Experts bring clarity to end-of-life difficulties

Understanding family perspective is an important factor

By Thomas R. Collins

A Vietnam veteran steered clear of the health care system for years, then showed up at the hospital with pneumonia and respiratory failure. He was whisked to the intensive care unit, and cancerous masses were found.

The situation – as described by Jeffrey Frank, MD, director of quality and performance at Vituity, a physician group in Emeryville, Calif. – then got worse.

“No one was there for him,” Dr. Frank said. “He’s laying in the ICU; he does not have the capacity to make decisions, let alone communicate. So the care team needs guidance.”

Too often, hospitalists find themselves in confusing situations involving patients near the end of their lives, having to determine how to go about treating a patient or withholding treatment when patients are not in a position to announce their wishes. When family is present, the health care team thinks the most sensible course of treatment is at odds with what the family wants to be done.

At the Society of Hospital Medicine 2019 Annual Conference, hospitalists with palliative care training offered advice on how to go about handling these difficult situations, which can sometimes become more manageable with certain strategies.

For situations in which there is no designated representative to speak for a patient who is unresponsive – the so-called “unbefriended patient” or

Continued on page 6
The QI pipeline supported by SHM Student Scholar Grants

By Emily Gottenborg, MD, and Ashley Duckett, MD, FHM

A
s falls arrive, new interns are rapidly gaining clinical confidence, and residency recruitment season is ramping up. It’s also time to announce the opening of the Society of Hospital Medicine’s Student Hospitalist Scholar Grant Program applications. We are now recruiting our sixth group of scholars for both the Summer and Longitudinal Programs.

Since its creation in 2015, the grant has supported 23 students in this incredible opportunity to allow trainees to engage in scholarly work with guidance from a mentor to better understand the practice of hospital medicine and to further grow our robust pipeline.

The 2018-2019 cohort of scholars, Matthew Fallon, Philip Huang, and Erin Rainosek, have just recently concluded their projects and are currently preparing their abstracts for submission for Hospital Medicine 2020, where there is a track for Early-Career Hospitalists.

The projects targeted a diverse set of domains, including improving upon the patient experience, readmission quality metrics, geographic cohorting, and clinical documentation integrity – all highly relevant topics for a practicing hospitalist.

Matthew Fallon collaborated with his mentor, Venkata Andukuri, MD, at Creighton University School of Medicine in Omaha, Neb., to reduce the rate of hospital readmission for patients with heart failure, by analyzing retrospective data in a root-cause analysis to identify factors that influence readmission rate, then targeting those directly. They also integrated the patient experience by seeking out patient input as to the challenges they face in the management of their heart failure.

Philip Huang worked with his mentor, Ethan Kuperman, MD, at the Carver College of Medicine, University of Iowa, to improve geographic localization for hospitalized patients to improve care efficiency. They worked closely with an industrial engineering team to create a workflow model integrated into the hospital EHR to designate patient location and were able to better understand the role that other professionals play in improving the health care delivery.

Finally, Erin Rainosek teamed up with her mentor, Luci Leykum, MD, at the University of Texas Health Science Center at San Antonio, to apply a design thinking strategy to redesign the health care experience for hospitalized patients. She engaged in over 120 hours of patient interviews and ultimately identified key themes that impact the experience of care, which will serve as target areas moving forward.

The student scholars in this cohort gained significant insight into the patient experience and quality issues relevant to the field of hospital medicine. We are proud of their accomplishments and look forward to their future successes and careers in hospital medicine.

If you would like to learn more about the experience of our scholars this past summer, they have posted full write-ups on the Future Hospitalist RoundUp blog in HMX, SHM’s online community.

For students interested in becoming scholars, SHM offers two options to eligible medical students – the Summer Program and the Longitudinal Program. Both programs allow students to participate in projects related to quality improvement, patient safety, clinical research, or hospital operations, in order to learn more about career paths in hospital medicine. Students will have the opportunity to conduct scholarly work with a mentor in these domains, with the option of participating over the summer during a 6- to 10-week period or longitudinally throughout the course of a year.

Discover additional benefits and how to apply on the SHM website. Applications will close in late January 2020.

Dr. Gottenborg is director of the Hospitalist Training Program within the Internal Medicine Residency Program at the University of Colorado. Dr. Duckett is assistant professor of medicine at the Medical University of South Carolina.
Unit-based rounding in the real world

By Tresa Muir McNeal, MD, FACP, SFHM

Many hospitalists agree that their most productive and also sometimes least productive work can happen in the setting of interdisciplinary rounds. How can this paradox be true?

Most hospitals strive to assemble the health care team every day for a brief discussion of each patient’s needs as well as barriers to a safe/ successful discharge. On most floors this requires a well-choreographed ‘dance’ of nurses, case managers, social workers, physicians, and advanced practice providers coming together at agreed-upon times. All team members commit to efficient synchronized swimming through the most high-yield details for each patient in order to benefit the patients and families being served.

Of course, there are always challenges to this process in the unpredictable world of patients with acute needs. One variable that is at least partially controllable and tends to promote a more cohesive interdisciplinary experience is that of hospitalist unit-based rounding.

The 2018 State of Hospital Medicine (SoHM) survey reveals that 68% of hospital medicine groups serving adults with greater than 30 physicians employ some degree of unit-based rounding; this trend decreases with smaller group size. About 54% of academic hospital medicine groups use some amount of unit-based rounding. Not surprisingly, smaller hospital medicine groups are less likely to have this routine, likely because they cover fewer total nursing units.

One of the most obvious benefits to unit-based rounding is that the physician or advanced practice provider is more reliably able to participate in the interdisciplinary discussions that day. When more of the team members are at the table each day, patients and families have the best chance of hearing a consistent message around the treatment and discharge plans.

There are challenges to unit-based rounding as well. If patients transfer to different floors for any variety of reasons, strict unit-based rounding may increase handoffs in care. If a hospital has times when it isn’t completely full and nursing units have a varying percentage of being occupied, strict unit-based rounding can cause significant workload inequities among physicians on different units, depending on numbers of patients on each unit.

If there is no attempt at unit-based rounding in larger hospitals, some physicians may be running among five or more units. They work to find different care managers, nurses, and pharmacists – not to mention the challenges of catching patients in their rooms between their departures for diagnostic studies and procedures.

It is often good to balance the benefit of promoting unit-based rounds with the reality of everyday patient care. Some groups maintain that the physician/patient relationship trumps the idea of perfect unit-based rounding. In other words, if a physician establishes a relationship with a patient while they are in the ED being admitted or boarding from overnight, that physician will continue seeing the patient regardless of the patient being assigned to a different unit. It can help for groups to agree that the pursuit of unit-based rounding may create some inequity in the numbers of patients seen each day because of these issues.

In a larger hospital, certain units are often dedicated to specialty care. While most hospitalists want to maintain general medical knowledge, there are some who may enjoy having portions of their practice devoted to perioperative medicine or cardiac care. For instance, this promotes familiarity among hospitalists and groups of consultant physicians and nurse practitioners/physician assistants. Over time this allows for enhanced teamwork among those physicians, the nursing team, and the specialty physicians.

Depending on the group’s schedule, patients can be reassigned coinciding with the primary change of service day. This resets the physicians’ patients in the most ideal unit-based way on the evening prior to the first day of rounding for that week or group of shifts.

No matter how you do it, the goal of unit-based rounding is time efficiency for the care team and care coordination benefits for patients and families. If you have other suggestions or questions, go online to SHM HMX to join the discussion.

Take-home message: Unit-based rounding likely has its benefits. Don’t let the inability to achieve perfection in patient distribution to the physicians each day lead to abandonment of attempting these processes.

Choosing Wisely® and its impact on low-value care

By Moises Auron, MD, SFHM

It is a well-known fact that health care expenditure in the United States occupies a large proportion of its gross domestic product. In fact, it was 17.8% in 2016, almost twice what is expended in other advanced countries. However, this expenditure does not necessarily translate into optimal patient outcomes.

In 2012, the Institute of Medicine reported that the U.S. health care system wastes $750 billion per year in spending that does not provide any meaningful outcome to patients or the system; and patients can also suffer a financial impact from the delivery of low-value care.

In 2013, the Pediatrics Committee of the Society of Hospital Medicine published five recommendations through the Choosing Wisely® campaign aimed to decrease the use of low-value interventions. These recommendations were:

1. Do not order chest radiographs (CXR) in children with asthma or bronchiolitis.
2. Do not use systemic corticosteroids in children aged under 2 years with a lower respiratory tract infection.
3. Do not use bronchodilators in children with bronchiolitis.
4. Do not treat gastroesophageal reflux in infants routinely with acid suppression therapy.
5. Do not use continuous pulse oximetry routinely in children with acute respiratory illness unless they are on supplemental oxygen.

This publication led to the implementation of quality improvement initiatives across different hospitals and institutions nationally. Eventually, a team of hospitalists developed a report card that could help measure the utilization of these interventions in hospitals that were part of the Children’s Hospital Association (CHA). The data stemming from the report card analysis would allow for benchmarking and comparing performance, as well as determining the secular trend in utilization of these procedures across the different institutions of the CHA.

Reyes et al. recently published the impact of utilization of these scorecards among all hospital members of the CHA in the Journal of Hospital Medicine, noting a positive impact of the SHM Choosing Wisely® recommendation in decreasing the utilization of low-value interventions. The

Continued on following page
Have lower readmission rates led to higher mortality for patients with COPD?

