importance in the acute care setting. Matthew Jared, MD, a hospitalist at St. Anthony Hospital in Oklahoma City, one of the five pilot RADEO sites, discussed his experience implementing specific RADEO interventions as well as the mentoring provided by Dr. Frederickson of the department of hospital medicine at CHI Health in Omaha, Neb.

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

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

For more information about SHM’s Center for QI, please visit www.hospitalmedicine.org/QI. For more information about SHM and hospital medicine, visit www.hospitalmedicine.org and follow SHM on Twitter at @SHMLive.
FHM designation symbolizes physician commitment to hospital medicine

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

By Felicia Steele

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

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

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

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

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

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

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

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

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

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

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

Ms. Steele is SHM’s communications coordinator.

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

By Brett Radler

Hospitalist specialty code becomes official designation

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

Assess your knowledge in hospital medicine with SPARK ONE

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

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

White paper now available: Hospitalist Attitudes Toward Electronic Medical Records

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

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

CONTINUED ON PAGE 10
This advertisement is not available for the digital edition.
By sharing these results, SHM hopes to raise awareness of the unacceptable performance of existing systems that contributes to slower-than-desired improvement in quality and safety as well as increasing provider frustration. SHM strongly believes that health care needs a renewed focus on initial goals of technology adoption. View the white paper at hospitalmedicine.org/EHR.

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

The SHM “speed mentoring” session, held on Tuesday, May 2 from noon to 1:00 p.m. at Hospital Medicine 2017, is designed to assist early-career hospitalists in specific areas of career development by providing a fresh perspective and rapid advice. Early-career hospitalists will be matched with three senior advisors by area of interest. The “mentee” will spend 10-15 minutes with each advisor and will then rotate to the next advisor. After the session, there will be time for additional informal discussion and networking among advisors and peers.

Pre-registration by March 31, 2017 is required; it will not be possible to register for this activity on-site at HM17. There is no additional fee to register. Registration will be limited to the first 20 participants. Visit hospitalmedicine2017.org/academic today.
Now available: 4 new antimicrobial stewardship modules

- SHM has developed four new antimicrobial stewardship modules to help you demonstrate an understanding of best practices to optimize and improve antimicrobial prescribing within your hospital:
  1. Optimizing Antibiotic Use for Hospitalized Patients
  2. Best Practices in Treatment of UTIs: “Low-Hanging Fruit”
  3. Best Practices in Acute Bacterial Skin Infection
  4. Antibiotic Use for Inpatient Respiratory Infections

View these resources at hospitalmedicine.org/abx.

Network with the largest gathering of pediatric hospital medicine professionals

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

PHM 2017 will be comprised of concurrent sessions featuring lectures and larger sessions, oral presentations of abstracts and clinical conundrums, and smaller, interactive workshops.

Acquire skills and knowledge from PHM experts, including peer-selected and nationally renowned leaders in the field of pediatric hospital medicine. To view the full meeting schedule and learn more, visit pediatrics.org.

Earn free CME in the enhanced SHM Learning Portal

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

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

Bringing SHM to you with local chapter meetings

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

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

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

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

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

Mr. Radler is Communications Specialist at the Society of Hospital Medicine.
Discussing advance care planning

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

By Mark A. Rudolph, MD, SFHM

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

What I Say and Do

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

Why I Do It

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

How I Do It

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

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

Key skills for optimal patient communications

Core principles: active listening, body language, empathy

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

Reference


Source: SHM’s Patient Experience Committee

CHECK OUT KEY COMMUNICATION TACTICS HIGHLIGHTED IN “Everything We Say and Do” at the-hospitalist.org.
What do you call a hospitalist focused on comanaging a single medical subspecialty?

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

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

The prevalence and diversity of specialty hospitalist positions suggests they can be readily arranged in ways that benefit and with which specialty. Although less than a quarter of groups responded to this question, we learned that a substantial portion of respondent groups employ such individuals (see Figure 1).

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

We look forward to tracking this area with subsequent surveys. Already, national meetings are developing for specialty hospitalists (for example, in oncology), and we see opportunities for specialty hospitalists to network through the Society of Hospital Medicine annual meeting and HMX online.