By Christopher Moriates, MD, SFHM

There is at least one aspect of ‘Obamacare’ that my mother-in-law and I can agree on: Hospitals should not get paid for frequent readmissions. The Hospital Readmission Reduction Program (HRRP), enacted by the Centers for Medicare & Medicaid Services in 2012 with the goal of penalizing hospitals for excessive readmissions, has great face validity and noble intentions. Does it also have a potentially disastrous downside?

The HRRP has been a remarkable success. It moved the national needle significantly on readmission rates. There are some caveats about increases in observation status patients and other shifts that could account for some of the difference, but it is fairly uncontroversial that, overall, there are fewer 30-day readmissions across the country following initiation of HRRP. That is encouraging evidence of the positive impact that policy can make to drive changes for specific targets.

However, there is also a more controversial side. A number of studies have suggested reductions in readmission rates may have been associated with an increase in mortality in some patient groups. You discharge a patient and hope they won’t return to the hospital, but perhaps you should be more careful what you actually wish for.

Overall, the evidence of an association between readmissions and mortality has been conflicting. Headlines have alternately raised alarm about increased deaths and then reassured that there has been no change or perhaps even some concordant improvements in mortality. Not necessarily surprising: These studies are all of observational design and use different criteria, datasets, and analytic models, which drive their seemingly conflicting results.

An article published recently in the Journal of Hospital Medicine examined the potential association between changes in rates of chronic obstructive pulmonary disease (COPD) readmissions and 30-day mortality following HRRP introduction. While the initial HRRP program and subsequent analyses included patients with heart failure, acute MI, and pneumonia, the program was extended in 2014 to include patients with COPD. So, what happened in this patient group?

The researchers seem to have found some important insights:

- The all-cause 30-day risk-standardized readmission rate declined from 2010 to 2017.
- The all-cause 30-day risk-standardized mortality rate increased from 2010 to 2017, and the rate of increase in mortality appears to be accelerating.
- Hospitals with higher readmission rates prior to COPD readmission penalties had a lower rate of increase in mortalities.
- Hospitals that had a larger decrease in readmission rates had a larger rate of increase in mortality.

These researchers could not evaluate data at the patient level and could not adjust for changes in disease severity. However, taken together, these findings suggest something bad may be happening here.

The authors note that the associations with increased mortality have largely been seen in patients with heart failure – and now COPD – which are chronic diseases characterized by exacerbations, as opposed to acute MI and pneumonia, which are episodic and treatable. Perhaps in those types of disease, efforts to avoid readmissions may be more universally helpful. Maybe.

I find it concerning that there is “biological plausibility” for this association. Hospitals know exactly how this might have happened. Have you heard of pop-up alerts that fire in the ED to let physicians know that this patient was discharged within the past 30 days? That alert is not meant to tell you what to do, but you might want to consider trying to discharge them or place them in observation – use your clinical judgment, if you know what I mean.

Within the past decade, observation units quickly cropped up all over the country, often not staffed by hospitalists nor cardiologists, where patients with decompensated heart failure, chest pain, and/or COPD, can be given Lasix and/or nebulizer treatments – at least just enough to let them walk back out that door without an admission.

As Ashish Jha, MD, wrote in 2018, “Right now, a high-readmission, low-mortality hospital will be penalized at 6-10 times the rate of a low-readmission, high-mortality hospital. The signal from policy makers is clear – readmissions matter a lot more than mortality – and this signal needs to stop.”

Dr. Moriates is the assistant dean for health care value at Dell Medical School at the University of Texas, Austin. This article first appeared on the Hospital Leader, SHM’s official blog, at hospitalleader.org.

December 2019 4 The Hospitalist

Continued from previous page

authors compared the performance before and after the publication of the recommendations for a 9-year period (2008-2017). The most relevant impact occurred in children with bronchiolitis, with a decrease of 36% of bronchodilator use and of 31% in CXR utilization. In children with asthma, CXR utilization decreased by 20.8%. The authors found that, although there was a steady decrease in the utilization of low-value services, this was still limited.

What factors could impact the effectiveness of high-value quality initiatives? First of all, quality improvement requires a substantial investment of collective effort and time. It requires a change in culture that often involves changing longstanding paradigms. The Choosing Wisely® recommendations target a very specific, low-clinical-severity population – the focus is on “uncomplicated” disease. This is important as you don’t want to pursue aggressive unnecessary intervention in children and potentially cause harm – for example, unnecessary use of steroids in a child with uncomplicated bronchiolitis who may improve with nasal suctioning alone. There is a need to appraise patients with more complex presentation of these diseases (for example, patients that require escalation of care to ICU), and this is beyond the scope of Choosing Wisely®.

Further research is needed to see if higher-value care interventions can be implemented among these higher acuity and severity patients.

In our institution, we have created specific care paths that facilitate following these recommendations. Essentially, we have leveraged the EHR order sets to avoid the inclusion of low-value interventions; all stakeholders (respiratory therapy, nursing, etc.) are aware of the care path and ensure compliance.

Even further, as a consequence of the change in culture toward high-value care, we have identified low-value interventions in settings where high-value quality improvement can be implemented – for example, we found that at least 20% of noncritically ill children undergoing an appendectomy receive unnecessary antacid prophylaxis treatment. Changes always start small; quality improvement requires a lot of effort, and we must focus our energy on “low-hanging fruit,” and also begin tackling higher complexity tasks. In the Choosing Wisely® manuscript cited above, the authors found that there was a change in performance with a tendency toward higher-value care, yet the change was not as substantial as originally thought.

How can we tackle higher complexity tasks if we find it difficult to implement solutions for those of lower complexity? My answer is simple. Maintain a consistent and continuous focus on high value, and ensure the message is iterative and redundant with feedback on performance, decrease in costs, and enhanced patient outcomes.

Dr. Auron is the quality improvement and patient safety officer in the department of hospital medicine at the Cleveland Clinic. He also serves as associate professor of medicine and pediatrics in the staff department of hospital medicine and department of pediatric hospital medicine. This article first appeared on the Hospital Leader, SHM’s official blog, at hospitalleader.org.
Some patients who spend three or more days in an intensive or critical care unit need extended recovery time in an acute-level setting before transitioning home.

These post-intensive care patients can benefit from specialized care provided by clinicians with expertise in treating critically ill and medically complex patients.

Our interdisciplinary care features daily physician oversight, ICU/CCU-level staffing and specially trained caregivers that seek to improve outcomes and reduce costly readmissions for difficult-to-treat patients.

For a clinical assessment of your medically complex patients needing prolonged acute-level care, visit kindredhospitals.com to find our hospital nearest you.

Dedicated to Hope, Healing and Recovery

Daily Physician Oversight • ICU/CCU-Level Staffing • Reduced Readmissions

© 2019 Kindred Healthcare, LLC. CSR 197883-04, EOE
Palliative care

“unrepresented patient” – any source of information can be valuable. And health care providers should seek out this input, Dr. Frank said.

“When there is a visitor at the bedside, and as long as they know the person, and they can start giving the medical providers some information about what the patient would have wanted, most of us will talk with that person and that's actually a good habit,” he said.

Thirty-nine states and the District of Columbia have regulations on whom health care providers should talk to when there is no obvious representative, Dr. Frank said, noting that most of these regulations follow a classic family-tree order. But in the discouraging results of many surveys of health care providers on the subject, most clinicians say that they do not know the regulations in their state, Dr. Frank said.

But he said such results betray a silver lining because clinicians say that they would be inclined to talk to when there is no obvious representative, Dr. Frank said, noting that most of these regulations follow a classic family-tree order. But in the discouraging results of many surveys of health care providers on the subject, most clinicians say that they do not know the regulations in their state, Dr. Frank said.

But he said such results betray a silver lining because clinicians say that they would be inclined to talk to when there is no obvious representative, Dr. Frank said, noting that most of these regulations follow a classic family-tree order. But in the discouraging results of many surveys of health care providers on the subject, most clinicians say that they do not know the regulations in their state, Dr. Frank said.

But he said such results betray a silver lining because clinicians say that they would be inclined to talk to when there is no obvious representative, Dr. Frank said, noting that most of these regulations follow a classic family-tree order. But in the discouraging results of many surveys of health care providers on the subject, most clinicians say that they do not know the regulations in their state, Dr. Frank said.

But he said such results betray a silver lining because clinicians say that they would be inclined to talk to when there is no obvious representative, Dr. Frank said, noting that most of these regulations follow a classic family-tree order. But in the discouraging results of many surveys of health care providers on the subject, most clinicians say that they do not know the regulations in their state, Dr. Frank said.

But he said such results betray a silver lining because clinicians say that they would be inclined to talk to when there is no obvious representative, Dr. Frank said, noting that most of these regulations follow a classic family-tree order. But in the discouraging results of many surveys of health care providers on the subject, most clinicians say that they do not know the regulations in their state, Dr. Frank said.
Ami Doshi, MD, director of palliative care inpatient services at Rady Children’s Hospital in San Diego, described the case of a baby girl that touched on the especially painful issues that can arise in pediatric cases. The 2-month-old girl had been born after a pregnancy affected by polyhydramnios and had an abnormal neurological exam and brain MRI, as well as congenital abnormalities. She’d been intubated for respiratory failure and was now on high-flow nasal cannula therapy. The girl was intolerant to feeding and was put on a nasojejunal feeding tube and then a gastrostomy-jejunostomy tube. But the baby’s vomiting continued, and she had bradycardia and hypoxia so severe she needed bag mask ventilation to recover. The mother started to feel like she was “torturing” the baby. The family decided to stop respiratory support but to continue artificial nutrition and hydration, which Dr. Doshi said, has an elevated status in the human psyche. Mentioning discontinuing feeding is fraught with complexity, she said.

“The notion of feeding is such a basic instinct, especially with a baby, that tackling the notion of discontinuing any sort of feeds, orally or tube feeds, is fraught with emotion and angst at times,” Dr. Doshi said. The girl had respiratory events but recovered from them on her own, but the vomiting and retching continued. Eventually the artificial nutrition and hydration was stopped. But after 5 days, the medical staff began feeling uncomfortable, Dr. Doshi said. “We’re starting to hear from nurses, doctors, other people, that something just doesn’t feel right about what’s happening: ‘She seems okay,’ and, ‘Is it really okay for us to be doing this?’ and ‘Gosh, this is taking a long time.’”

The medical staff had, in a sense, joined the family on the emotional roller coaster. Dr. Doshi said it’s important to remember that there is no ethical or moral distinction between withdrawing a medical intervention and withholding one.

“Stopping an intervention once it has started is no different ethically or legally than not starting it in the first place,” she said.

According to Dr. Doshi, there is a consensus among medical societies that artificial nutrition and hydration is a medical intervention just like any other and that it should be evaluated within the same framework: Is it overly burdensome? Are we doing harm? Is it consistent with the goal of care? In so doing, be sure to respect patient autonomy and obtain informed consent.

As with so much in medicine, careful communication is a must. “Paint a picture of what the patient’s trajectory is going to look like with and without artificial nutrition and hydration. At the end of the day, having done all of that, we’re going to ultimately respect what the patient or the surrogate decision maker decides,” Dr. Doshi said.

After assessment of the data and the chances of success, and still without clarity about how to proceed, a good option might be considering a “time-limited trial” in which the medical team sits with the family and agrees on a time frame for an intervention and chooses predetermined endpoints for assessing success or failure.

“This can be very powerful to help us understand whether it is beneficial, but also – from the family’s perspective – to know everything was tried,” Dr. Doshi said.

Hospitalists should emphasize what is being added to treatment so that families don’t think only of what is being taken away, she said.

“Usually we are adding a lot – symptom management, a lot of psychosocial support. So what are all the other ways that we’re going to continue to care for the patient, even when we are withdrawing or withholding a specific intervention?” Dr. Doshi noted.

Sometimes, the best healer of distress in the midst of end-of-life decision making is time itself, Dr. Gundersen said.

“In a condolence call, she once spoke with a family member involved in an agonizing case in which the medical team and family were at odds. Yet the man told her: ‘I know that you all were telling us the entire time that this was going to happen, but I guess we just had to go through our own process.’

“When there is a visitor at the bedside, and as long as they know the person, and they can start giving the medical providers some information about what the patient would have wanted, most of us will talk with that person.”

—Dr. Frank
Diversity of training backgrounds

Y
ou’ve probably heard of a “nocturnist,” but have you ever heard of a “weekendist?”

The field of hospital medicine (HM) has evolved dramatically since the term “hospitalist” was introduced in the literature in 1996.1 There is a saying in HM that, “if you know one HM program, you know one HM program,” alluding to the fact that every HM program is unique. The diversity of individual HM programs combined with the overall evolution of the field has expanded the range of jobs available in HM.

The nomenclature of adding an -ist to the end of the specific roles (e.g., nocturnist, weekendist) has become commonplace. These roles have developed with the increasing need for day and night staffing at many hospitals secondary to increased and more complex patients, less availability of residents because of work hour restrictions, and the Accreditation Council for Graduate Medical Education (ACGME) rules that require overnight supervision of residents.

Additionally, the field of HM increasingly includes physicians trained in internal medicine, family medicine, pediatrics, and medicine-pediatrics (med-peds). In this article, we describe the variety of roles available to trainees joining HM and the multitude of different training backgrounds hospitalists come from.

Nocturnists

The 2018 State of Hospital Medicine Report notes that 76.1% of adult-only HM groups have nocturnists, hospitalists who work primarily at night to admit and to provide coverage for admitted patients.3 Nocturnists often provide benefit to the rest of their hospitalist group by allowing fewer required night shifts for those that prefer to work during the day.

Nocturnists may choose a nighttime schedule for several reasons, including the ability to be home more during the day. They also have the potential to work fewer total hours or shifts while still earning a similar or increased income, compared with predominantly daytime hospitalists, increasing their flexibility to pursue other interests. These nocturnists become experts in navigating the admission process and responding to inpatient emergencies often with less support when compared with daytime hospitalists.

In addition to career nocturnist work, nocturnist jobs can be a great fit for those residency graduates who are undecided about fellowship and enjoy the acuity of inpatient medicine. It provides an opportunity to hone their clinical skill set prior to specialized training while earning an attending salary, and offers flexible hours which may allow for research or other endeavors. In academic centers, nocturnist educational roles take on a different character as well and may involve more educational experiences. The role of nocturnists as educators is expanding as ACGME rules call for more oversight and educational opportunities for residents who are working at night. However, challenges exist for nocturnists, including keeping abreast of new changes in their HM groups and hospital systems and engaging in quality initiatives, given that most meetings occur during the day. Additionally, nocturnists must adapt to sleeping during the day; potentially getting less sleep then they would otherwise and being “off cycle” with family and friends.

Weekendists

Another common hospitalist role is the weekendist, hospitalists who spend much of their clinical time preferentially working weekends. Similar to nocturnists, weekendists provide benefit to their hospitalist group by allowing others to have more weekend off. Weekendists may prefer working weekends because of fewer total shifts or hours and/or higher compensation per shift. Additionally, weekendists have the flexibility to do other work on weekdays, such as research or another hospitalist job.

Internal medicine hospitalists may be the most common hospitalists encountered in many hospitals and at each Society of Hospital Medicine annual conference, but there has also been rapid growth in hospitalists from other specialties and backgrounds.”

SNFists

With increasing emphasis on transitions of care and the desire to avoid readmission penalties, some hospitalists have transitioned to work partly or primarily in skilled nursing facilities (SNF) and have been referred to as “SNFists.” Some of these hospitalists may split their clinical time between SNFs and acute care hospitals, while others may work exclusively at SNFs.

SNFists have the potential to be invaluable in improving transitions of care after discharge to post–acute care facilities because of increased provider presence in these facilities, comfort with medically complex patients, and appreciation of government regulations.2 SNFists may face potential challenges of needing to staff more than one post–acute care hospital and of having less resourc-
es available, compared with an acute care hospital.

**Specific specialty hospitalists**
For a variety of reasons including clinical interest, many hospitalists have become specialized with regards to their primary inpatient population. Some hospitalists spend the majority of their clinical time on a specific service in the hospital, often working closely with the subspecialist caring for that patient. These hospitalists may focus on hematology, oncology, bone-marrow transplant, neurology, cardiology, surgery services, or critical care, among others. Hospitalists focused on a specific service often become knowledge experts in that specialty. Conversely, by focusing on a specific service, certain pathologies may be less commonly seen, which may narrow the breadth of the hospital medicine job.

**Hospitalist training**
Internal medicine hospitalists may be the most common hospitalists encountered in many hospitals and at each Society of Hospital Medicine annual conference, but there has also been rapid growth in hospitalists from other specialties and backgrounds.

Family medicine hospitalists are a part of 64.9% of HM groups and about 9% of family medicine graduates are choosing HM as a career path. Most family medicine hospitalists work in adult HM groups, but some, particularly in rural or academic settings, care for pediatric, newborn, and/or maternity patients. Similarly, pediatric hospitalists have become entrenched at many hospitals where children are admitted. These pediatric hospitalists, like adult hospitalists, may work in a variety of different clinical roles including in EDs, newborn nurseries, and inpatient wards or ICUs; they may also provide consult, sedation, or procedural services.

Med-peds hospitalists that split time between internal medicine and pediatrics are becoming more commonplace in the field. Many work at academic centers where they often work on each side separately, doing the same work as their internal medicine or pediatrics colleagues, and then switching to the other side after a period of time. Some centers offer unique roles for med-peds hospitalists including working on adult consult teams in children’s hospitals, where they provide consult care to older patients that may still receive their care at a children’s hospital. There are also nonacademic hospitalists that primarily staff med-peds hospitalists, where they can provide the full spectrum of care from the newborn nursery to the inpatient pediatric and adult wards.

Hospital medicine is a young field that is constantly changing with new and developing roles for hospitalists from a wide variety of backgrounds. Stick around to see which “-ist” will come next in HM.

**References**
A novel communication framework for inpatient pain management

By Sarah Horman, MD, and Sarah Richards, MD

Background
The Society of Hospital Medicine published a consensus statement in the Journal of Hospital Medicine in 2018 that included 16 clinical recommendations on the safe use of opioids for the treatment of acute pain in hospitalized adults. In regard to communication about pain, clinicians are encouraged to set realistic goals and expectations of opioid therapy, closely monitor response to opioid therapy, and provide education about the side effects and potential risks of opioid therapy for patients and their families. However, even when these strategies are employed, the social and behavioral complexities of individual patients can contribute to unsatisfactory interactions with health care staff. Because difficult encounters have been linked to provider burnout, enhanced communication strategies can benefit both the patient and physician. SHM’s Patient Experience Committee saw an opportunity to provide complementary evidence-based best-practice tips for communication about pain. Specifically, the committee worked collectively to develop a framework that can be applied to more challenging encounters.