My prediction is for growth in the number of groups reporting the employment of specialty hospitalists, but only time will tell. Hospital medicine group leaders should consider both participating in the next SOHM survey and digging into the details of the current report as ways to advance the best practices for developing specialty hospitalist positions.

SHM’s Center for Quality Improvement (QI) is Your Partner in Quality and Patient Safety

The Center for QI’s mentored implementation programs are deployed in hundreds of hospitals and have been awarded in the past with the John M. Eisenberg Award. More recently, our program addressing opioid safety (RADEO) was recognized by CMS for its efforts to enhance patient safety.

We partner with academic institutions to support program development and implementation. We also provide solutions to address your QI-related challenges.

“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 hospital.”

- Eric Howell, MD, MHM

For more information on how to partner, please email thecenter@hospitalmedicine.org.
Kevi"...
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**Lucidity® is that choice.**

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

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

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

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

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Predicting 30-day pneumonia readmissions using electronic health record data

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

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

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

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

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

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

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

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

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*“Thracia” from The Big Picture: Gross Anatomy by David A. Morton, K. Bo Foreman, and Kurt H. Albertine, one of the thousands of illustrations and photographs found on AccessMedicine.
Physician reviews of HM-centric research

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

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

1 Antipsychotics ineffective for symptoms of delirium in palliative care

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

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

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

SETTING: Eleven Australian inpatient hospice or palliative care services.

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

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


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

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

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

STUDY DESIGN: Single-blind cluster randomized trial.

SETTING: Twenty-two nursing homes in North Carolina.

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

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


3 Readmission rates after passage of the hospital readmissions reduction program

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

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

STUDY DESIGN: Retrospective pre-post analysis.

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

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

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


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

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

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

STUDY DESIGN: Systematic review and meta-analysis.

SYNOPSIS: Thirty-nine trials were deemed eligible for inclusion in the meta-analysis. Twenty-five of these were prospective and 14 were retrospective. The overall incidence of deep vein thrombosis (DVT) and pulmonary embolism was 0.9% (across 20 studies) and 0.3% (across 19 studies), respectively. Pharmacologic prophylaxis overall reduced DVT incidence (0.5% vs. 1.2%; relative risk, 0.51; P = .03). Subgroup analysis demonstrated this was significant for abdominal/pelvic surgeries and with low molecular weight heparin. Six studies compared duration of stand-
and prophylaxis (10 days) with extended prophylaxis (4 weeks), with a lower VT rate in the extended group. Bleeding events were noted in 13 studies and pharmaco logic prophylaxis significantly increased bleeding risk (2.7% vs. 8%; RR 2.51; P less than .0001).

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


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

**SYNOPSIS:** Retrospective chart review.

**SETTING:** Academic tertiary care center.

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

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


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

**BY DAVID ECKER, MD**

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

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

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

**STUDY DESIGN:** Systematic review & meta-analysis.

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

**SYNOPSIS:** Twenty independent comparisons from 19 studies (1,550 physicians of any specialty, including trainees, were included. All reported burnout outcomes after either physician- or organization-directed interventions designed to relieve stress and/or improve physician perfor-
Based on available evidence, it is reasonable to utilize an alpha blocker as medical expulsive therapy in patients with larger ureteric stones.

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**PEDIATRIC HM LITERATURE**  |  By Carl Galloway, MD, FAAP

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

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

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

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

In 2014, the Joint Commission made the issue of alarm system safety and alarm fatigue a priority for hospitals.1 Multiple studies have been published addressing alarm fatigue in hospitalized adult patients, but this issue is less well studied in pediatrics, including little guidance on optimizing alarm parameters.

Widely used reference ranges and guides are based on limited evidence, primarily based on observational data in healthy outpatients or consensus data.

A 2013 study used vital sign data from hospitalized children to develop percentile curves for heart rate (HR) and respiratory rate (RR) and estimated that 54% of vital sign measurements in hospitalized children are out of range using currently accepted reference ranges.2 To safely decrease the number of out-of-range vital sign measurements resulting from current reference ranges, this study used data from non–critically ill hospitalized children to develop HR and RR percentile charts, and then performed retrospective safety analysis by evaluating effects of modifying the alarm limits on identification of cardiopulmonary arrests (CRA) and rapid response team (RRT) activations.