The VIEW Framework

VISIT the patient’s chart and your own mental state.
First, visit the patient’s chart to review information relevant to the patient’s pain history. The EHR can be leveraged through filters and search functions to identify encounters, consultations, and notes relevant to pain management.

Look at the prior to admission medication list and active medication list and see if there are discrepancies. The medication administration record (MAR) can help identify adjunctive medications that the patient may be refusing. PDMP data should be screened for signs of aberrant use, including multiple pharmacies, multiple prescribers, short intervals between prescriptions, and serially prescribed, multiple, low-quantity prescriptions.

While documented pain scores can be a marker of patient distress, objective aspects of the patient’s functional status can shed light on how much his/her discomfort impairs day-to-day living. Examples of these measures include nutritional intake, sleep cycle, out of bed activity, and participation with therapy. Lastly, assess for opioid-related side effects including constipation, decreased respiratory rate, and any notation of over sedation in narrative documentation from ancillary services.

Once this information has been accrued, it is important to take a moment of mindfulness before meeting with the patient. Take steps to minimize interruptions with electronic devices by silencing your pager/cell phone and disengaging from computers/tablets. Some examples of mindfulness-based practices include taking cycles of deep breathing, going for a short walk to appreciate hospital artwork or view points, or focusing on the sensory aspects of washing your hands prior to seeing the patient. Self-reflection on prior meaningful encounters can also help reset your state of mind. These activities can help clear prior subconscious thoughts and frustrations and prepare for the task ahead of you.

Intense focus and awareness can enhance your recognition of patient distress, increase your ability to engage in active listening, and enable you to be more receptive to verbal and nonverbal cues. Additionally, mindful behaviors have been shown to contribute to decreased burnout and improved empathy.

INTERVIEW the patient.
Once you enter the room, introduce yourself to the patient and others who are present. Interview the patient by eliciting subjective information. Use open-ended and nonjudgmental language, and take moments to summarize the patient’s perspective.

Inquire about the patient’s home baseline pain scores and past levels of acceptable function. Further explore the patient’s performance goals related to activities of daily living and quality of life. Ask about any prior history of addiction to any substance, and if needed, discuss your specific concerns related to substance misuse and abuse.

KEY CLINICAL QUESTION

What is the VIEW Framework?

Dr. Horman Dr. Richards

Dr. Horman is a hospitalist and assistant professor of medicine at UC San Diego Health. Dr. Richards is a hospitalist and assistant professor of medicine at the University of Nebraska Medical Center in Omaha. Dr. Horman and Dr. Richards note that they wrote this article in collaboration with the Society of Hospital Medicine Patient Experience Committee.

EMPATHIZE with the patient.
Integrate empathy into your interview by validating any frustrations and experience of pain. Identifying with loss of function and quality of life can help you connect with the patient and initiate a therapeutic relationship. Observe both verbal and nonverbal behaviors that reveal signs of emotional discomfort. Use open-ended questions to create space and trust for patients to share their feelings.

Pause to summarize the patient’s perspective while acknowledging and validating emotions that he or she may be experiencing such as anxiety, fear, frustration, and anger. Statements such as “I know it is frustrating to...” or “I can’t imagine what it must feel like to...” can help convey empathy. Multiple studies have suggested that enhanced provider empathy and positive messaging can also reduce patient pain and anxiety and increase quality of life. Emotional responses to negative emotional expressions from patients have also been associated with higher ratings of communication.

Finally, WRAP UP by aligning expectations with the patient for
pain control and summarize your management recommendations. Educate the patient and his/her family on the risks and benefits of recommended therapy as well as the expected course of recovery. Setting shared goals for functionality relevant to the patient’s personal values and quality of life can build connection between you and your patient.

While handing over the patient to the next provider, refrain from using stereotypical language such as “narcotic-seeking patient.” Clearly communicate the management plan and milestones to other team members, such as nurses, physical therapists, and oncoming hospitalists, to maintain consistency. This will help align patients and their care team and may stave off maladaptive patient behaviors such as splitting.

The VIEW framework as it applies to the case

Visit

Upon visiting the medical chart, the physician realized that the patient’s opioid use began in his 20s when he injured his back in a traumatic motor vehicle accident. His successful athletic career came to a halt after this injury and opioid dependence ensued.

While reviewing past notes and prescription data via the PDMP, the physician noted that the patient had been visiting many different providers in order to get more pain medications. The most recent prescription was for oral hydromorphone 4 mg every 4 hours as needed, filled 1 week prior to this presentation.

She reviewed his vital signs and found that he had been persistently hypertensive and tachycardic. His nurse mentioned that the patient appeared to be in severe pain because of facial grimacing with standing and walking.

Prior to entering the patient’s room, the physician took a moment of mindfulness to become aware of her emotional state because she recognized that she was worried this could be a difficult encounter.

She considered how hard his life has been and how much emotional and physical pain he might be experiencing. She took a deep breath, silenced her mobile phone, and entered the room.

Interview

The physician sat at the bedside and interviewed the patient using a calm and nonjudgmental tone. It was quickly obvious to her that he was experiencing real pain. His cellulitis appeared severe and was tender to even minimal palpation. She learned that the pain in his leg had been worsening over the past week to the point that it was becoming difficult to ambulate, sleep, and perform his daily hygiene routine. The patient was taking 4 mg tablets of hydromorphone every 2 hours, and he had run out a few days ago. He added that his mood was increasingly depressed, and he had even admitted to occasional suicidal thoughts because the pain was so unbearable.

When asked directly, he admitted that he was worried he was addicted to hydromorphone. He had first received it for low back pain after the motor vehicle accident, and it been refilled multiple times for ongoing pain over the course of a year. Importantly, she also learned that he felt he was often treated as an addict by medical professionals and that doctors no longer listened to him or believed him.

Continued on following page
The patient was on chronic baseline opioids and also had objective signs of acute pain, she started an initial regimen of hydromorphone 6 mg tablets every 4 hours as needed (a 50% increase over his home dose) and added acetaminophen 1000 mg every 6 hours and ibuprofen 600 mg every 8 hours.

She informed the patient that she would check on him in the afternoon and that the ultimate plan would be to taper down on his hydromorphone dose each day as his cellulitis improved. She also communicated that bidirectional respect between the patient and care team members was critical to a successful pain management.

Finally, she explained that there was going to be a different doctor covering at night and major changes to the prescription regimen would be deferred to daytime hours.

When she left the room, the physician summarized the plan with the patient's nurse and shared a few details about the patient's difficult past. At the end of the shift, the physician signed out to the overnight team.

At the end of the shift, the physician arranged for follow-up in the opioid taper clinic and communicated the plan with the patient's primary care provider.

References
Previously healthy patients hospitalized for sepsis show increased mortality

By Mitchel L. Zoler
MDeDge News

WASHINGTON / Although severe, community-acquired sepsis in previously healthy U.S. adults is relatively uncommon, it occurs often enough to strike about 40,000 people annually, and when previously healthy people are hospitalized for severe sepsis, their rate of in-hospital mortality was double the rate in people with one or more comorbidities who have severe, community-acquired sepsis, based on a review of almost 7 million Americans hospitalized for sepsis.

The findings "underscore the importance of improving public awareness of sepsis and emphasizing early sepsis recognition and treatment in all patients," including those without comorbidities. Chanu Rhee, MD, said at an annual scientific meeting on infectious diseases. He hypothesized that the increased sepsis mortality among previously healthy patients may have stemmed from factors such as delayed sepsis recognition resulting in hospitalization at a more advanced stage and less aggressive management.

In addition, "the findings provide context for high-profile reports about sepsis death in previously healthy people," said Dr. Rhee, an infectious diseases and critical care physician at Brigham and Women's Hospital in Boston. Dr. Rhee and associates found that, among patients hospitalized with what the researchers defined as "community-acquired" sepsis, 3% were judged previously healthy by having no identified major or minor comorbidity or pregnancy at the time of hospitalization, a percentage that – while small – still translates into roughly 40,000 such cases annually in the United States. That helps explain why every so often a headline appears about a famous person who died suddenly and unexpectedly from sepsis, he noted.

The study used data collected on hospitalized U.S. patients in the Cerner Health Facts, HCA Healthcare, and Institute for Health Metrics and Evaluation databases, which included about 6.7 million people total including 337,983 identified as having community-acquired sepsis, defined as patients who met the criteria for adult sepsis advanced by the Centers for Disease Control and Prevention within 2 days of their hospital admission.

The researchers looked further into the hospital records of these patients and divided them into patients with one or more major comorbidities (96% of the cohort), patients who were pregnant or had a “minor” comorbidity such as a lipid disorder, benign neoplasm, or obesity (1% of the study group), or those with no chronic comorbidity (3%; the subgroup the researchers deemed previously healthy).

In a multivariate analysis that adjusted for patients’ age, sex, race, infection site, and illness severity at the time of hospital admission, the researchers found that the rate of in-hospital death among the previously healthy patients was exactly twice the rate of those who had at least one major chronic comorbidity. Dr. Rhee reported.