**STUDY DESIGN:** Retrospective, cross-sectional study.

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

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

The training set used 62,508 vital sign measurements for 7,202 patients to calculate percentiles for HR and RR among 14 different age groups. The validation set consisted of 82,993 vital sign measurements for 2,287 patients. Using the 5th and 95th percentiles for HR and RR resulted in 24,045 (55.6%) fewer out-of-range measurements in the validation set compared to NIH reference ranges (45% fewer HR values, 61% fewer RR values). This finding, as well as the vital sign percentile ranges, was consistent with the data published in the 2013 study.1

Data for all 148 out-of-ICU RRT and CRA events during the same time period were reviewed using manual chart review. Evaluating vital signs within the 12 hours preceding the events, 144 patients had out-of-range HR or RR measurements using NIH ranges. One hundred thirty-six (86.4%) of these 144 patients also had out-of-range measurements using the study-derived 5th and 95th percentile values.

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


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**References**


2. Boniface CP, Brady PW, Keen R, Conway PH, Maradei K, Dayeend CF. Development of heart and respiratory rate percentile curves for hospitalized children. Pediatrics. 2013;131(4):e1150-1157. Dr. Galloway is a pediatric hospitalist at Sanford Children’s Hospital in Sioux Falls, S.D., assistant professor of pediatrics at the University of South Dakota Sanford School of Medicine, and vice chief of the division of hospital pediatrics at USD SSOM and Sanford Children’s Hospital.
Hospitalists can help enlist patients in the movement toward improved patient safety, and they can begin simply by sharing their notes. OpenNotes offers a new platform to do that, according to a BMJ Quality & Safety article, “A patient feedback reporting tool for OpenNotes: implications for patient-clinician safety and quality partnerships.”

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

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

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

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

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

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

**Reference**


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**QUALITY**

Create hospitalist-patient partnerships for safety and quality

Study reports sharing tool strengthens relationships, improves safety

**Hospitalists seek tools for more efficient admissions**

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

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

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

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

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

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

**Reference**


TECHNOLOGY

Enlisting social networks for better health outcomes

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

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

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

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

Moving up the ladder, a hospitalist might help set up a network of other patients with heart failure, so that they can help each other in a kind of peer mentorship. “These peer-to-peer connections might require Web-based platforms or social support groups, so that kind of activity is a lot more complicated, but the general theme is: Can hospitalists think about ways to constructively engage the social networks that already surround patients, so they don’t need to invoke the health system to do it?”

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

Reference

QUICK BYTE

ACA jump-starts 61,000 demo projects

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

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

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

Reference

Consider apps for better patient health

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

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

“Patient-facing mobile health applications (mHealth apps) – those intended for use by patients to manage their health – have the potential to help high-need, high-cost populations manage their health, but gaps remain.”

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

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

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

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

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

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

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

Reference

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

22 THE HOSPITALIST I APRIL 2017 I www.the-hospitalist.org
There is only one annual meeting dedicated to hospitalists, designed by hospitalists, and focusing purely on issues important to hospitalists. But even that isn’t enough to make sure more hospitalists show up every year.

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

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

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

That’s an unlikely complaint this year.

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

“We’re really excited to be able to offer more clinical content,” said HM17 course director Lenny Feldman, MD, FAAP, FACP, SFHM. “One of our top priorities on the planning committee is to create a diversity of topics.”

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

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

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

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

“Training our hospitalists to use the best diagnostic reasoning in their approach to their patients is a big push in hospital medicine right now,” Dr. Feldman said. “Hopefully, a track on that topic will excite people who love thinking about medicine, who got into medicine because of the mystery and the roll of the Affordable Care Act and what that could mean for access to care. "But that says something about the content that’s being delivered, but that’s not very comfortable for folks who want to sit comfortably for folks who want to sit on floors or gathered to eavesdrop on doorways. "That says something about the content that’s being delivered, but that’s not very comfortable for folks who want to sit comfortably for folks who want to sit on floors or gathered to eavesdrop on doorways. 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The future of health care policy

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

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

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

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

“I would view it as an opportunity as well,” said Dr. Conway, who still moonlights as a chief medical officer. “Everyday, trying to find more efficient, everybody’s working and innovating in ways that, while important, are more the issues that, while important, are more the predictable path. Not that that path didn’t include a ton of change, but at least it was a predictable path.”

He retained the top post at CMS while President Donald J. Trump’s nominee to lead the agency, Seema Verma, awaited a confirmation hearing before the U.S. Senate. Dr. Conway’s prior title was principal deputy administrator and CMS chief medical officer.

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

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

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

“They’re now in a feedback loop where we can say — ‘When we’ve built a care system like this or when we pay this way, we are actually seeing improved outcomes’ — and change doesn’t take as long,” Dr. DeSalvo said.

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

“I want to leave people with the idea that value-based payment innovation and delivery system reform will continue to be critical aspects of improving U.S. health care.”

Adapting to change: Dr. Robert Wachter

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

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

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

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

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

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

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

“The business model for hospitals will be massively challenged, and it could get worse if a lot of your patients lose insurance or their payments go down,” he said. But if the past decade of Dr. Wachter’s insights delivered at SHM annual meetings are any indication, his message of trepidation and concern will end on a high note.

The veteran doctor in him says “don’t get too distracted by all of the zigs and zags,” The utopian political in him says “don’t ever forget the core values and imperatives remain.” Perhaps that really is what happens when a political science major becomes an academic physician.
HM17’s “must-see sessions”

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

N ot to sound like a Sin City come on, but pick a course, any course.

No, seriously.

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

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

The committee does its job to fill the meeting with best-in-class educational sessions.

Now allow The Hospitalist’s physician editors and volunteer editorial board do their. Here are some of the group’s recommendations for this year’s meeting:

1. The Hospitalist’s Role in the Opioid Epidemic
   Tuesday, May 2; 1:35 p.m. - 2:35 p.m.

2. Opioids for Acute Pain Management in the Seriously Ill – How to Safely Prescribe
   Wednesday, May 3; 2:50 p.m. - 3:30 p.m.

3. Non-opiate Pain Management for the Hospitalist
   Wednesday, May 3; 4:20 p.m. - 5 p.m.

4. Focus on POCUS – Introduction to Point-of-Care Ultrasound for Pediatric Hospitalists
   Tuesday, May 2; 10:35 a.m. - 11:35 a.m.

5. Things We Do for No Reason in Pediatrics
   Wednesday, May 3; 11 a.m. - noon

6. Foundations of a Hospital Medicine Telemedicine Program
   Wednesday, May 3; 4:15 p.m. - 5:20 p.m.

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

CONTINUED ON PAGE 29

SHM to honor new Fellows, Award winners

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

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

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

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

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

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

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

The 2017 Award winners include:

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

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

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

Dr. Arora
Dr. Kealey
Dr. Slataper

PHOTOS: COURTESY OF SHM

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WHAT'S NEW

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

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

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

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

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

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

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

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

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Networking: A skill worth learning

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

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

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

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

Mr. Misner is really good at networking.

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

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

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

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

The mindset is making sure one’s approach doesn’t feel artificial,” Mr. Misner said. “A lot of people, when they go to some kind of networking environment, they feel they like they need to get a shower afterward and think, ‘Ick, I don’t like that.’”

“If the best way to become an effective networker is to go to networking events with the idea of being willing to help people and really believe in that and practice that, I’ve been doing this a long time and where I see it done wrong is when people use face-to-face networking as a cold-calling opportunity.”

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

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

But even when a relationship gets stuck early on, networking must be more than a few minutes at an SHM conference, a local chapter mixer, or a medical school reunion. It’s the follow-up that makes all the impact. Mr. Misner calls that process 24/7/30.

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

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

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

Richard Quinn is a freelance writer in New Jersey.
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—Mr. Miser

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

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

“...It’s not what you know or who you know that really counts,” he added. “And meeting people at events like HM17 is only the start of the process. It’s not the end of the process by any means, if you want to do this well.”