Differences in the treatment received by the previously healthy patients or in their medical status compared with patients with a major comorbidity suggested that the previously healthy patients were sicker. They had a higher rate of mechanical ventilation, 30%, compared with about 18% for those with a comorbidity; a higher rate of acute kidney injury, about 43% in those previously healthy and 28% in those with a comorbidity; and a higher percentage had an elevated lactate level, about 41% among the previously healthy patients and about 22% among those with a comorbidity.

Fewer bloodstream infections with FMT for C. difficile

Patients also had shorter hospital stays

By Bianca Nogrady
MDeDge News

Treating Clostridioides difficile infection with fecal microbiota transplantation is associated with a lower risk of bloodstream infection and recurrence than treatment with antibiotics, new research has found.

A paper published in Annals of Internal Medicine presents outcomes of a prospective cohort study in 290 inpatients with recurrent C. difficile infection, 109 of whom were treated with fecal microbiota transplantation (FMT); the remaining patients in the study were treated with antibiotics including metronidazole, vancomycin, and fidaxomicin.

While the FMT group had a higher mean number of previous C. difficile infections than the antibiotics group (2.82 vs. 1.23, respectively), a sustained cure was achieved in 97% of the FMT group, compared with 38% in the antibiotics group. Blood cultures were done if patients developed a temperature above 30°C or showed symptoms that might be attributable to sepsis. Bloodstream infections were diagnosed in 5% (5 patients) of those treated with FMT, and 22% (40 patients) in the antibiotics group.

The patients in the FMT group with bloodstream infections all had bacterial infections – one of which was polymicrobial – and there were no cases of fungal bloodstream infections. In the antibiotics group, 28 patients (15%) had bacterial bloodstream infections – 11 of which were polymicrobial – and 12 (7%) had fungal bloodstream infections. Bloodstream infections were particularly evident among the 11 inpatients whose C. difficile infection was treated with fidaxomicin, of whom a higher 7% developed a bloodstream infection.

Overall, 27% of patients died during the 90-day follow-up, with 7% dying because of bloodstream infections, all of whom were in the antibiotic-treated cohort. Three patients in the FMT group died because of overwhelming C. difficile infection, compared with 12 in the antibiotic cohort.

Nearly three-quarters of deaths occurred within 30 days of the end of treatment; 5 of these deaths were in the FMT group, and 53 were in the antibiotics group.

"These findings suggest that the longer 90-day [overall survival] of patients in the FMT group is attributable to cure of [C. difficile infection] leading to an improvement in clinical condition," wrote Gianluca Ianiro, MD, from the Catholic University of the Sacred Heart in Rome, and coauthors.

The 90-day overall survival rate was 92% in the FMT group and 61% in the antibiotic group. Patients treated with FMT also showed significantly shorter mean duration of hospital stay at 13.3 days, compared with 29.7 days in patients treated with antibiotics.

The authors noted the results should be interpreted with caution because of baseline differences between the two groups that were not entirely accounted for by using propensity matching.

However, even in the propensity-matched cohort of 57 patients from each group, there was still a significantly higher overall survival at 90 days among patients treated with FMT.

One author declared grants from the pharmaceutical sector outside the submitted work. No funding or other conflicts of interest were reported by the coauthors.
Hospitalist work schedules have been the subject of much reporting – and recent research. Studies have shown that control over work hours and schedule flexibility are predictors of clinicians’ career satisfaction and burnout, factors linked to quality of patient care and retention.

Starting in January 2017, an academic hospital medicine group at the University of Colorado at Denver, Aurora, undertook a scheduling redesign using improvement methodology, combined with purchased scheduling software. Tyler Anstett, DO, a hospitalist and assistant professor at the university, and colleagues presented the results in an abstract published during the SHM 2019 annual conference last March.

“We wrote this abstract as a report of the work that we did over several years in our hospital medicine group to improve hospitalist satisfaction with their schedules,” said Dr. Anstett. “We identified that, despite not following the traditional 7-on, 7-off model and 100% fulfillment of individual schedule requests, the majority of clinicians were dissatisfied with the scheduling process and their overall clinical schedules. Further, building these complex, individualized schedules resulted in a heavy administrative burden. We strove to provide better alignment of schedule satisfaction and the administrative burden of incorporating individualized schedule requests.”

Prior to January 2017, service stretches had ranged from 5 to 9 days, and there were few limits on time-off requests.

“Through sequential interventions, we standardized service stretches to 7 days (Tuesday-Monday), introduced a limited number of nonguaranteed 7-day time-off requests (Tuesday-Monday), and added a limited number of nonguaranteed 3-day flexible time-off requests,” according to the authors. “This simplification improved the automation of the scheduling software, which increased the schedule release lead time to an average of 16 weeks. Further, despite standardizing service stretches to 7 days and limiting time-off requests, physicians surveyed reported improved satisfaction with both their scheduling process (94% of participants ‘satisfied’ in 2017 to 67% in 2018) and their overall clinical schedules (50% of participants ‘satisfied’ in 2017 to 75% in 2018).”

Cultivating patient activation through tech

Tech alone is not enough

Patient activation refers to an individual’s knowledge, skill, and confidence in managing their health and health care, according to a recent BMJ editorial. It’s recognized as a critical aspect of high-quality, patient-centered health care – patient activation has the potential to improve patient outcomes while reducing costs.

Total knee replacement offers a great opportunity to study patient activation, said editorial lead author Jesse I. Wolfstadt, MD, MS, FRCSC, of the University of Toronto. “It may help address the one in five patients who are unsatisfied with their knee replacement despite an otherwise technically sound procedure.”

The authors considered some patient activation studies that have shown positive results for cultivating activation through technology. In one, patients engaging with a bedside multimedia intervention on a tablet after undergoing knee replacement reported better pain scores, length of stay, knee function, and satisfaction with care. Another study showed patients who received automated text messages after joint replacement improved time spent on home exercises, decreased their use of narcotics, and had fewer calls to the surgeon’s office.

But “negative mobile app studies may suffer,” according to the editorial. “One possible key ingredient to successful patient activation is the engagement of the health care team that is facilitated through mobile technology. ... Mobile apps and other technological interventions also must have clear goals if they are to be used successfully; and these goals are likely to differ for different patient populations and disease processes.”

Technology alone is not enough to affect patient activation, Dr. Wolfstadt said. “The key to success will likely involve facilitating increased engagement with the health care team. You can’t just give a patient an app or other form of technology and expect it to replace the function of patient-clinician communication.”

Reference


Reference

Improving sepsis-related outcomes
Performance data provided a key goal

Sepsis is a leading cause of death and disease among patients in hospitals, and it’s the subject of a recent quality improvement study in the Journal for Healthcare Quality.

“The number of cases per year has been increasing in the U.S., and it is the most expensive condition treated in U.S. hospitals,” said lead author M. Courtney Hughes, PhD, of Northern Illinois University.

But early identification of symptoms can be difficult for clinicians, meaning there’s a continuing need for studies examining sepsis identification and prevention. “The purpose of this study was to examine a QI project that consisted of clinical alerts, audit and feedback, and staff education,” she said.

In a retrospective analysis, the researchers examined data from three health systems to determine the impact of a 10-month sepsis QI program that consisted of clinical alerts, audit and feedback, and staff education. The results showed that, compared with the control group, the intervention group significantly decreased length of stay and costs per stay.

“One way to improve sepsis health outcomes and decrease costs may be for hospitals to implement a sepsis quality improvement program,” Dr. Hughes said. "Providing sepsis performance data and education to hospital providers and administrators can arm staff with the knowledge and tools necessary for improving processes and performance related to sepsis.”

Reference

Treating pain with virtual reality
Pilot studies are underway

Physicians may soon have another tool to help patients deal with pain: virtual reality (VR) therapy. A New York Times article earlier this year described the way immersive VR experiences seem to crowd pain sensations out of the brain.

Jeffrey I. Gold, PhD, director of the Children’s Outcomes, Research, and Evaluation program at Children’s Hospital Los Angeles, told the newspaper that VR was “like an endogenous narcotic providing a physiological and chemical burst that causes you to feel good.”

So far, VR has been most successfully used in cases of acute pain. “But it can also enhance the effectiveness of established techniques like physical therapy, hypnosis and cognitive behavioral therapy to treat debilitating chronic pain,” the New York Times reported.

“Using VR as an adjunct, we can teach coping skills, techniques patients can use on their own that will help diminish chronic pain,” said Hunter Hoffman, PhD, principal investigator at the Human Photonics Laboratory of the University of Washington, Seattle. “Learning changes the brain and gives patients something that continues to work when they take the helmet off. When patients realize their pain isn’t inevitable, they’re more receptive to physical therapy.”

Others with experience in VR say the technique can foster mindfulness, which teaches the mind how to quiet the body and nervous system through breathing.

Pilot studies of VR and pain management are underway, and software companies are developing programs that create therapeutic VR environments.

Reference
By Kathryn Brouillette, MDCM; Nicholas Dupuis, DO; Lesley B. Gordon, MD, MS; Elizabeth Herrle, MD; and Emily Zarokian, MD
Maine Medical Partners Hospital Medicine, Maine Medical Center, Portland

IN THIS ISSUE

1. Complications and death within 30 days after noncardiac surgery
2. Eosinophilia-guided treatment cuts corticosteroid exposure in COPD exacerbations
3. A standardized approach to postop management of DOACs in AFib
4. Overdiagnosis and overtreatment of COPD appears rampant
5. DOACs show safety benefit in early stages of CKD
6. Covert stroke after noncardiac surgery linked with cognitive decline
7. Think twice before intensifying BP regimen in older hospitalized patients
8. Limiting antibiotic therapy after surgical drainage for native joint bacterial arthritis

By Kathryn Brouillette, MDCM

1. Complications and death within 30 days after noncardiac surgery

**CLINICAL QUESTION:** What is the frequency and timing of perioperative complications associated with death after noncardiac surgery?

**BACKGROUND:** There have been advances in perioperative care and technology for adults, but at the same time the patient population is increasingly medically complex. We do not know the current mortality risk of noncardiac surgery in adults.

**STUDY DESIGN:** Prospective cohort study.

**SETTING:** Twenty-eight academic centers in 14 countries in North America, South America, Asia, Europe, Africa, and Australia. At least four academic centers represented each of these continents, except Africa, with one center reporting there.

**SYNOPSIS:** The VISION study included 40,044 inpatients, aged 45 years and older, followed for 30-day mortality after noncardiac surgery. One-third of surgeries were considered low risk. A startling 99.1% of patients completed the study. Mortality rate was 1.8%, with 71% of patients dying during the index admission and 29% dying after discharge.

Nine events were independently associated with postoperative death, but the top three—major bleeding, myocardial injury after noncardiac surgery (MINS), and sepsis—accounted for 45% of the attributable fraction. These, on average, occurred within 1-6 days after surgery. The other events (infection, kidney injury with dialysis, stroke, venous thromboembolism, new atrial fibrillation, and congestive heart failure) constituted less than 3% of the attributable fraction. Findings suggest closer monitoring in the hospital and post discharge might improve survival after noncardiac surgery.

**LIMITATIONS:**

- Limitations for hospitals include that patients were younger and less medically complex than our typically comanaged patients:
- More than half of patients were aged 65-75, less than 10% had chronic kidney disease stage 3b or greater, and only 20% had diabetes mellitus.

**BOTTOM LINE:** Postoperative and postdischarge bleeding, myocardial injury after noncardiac surgery, and sepsis are major risk factors for 30-day mortality in adults undergoing noncardiac surgery. Closer postoperative monitoring for these conditions should be explored.

**CITATION:** The Vision Study Investigators (Spence J et al.) Association between complications and death within 30 days after noncardiac surgery. CMAJ. 2019 Jul 29;191(30):E830-7.

By Nicholas Dupuis, DO

2. Eosinophilia-guided treatment cuts corticosteroid exposure in COPD exacerbations

**CLINICAL QUESTION:** Is eosinophilia-guided therapy in the setting of a chronic obstructive pulmonary disease (COPD) exacerbation a safe way to reduce total systemic steroid exposure?

**BACKGROUND:** Corticosteroids in the setting of an acute exacerbation of COPD symptoms but do not affect the decline in lung function, rate of repeat exacerbations after a month, or mortality. There is concern regarding the cumulative adverse effects over time. Limited prior research suggests that a patient’s blood eosinophil count may be useful for determining the necessity of steroids for treatment of exacerbation.

**STUDY DESIGN:** Randomized, controlled, open-label trial.

**SETTING:** Respiratory departments of three university hospitals in Denmark.

**SYNOPSIS:** A total of 318 patients admitted for COPD exacerbation were randomized to standard or eosinophilia-guided therapy. On day 1, all patients received 80 mg of IV methylprednisolone. The standard-therapy group then received 375 mg of oral prednisolone for 4 more days. In contrast, the eosinophilia-guided group received prednisolone only if their blood eosinophil count was 300 cells/mL or greater.

**The primary outcome of days alive and out of the hospital within 14 days after recruitment was similar between groups (9: P = .34), along with the secondary outcome of treatment failure (26%; P = .90). Importantly, the cumulative steroid dose in the eosinophilia-guided group was lower than that of the control group at days 5, 30, and 90 (P less than or equal to .0002). Additionally, the control arm had worsening of baseline diabetes within 30 days and was more likely to require antibiotics for infections within 90 days.

**BOTTOM LINE:** Eosinophilia-guided treatment of COPD exacerbations reduced the cumulative exposure of steroid therapy, thereby decreasing side effects, although further study of safety profile is warranted.


By Lesley B. Gordon, MD, MS

3. A standardized approach to postop management of DOACs in AFib

**CLINICAL QUESTION:** Is it safe to adopt a standardized approach to direct oral anticoagulant (DOAC) interruption for patients with atrial fibrillation (AFib) who are undergoing elective surgeries/procedures?

**BACKGROUND:** At present, perioperative management of DOACs for patients with AFib has significant variation, and robust data are absent. Points of controversy include: The length of time to hold DOACs before and after the procedure, whether to bridge with heparin, and whether to measure coagulation function studies prior to the procedure.

**STUDY DESIGN:** Prospective cohort study.

**SETTING:** Conducted in Canada, the United States, and Europe.

**SYNOPSIS:** The PAUSE study in... Continued on page 18

By Kathryn Brouillette, MDCM; Nicholas Dupuis, DO; Lesley B. Gordon, MD, MS; Elizabeth Herrle, MD; and Emily Zarokian, MD
Maine Medical Partners Hospital Medicine, Maine Medical Center, Portland

By Kathryn Brouillette, MDCM

1. Complications and death within 30 days after noncardiac surgery

**CLINICAL QUESTION:** What is the frequency and timing of perioperative complications associated with death after noncardiac surgery?

**BACKGROUND:** There have been advances in perioperative care and technology for adults, but at the same time the patient population is increasingly medically complex. We do not know the current mortality risk of noncardiac surgery in adults.

**STUDY DESIGN:** Prospective cohort study.

**SETTING:** Twenty-eight academic centers in 14 countries in North America, South America, Asia, Europe, Africa, and Australia. At least four academic centers represented each of these continents, except Africa, with one center reporting there.

**SYNOPSIS:** The VISION study included 40,044 inpatients, aged 45 years and older, followed for 30-day mortality after noncardiac surgery. One-third of surgeries were considered low risk. A startling 99.1% of patients completed the study. Mortality rate was 1.8%, with 71% of patients dying during the index admission and 29% dying after discharge.

Nine events were independently associated with postoperative death, but the top three—major bleeding, myocardial injury after noncardiac surgery (MINS), and sepsis—accounted for 45% of the attributable fraction. These, on average, occurred within 1-6 days after surgery. The other events (infection, kidney injury with dialysis, stroke, venous thromboembolism, new atrial fibrillation, and congestive heart failure) constituted less than 3% of the attributable fraction. Findings suggest closer monitoring in the hospital and post discharge might improve survival after noncardiac surgery.

**LIMITATIONS:**

- Limitations for hospitals include that patients were younger and less medically complex than our typically comanaged patients:
- More than half of patients were aged 65-75, less than 10% had chronic kidney disease stage 3b or greater, and only 20% had diabetes mellitus.

**BOTTOM LINE:** Postoperative and postdischarge bleeding, myocardial injury after noncardiac surgery, and sepsis are major risk factors for 30-day mortality in adults undergoing noncardiac surgery. Closer postoperative monitoring for these conditions should be explored.

**CITATION:** The Vision Study Investigators (Spence J et al.) Association between complications and death within 30 days after noncardiac surgery. CMAJ. 2019 Jul 29;191(30):E830-7.

By Nicholas Dupuis, DO

2. Eosinophilia-guided treatment cuts corticosteroid exposure in COPD exacerbations

**CLINICAL QUESTION:** Is eosinophilia-guided therapy in the setting of a chronic obstructive pulmonary disease (COPD) exacerbation a safe way to reduce total systemic steroid exposure?

**BACKGROUND:** Corticosteroids in the setting of an acute exacerbation of COPD symptoms but do not affect the decline in lung function, rate of repeat exacerbations after a month, or mortality. There is concern regarding the cumulative adverse effects over time. Limited prior research suggests that a patient’s blood eosinophil count may be useful for determining the necessity of steroids for treatment of exacerbation.

**STUDY DESIGN:** Randomized, controlled, open-label trial.

**SETTING:** Respiratory departments of three university hospitals in Denmark.

**SYNOPSIS:** A total of 318 patients admitted for COPD exacerbation were randomized to standard or eosinophilia-guided therapy. On day 1, all patients received 80 mg of IV methylprednisolone. The standard-therapy group then received 375 mg of oral prednisolone for 4 more days. In contrast, the eosinophilia-guided group received prednisolone only if their blood eosinophil count was 300 cells/mL or greater.

**The primary outcome of days alive and out of the hospital within 14 days after recruitment was similar between groups (9: P = .34), along with the secondary outcome of treatment failure (26%; P = .90). Importantly, the cumulative steroid dose in the eosinophilia-guided group was lower than that of the control group at days 5, 30, and 90 (P less than or equal to .0002). Additionally, the control arm had worsening of baseline diabetes within 30 days and was more likely to require antibiotics for infections within 90 days.

**BOTTOM LINE:** Eosinophilia-guided treatment of COPD exacerbations reduced the cumulative exposure of steroid therapy, thereby decreasing side effects, although further study of safety profile is warranted.