### MUST-SEE SESSIONS

#### 7 Hot Topics in Health Policy for Hospitalists
**Thursday, May 4; 7:40 a.m. - 8:35 a.m.**

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

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

#### 9 Healthcare Payment Reform for Hospitalists 2017: Tips for MIPS and Beyond
**Thursday, May 4; 9:50 a.m. - 10:45 a.m.**

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

### WORKSHOP: Hospitalists as Leaders in Patient Flow and Hospital Throughput
10 a.m. - 11:30 a.m.

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

### COURSE LEGEND

- **Clinical Update**
- **Practice Management**
- **Academic/Research**
- **High-Value Care**
- **Pediatric**
- **Diagnostic Reasoning**
- **Polypharmacy**
- **Co-Management Perioperative Medicine**
- **On Demand**
- **Repeatability Session**
- **MOC Credit**
RIV: Always a highlight

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

But inevitability has nothing to do with it, said Margaret Fang, MD, MPH, FHM, and program chair for HM17’s scientific abstracts competition, RIV’s more formal sobriquet. “Certainly, there is some natural evolution,” said Dr. Fang, a hospitalist, researcher, and anticoagulation clinic director at the University of California San Francisco. “But not all specialty societies embrace research or encourage its growth, so I would give a lot of credit to the Society of Hospital Medicine for being very deliberate in trying to strengthen its research program, highlight the research that hospitalists do, and make research a core pillar of what SHM stands for.”

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

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

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

HM17 course director Lenny Feldman, MD, FAAP, FACP, SFHM, believes that the commitment of SHM’s founding generation to do research for the past decade has created a group of mentors that push younger hospitalists to do more of the same. “If we didn’t have the research engine part of hospital medicine, if we didn’t have the folks who are getting into administration and other important leadership areas, we wouldn’t see the maturation of this specialty and we would in many ways be stuck at the point at which we started,” Dr. Feldman said. “The only way for us to move forward is to do the research, to be in position to make sure that hospital medicine continues to grow in a direction that is good for our patients, and for us and for the entire system.”

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

The annual RIV abstracts competition is larger in 2017 than ever before.
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![Northwestern Medicine Lake Forest Hospital](image)

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- http://go.osu.edu/hospitalmedicine
- hospitalmedicine@osumc.edu
- 614/366-2360

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

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**Contact**
- Paul Tesoriere, MD
  - PITESORI@sentara.com

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HOSPITALISTS & NOCTURNISTS

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

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For more details, contact: Department Chair Jerome Sy, M.D., SFHM. For more details, contact: Department Chair Jerome Siy, M.D., SFHM.

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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 of 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
Noksoka@upmc.edu
Fax 412 692-4825
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We are also recruiting for a Nocturnist that is open to work 10-14 nights per month with flexible schedule. Working with the support of House staff of NP/PA and covering Hospitalist service only.

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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 at Penn State College of Medicine and will be responsible for the care of 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 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.

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Successful candidates require the following:
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• Completion of an accredited Internal Medicine Residency program
• Eligibility to obtain 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.

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

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

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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 of 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, 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.

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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 Gellen, MD — Director, Hospitalist Medicine
Penn State Milton S. Hershey Medical Center
c/o Heather Peffley, PHR FASPR — Physician Recruiter
hpelfley@hmc.psu.edu

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Hospitalist/Nocturnist Opportunities
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We are currently recruiting BC/BE Hospitalist/Nocturnist to join our division of approximately 20 physicians to cover inpatient services at both our Cambridge and Everett campuses. This position has both day and night clinical responsibilities. Ideal candidates will have FT (will consider PT), patient centered, possesses excellent clinical/communication skills and demonstrate a strong commitment to work with a multicultural, underserved patient population. Experience and interest in performing procedures, as well as resident and medical student teaching is preferred. All of our Hospitalists/Nocturnists hold academic appointments at Harvard Medical School.