By Lesley B. Gordon, MD, MS

3. A standardized approach to postop management of DOACs in AFib

**CLINICAL QUESTION:** Is it safe to adopt a standardized approach to direct oral anticoagulant (DOAC) interruption for patients with atrial fibrillation (AFib) who are undergoing elective surgeries/procedures?

**BACKGROUND:** At present, perioperative management of DOACs for patients with AFib has significant variation, and robust data are absent. Points of controversy include: The length of time to hold DOACs before and after the procedure, whether to bridge with heparin, and whether to measure coagulation function studies prior to the procedure.

**STUDY DESIGN:** Prospective cohort study.

**SETTING:** Conducted in Canada, the United States, and Europe.

**SYNOPSIS:** The PAUSE study in... Continued on page 18
As a physician-owned group, we protect each other.

As a hospitalist, the possibility of medical malpractice suits can weigh heavy on your mind. When you join US Acute Care Solutions, the scales are tipped in your favor. Every full-time HM and EM physician becomes an owner in our group, giving us the power to reduce risk and protect our own. In fact, our continuing education and risk management programs cut lawsuits to less than half the national average. If a case is ever brought against you, we’ll have your back with our legendary Litigation Stress Support Team and the best medical malpractice insurance. It’s one more reason to weigh the importance of physician ownership. It matters.

Discover the benefits of physician ownership at USACS.com.
# Overdiagnosis and overtreatment of COPD appears rampant

**CLINICAL QUESTION:** How frequently is chronic obstructive pulmonary disease (COPD) overdiagnosed and overtreated in the general population?

**BACKGROUND:** COPD is a highly morbid disease, and there is a need for a better understanding of the true prevalence. Little is known regarding overdiagnosis of COPD. According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD), airflow limitation by spirometry is a key criteria for diagnosis.

**STUDY DESIGN:** Population-based survey.

**SETTING:** Altogether, 23 sites in 20 countries worldwide were included.

**SYNOPSIS:** The Burden of Obstructive Lung Disease (BOLD) study recruited community-dwelling adults who underwent questionnaires, as well as spirometry. Of the 16,717 participants, 9,19 self-reported a COPD diagnosis. Of these, more than half were found to not meet obstructive lung disease criteria on spirometry, and therefore were misdiagnosed: 62% when defined as forced expiratory volume in 1 second to forced vital capacity (FEV1/FVC) ratio less than the lower limit of normal and 55% when using the GOLD definition of FEV1/FVC less than 0.7. After patients with reported asthma were excluded, 34% of participants with false-positive COPD were found to be treated with respiratory medications as outpatients.

Overdiagnosis of COPD was noted to be more prevalent in high-income countries than in low- to middle-income countries (4.9% versus 1.9% of the participants sampled).

**BOTTOM LINE:** For patients with moderate-risk atrial fibrillation, a standardized approach to DOAC interruption in the perioperative period that omits bridging along with coagulation function testing appears safe in this preliminary study.


---

**By Elizabeth Herrle, MD**

5 DOACs show safety benefit in early stages of CKD

**CLINICAL QUESTION:** In terms of efficacy and bleeding risk, what is known about anticoagulation in patients with chronically impaired renal function?

**BACKGROUND:** Chronic kidney disease (CKD) is both a prothrombotic state and a condition with an elevated bleeding risk that increases in a linear fashion as estimated glomerular filtration rate (eGFR) decreases. These features of the disease along with the exclusion of patients with CKD from most anticoagulation trials have resulted in uncertainty about overall risks and benefits of anticoagulant use in this population.

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

**SETTING:** Variable across included trials.

**SYNOPSIS:** Forty-five randomized, controlled trials of anticoagulation covering a broad range of anticoagulants, doses, indications, and methodologies were included in this meta-analysis, representing 34,082 patients with CKD or end-stage kidney disease.

The most compelling data were seen in the management of atrial fibrillation in early-stage CKD (five studies representing 11,332 patients) in which high-dose DOACs were associated with a lower risk for stroke or systemic embolism (risk ratio, 0.79; 95% confidence interval, 0.66-0.92), hemorrhagic stroke (RR, 0.48; 95% CI, 0.30-0.76), and all-cause death (RR, 0.88; 95% CI, 0.78-0.99). Overall stroke reduction was primarily hemorrhagic, and DOACs were equivalent to vitamin K antagonists (VKAs) for ischemic stroke risk.

The analysis also suggests that, in CKD, DOACs may reduce major bleeding when compared with VKAs across a variety of indications, though that finding was not statistically significant.

Efficacy of DOACs, compared with VKAs, in treatment of venous thromboembolism was uncertain, and patients with end-stage kidney disease and advanced CKD (creatinine clearance, less than 25 mL/min) were excluded from all trials comparing DOACs with VKAs, with limited overall data in these populations.

**BOTTOM LINE:** For patients with atrial fibrillation and early-stage CKD, direct oral anticoagulants show a promising risk-benefit profile when compared with vitamin K antagonists. Very few data are available on the safety and efficacy of anticoagulants in patients with advanced CKD and end-stage kidney disease.


---

6 Covert stroke after noncardiac surgery linked with cognitive decline

**CLINICAL QUESTION:** Does covert stroke increase the risk of cognitive decline after noncardiac surgery in patients older than 65 years?

**BACKGROUND:** Prior studies have established an increased risk of overt stroke after noncardiac surgery, with significant associated morbidity and mortality. Similarly, covert stroke in the nonsurgical population is well described and has been shown to be associated with cognitive decline.

**STUDY DESIGN:** Prospective cohort study.

**SETTING:** Academic centers in nine countries.

**SYNOPSIS:** This study evaluated 1,114 patients older than 65 years who were hospitalized for noncardiac surgery, excluding patients with carotid and neurosurgical procedures. All enrolled participants completed diffusion-weight MRI of the brain within 9 days of surgery. Follow-up rates for clinical outcomes (1,112; greater than 99%) were excellent, and the primary outcome measure, follow-up Montreal Cognitive Assessment (MOCA) at 1 year, was defined in 1,001 (90%) of the study subjects.

Covert stroke was detected in 78 (7%) of the study participants. Those with covert stroke had a higher incidence of cognitive decline at 1 year (adjusted odds ratio, 1.98; 95% confidence interval, 1.22-3.3) with an absolute risk increase of 13%. Patients with covert stroke also had a higher rate of delirium within 3 days of surgery (hazard ratio, 2.24; 95% CI, 1.06-4.73) and a higher rate of overt stroke and transient ischemic attack at 1 year (HR, 4.13; 95% CI, 1.14-14.99).

This study helps to establish the incidence of covert stroke after noncardiac surgery and provides support for covert stroke as a risk factor for cognitive impairment.

**BOTTOM LINE:** Covert stroke following noncardiac surgery is common, affecting 1 in 14 patients in this study, and it is associated with an increased risk of cognitive decline, perioperative delirium, and subsequent overt stroke.

**CITATION:** The NeuroVISION Investigators (Mrkobrada M et al.). Perioperative covert stroke in patients undergoing noncar-
By Emily Zarookian, MD

Think twice before intensifying BP regimen in older hospitalized patients

**CLINICAL QUESTION:** Does intensifying antihypertensive regimens in older patients hospitalized for noncardiac conditions lead to better long-term blood pressure control or does this practice potentially cause harm?

**BACKGROUND:** It is common practice for providers to intensify antihypertensive regimen during admission for noncardiac conditions even if a patient has a history of well-controlled blood pressure as an outpatient. Many providers have assumed that these changes will benefit patients; however, this outcome had never been studied.

**STUDY DESIGN:** Retrospective cohort study.

**SETTING:** Veterans Affairs hospitals.

**SYNOPSIS:** The authors analyzed a well-matched retrospective cohort of 4,056 adults aged 65 years or older with hypertension who were admitted for noncardiac conditions including pneumonia, urinary tract infection, and venous thromboembolism. Half of the cohort was discharged with intensification of their antihypertensives, defined as a new antihypertensive medication or an increase of 20% of a prior medication.

Patients discharged with regimen intensification were more likely to be readmitted (hazard ratio, 1.23; 95% confidence interval, 1.07-1.42; number needed to harm = 27), experience a medication-related serious adverse event (HR, 1.42; 95% CI, 1.06-1.88; NNH = 63), and have a cardiovascular event (HR, 1.65; 95% CI, 1.13-2.4) within 30 days of discharge. At 1 year, no significant difference in mortality, cardiovascular events, or systolic BP were noted between the two groups.

A subgroup analysis of patients with poorly controlled blood pressure as outpatients (defined as systolic blood pressure greater than 140 mm Hg) who had their antihypertensive medications intensified did not show significant difference in 30-day readmission, severe adverse events, or cardiovascular events.

**Limitations of the study include** observational design and majority male sex (97.5%) of the study population.

**BOTTOM LINE:** Intensification of antihypertensive regimen among older adults hospitalized for noncardiac conditions with well-controlled blood pressure as an outpatient can potentially cause harm.


---

**Dose of ibuprofen may not affect analgesia**

A randomized, double-blind, equivalency trial of 225 patients found no difference in analgesic effect among ibuprofen doses of 400 mg, 600 mg, and 800 mg within 1 hour of administration. The study did not examine anti-inflammatory effect and did not examine effect after 1 hour.