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

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- Board Certified in IM or FP
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A.O. Fox Hospital

HOSPITALIST

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For confidential consideration, please contact:
Debra Ferrari, Manager, Medical Staff Recruitment Bassett Healthcare Network phone: 607-547-6882; fax: 607-547-3651 or email: debra.ferrari@bassett.org

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To apply for this position, please visit the MU web site at hrs.missouri.edu/find-a-job/academic/. For additional information about the position, please contact Syed Naqvi, Director, Division of Hospital Medicine (naqvi@health.missouri.edu). Active review of applications will begin immediately, and the search will continue until the position is filled.

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Hospitalist or Nocturnist
Montgomery County, PA

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• On-site medical directors
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Dr. Du Smits, Director
Daniel Mowry, Physician Services Coordinator/Recruiter for Medicine
Phone: 404-778-7726
daniel.mowry@emoryhealthcare.org

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Join our Hospital Medicine Team in Kentucky!

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

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

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

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

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

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

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

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

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

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

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

4 Define our stance regarding specialty recognition: The complexities of this issue are political as well as logistical.
SHM has continued to build out the infrastructure for Recognition of Focused Practice with the launch of SPARK ONE (our Focused Practice in Hospital Medicine exam preparation product), but the gaps between the curricula of internal medicine and family medicine residencies, and our daily clinical realities, will continue to exist for the foreseeable future. Pediatrics has established a board requirement for pediatric hospital medicine, but it is still unclear if this is the future of adult hospital medicine.

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

I look forward to continuing to serve an active role in SHM, an organization that can provide you with those same opportunities and resources to help you grow, evolve, and be an active participant in the hospital medicine movement.
An abbreviated, step-by-step guide to your next job move

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

The steps below are recommendations to make this process smoother.

STEP 1: Determine how you are leaving the practice and your proposed timeline
Before anything else, you should decide how you are leaving your practice. Are you leaving the practice of medicine altogether, or are you simply leaving your current position for a different position elsewhere? This distinction will dictate what steps are necessary. Timing is also critical when leaving a practice, as it will dictate what steps should be taken and when. Having specific but realistic goals is imperative. Select a goal date for leaving the practice, but be aware that this goal may need to be adjusted.

STEP 2: Create your team of advisers
Whether you are leaving your current practice or transitioning to a different position, it is extremely important to have the right individuals on your team. You should consider enlisting an attorney, a financial adviser, and an accountant to help facilitate the process. Enlisting lawyers with certain areas of expertise, such as in the areas of employment restrictive covenants, health care, or tax, may also be extremely beneficial and helpful throughout the process.

STEP 3: Review your current employment agreement
It is quite likely that at the onset of your current employment arrangement, you signed an employment agreement with your hospital or group. You will want to carefully review this agreement, as it may contain provisions that can affect the steps you should take before you leave your current practice and work elsewhere. These provisions include the following:

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

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

STEP 4: Licensure obligations
To comply with licensure requirements on your behalf, you will want to determine the license obligations in the state you practice. If you are leaving your hospital job to work in another state, you will want to determine whether you need to become licensed in that new state. If you are transitioning into a nonmedical role, you will want to determine whether you have to change your license status in the state where you are licensed.

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

STEP 5: Discuss your transition with your insurance representative
Even after you leave your current practice, you may be exposed to litigation for services you provided while you were employed or otherwise retained by such practice. To ensure that you are protected, discuss your insurance policy with your insurance representative. Review whether your insurance policy is “occurrence” or “claims-made.” If you have an occurrence policy, you are protected from covered incidents that occur during the policy period, regardless if your policy is still in existence. Claims-made policies provide coverage for claims only where both the incident and the claim occur during the policy period. For example, if you cancel your policy on March 1, and are sued on April 1 for an incident that allegedly occurred on Feb. 1, your claims-made insurance policy will not protect you. Therefore, it is important to analyze your policies to determine if tail insurance is needed.

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

Hospitalists should understand who is in, and the selection criteria

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

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

Postacute care network selection criteria

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

A few caveats regarding specific selection criteria:

*Star ratings on Nursing Home Compare*

These are derived from nursing staffing ratios, health inspections, and 16 quality measures.

More than half of the quality measures pertain to long-stay residents who typically are not in the ACO or bundled payment program for which the network was created.

*SNF length of stay*

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

*What about patient choice?*

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

*What role should hospitalists play in network referrals?*

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