---

**Staying alive: Compression rate and depth affects survival**

Employing 107 compressions per minute with a depth of 4.7 cm is associated with improved outcomes for out-of-hospital cardiac arrest. A cohort study of 3,643 patients with out-of-hospital cardiac arrest showed that survival was higher when CPR was performed within 20% of the above values (6% vs 4.3% outside of range; P = .02).

**CITATION:** Duval S et al. Optimal combination of compression rate and depth during cardiopulmonary resuscitation for functionally favorable survival. JAMA Cardiol. 2019;4(9):900-8.

---

**SHORT TAKES**

---

**SHM’s State of Hospital Medicine Survey opens January 6, 2020.**

Be part of the data that powers the most comprehensive snapshot of hospital medicine by gathering and submitting your group’s information.

**Pre-register to participate in the Survey today.**

hospitalmedicine.org/sohm

---

Connect with more than 12,000 hospital medicine professionals

Visit our members-only online community to interact with your local chapter, special interest groups, committees and more.

hospitalmedicine.org/hmx
The most frequent pathogen was Staphylococcus aureus (31%) with no methicillin-resistant strains. There was a low incidence of patients with bacteremia (4%) and chronic immune compromise (10%). Antibiotic regimen varied with 13 different initial intravenous regimens and 11 different oral regimens.

The primary study outcome was rate of recurrent infection within 2 years, which was low with only one recurrence in the 2-week arm and two recurrences in the 4-week arm. This difference was well within the 10% noninferiority margin selected by the authors.

The study was underpowered for nonhand and nonwrist cases, limiting generalizability.

**BOTTOM LINE:** Consider a shorter duration of antibiotic therapy after surgical drainage for native joint bacterial arthritis noninferior to 4 weeks of antibiotic therapy. Is 2 weeks of antibiotic therapy after surgical drainage for native joint bacterial arthritis noninferior to 4 weeks of antibiotic therapy? Setting: Single center in Geneva. **SYNOPSIS:** In total, 154 patients were randomized to either 2 weeks or 4 weeks of antibiotic regimen selected in consultation with infectious disease specialists after surgical drainage for native joint bacterial arthritis.

The study population was 38% women with a median age of 51 years. Sites of infection were majorly hand and wrist arthritis (64%). The most frequent pathogen was Staphylococcus aureus (31%) with no methicillin-resistant strains. There was a low incidence of patients with bacteremia (4%) and chronic immune compromise (10%). Antibiotic regimen varied with 13 different initial intravenous regimens and 11 different oral regimens.

The primary study outcome was rate of recurrent infection within 2 years, which was low with only one recurrence in the 2-week arm and two recurrences in the 4-week arm. This difference was well within the 10% noninferiority margin selected by the authors.

The study was underpowered for nonhand and nonwrist cases, limiting generalizability.

**BOTTOM LINE:** Consider a shorter duration of antibiotic therapy after surgical drainage for native joint bacterial arthritis noninferior to 4 weeks of antibiotic therapy.

**STUDY DESIGN:** Prospective, unblinded, randomized, noninferiority.

**SETTING:** Single center in Geneva.

**SYNOPSIS:** In total, 154 patients were randomized to either 2 weeks or 4 weeks of antibiotic regimen selected in consultation with infectious disease specialists after surgical drainage for native joint bacterial arthritis.

The study population was 38% women with a median age of 51 years. Sites of infection were majorly hand and wrist arthritis (64%). The most frequent pathogen was Staphylococcus aureus (31%) with no methicillin-resistant strains. There was a low incidence of patients with bacteremia (4%) and chronic immune compromise (10%). Antibiotic regimen varied with 13 different initial intravenous regimens and 11 different oral regimens.

The primary study outcome was rate of recurrent infection within 2 years, which was low with only one recurrence in the 2-week arm and two recurrences in the 4-week arm. This difference was well within the 10% noninferiority margin selected by the authors.

The study was underpowered for nonhand and nonwrist cases, limiting generalizability.

**BOTTOM LINE:** Consider a shorter duration of antibiotic therapy after surgical drainage for native joint bacterial arthritis noninferior to 4 weeks of antibiotic therapy.
Recommendations to fight clinician burnout

NAM generates six-goal approach

By Kerry Dooley Young

WASHINGTON / The practice of medicine needs a major reset to address the stresses that lead to clinician burnout, a condition now estimated to affect a third to a half of clinicians in the United States, according to a report from an influential federal panel.


There must be a concerted effort by leaders of many fields of health care to create less stressful workplaces for clinicians. Pascale Carayon, PhD, cochair of the NAM committee that produced the report, said during the NAM press event.

“This is not an easy process,” said Dr. Carayon, a researcher into patient safety issues at the University of Wisconsin–Madison. “There is no single solution.”

The NAM report assigns specific tasks to many different participants in health care through a six-goal approach, as described below.

• Improve usability and relevance of health information technology (IT). Medical organizations should develop and buy systems that are as user-friendly and easy to operate as possible. They also should look to use IT to reduce documentation demands and automate nonessential tasks.

• Reduce stigma and improve burnout recovery services. State officials and legislative bodies should make it easier for clinicians to use mental health services, and help providers without the information being admissible in malpractice litigation. The report notes the recommendations from the Federation of State Medical Boards, American Medical Association, and the American Psychiatric Association on limiting inquiries in licensing applications about a clinician’s mental health. Questions should focus on current impairment rather than reach well into a clinician’s past.

• Create positive workplaces. Leaders of health care systems should consider how their business and management decisions will affect clinicians’ jobs, taking into account the potential to add to their levels of burnout. Executives need to continuously monitor and evaluate the extent of burnout in their organizations, and report on this at least annually.

• Address burnout in training and in clinicians’ early years. Medical, nursing, and pharmacy schools should consider steps such as monitoring workload, implementing pass-fail grading, improving access to scholarships and affordable loans, and creating new loan repayment systems.

• Reduce administrative burden. Federal and state bodies and organizations such as the National Quality Forum should reconsider how their regulations and recommendations contribute to burnout. Organizations should seek to eliminate tasks that do not improve the care of patients.

• Create a national research agenda on clinician well-being. By the end of 2020, federal agencies – including the Agency for Healthcare Research and Quality, the National Institute for Occupational Safety and Health, the Health Resources and Services Administration, and the U.S. Department of Veterans Affairs – should develop a coordinated research agenda on clinician burnout, the report said.

In casting a wide net and assigning specific tasks, the NAM report seeks to establish efforts to address clinician burnout as a broad and shared responsibility. It would be too easy for different medical organizations to depict addressing burnout as being outside of their responsibilities, Christine K. Cassel, MD, the cochair of the NAM committee that produced the report, said during the press event.

“Nothing could be farther from the truth. Everyone is necessary to solve this problem,” said Dr. Cassel, who is a former chief executive officer of the National Quality Forum.

Darrell G. Kirch, MD, chief executive of the Association of American Medical Colleges, described the report as a “call to action” at the press event.

Previously published research has found between 35% and 54% of nurses and physicians in the United States have substantial symptoms of burnout, with the prevalence of burnout ranging between 45% and 60% for medical students and residents, the NAM report said.

Leaders of health organizations must consider how the policies they set will add stress for clinicians and make them less effective in caring for patients, said Vindell Washington, MD, chief medical officer of Blue Cross Blue Shield of Louisiana and a member of the NAM committee that wrote the report.

“Those linkages should be incentives and motivations for boards and leaders more broadly to act on the problem,” Dr. Washington said at the NAM event.

Dr. Kirch said he experienced burnout as a first-year medical student. He said a “brilliant aspect” of the NAM report is its emphasis on burnout as a response to the conditions under which medicine is practiced. In the past, burnout has been viewed as being the fault of the physician or nurse experiencing it, with the response then being to try to “fix” this individual, Dr. Kirch said at the event.

The NAM report instead defines burnout as a “work-related phenomenon studied since at least the 1970s,” in which an individual may experience exhaustion and detachment. Depression and other mental health issues such as anxiety disorders and addiction can follow burnout.

In Dr. Rotella’s view, the NAM report provides a solid framework for what remains a daunting task, addressing the many factors involved in burnout.

“The most exciting thing about this is that they don’t have 500 recommendations. They had six and that’s something people can organize around,” he said. “They are not small goals. I’m not saying they are simple.”

The NAM report delves into the factors that contribute to burnout. These include a maze of government and commercial insurance plans that create “a confusing and onerous environment for clinicians,” with many of them juggling “multiple payment systems with complex rules, processes, metrics, and incentives that may frequently change.”

Clinicians face a growing field of measurements intended to judge the quality of their performance. While some of these are useful, others are duplicative and some are not relevant to patient care, the NAM report said.

The report also noted that many clinicians describe electronic health records as taking a toll on their work and private lives. Previously published research has found that, for every hour spent with a patient, physicians spend an additional 1-2 hours on the EHR at work, with additional time needed to complete this data entry at home after work hours, the report said.

In an interview, Cynda Rushton, RN, PhD, a Johns Hopkins University researcher and a member of the NAM committee that produced the report, said this new publication will support efforts to overhaul many aspects of current medical practice. She hopes it will be a “catalyst for bold and fundamental reform.”

“It’s taking a deep dive into the evidence to see how we can begin to dismantle the system’s contributions to burnout,” she said. “No longer can we put Band-Aids on a gaping wound.”
Hospitalists and Nocturnists Opportunities Available

Your work is your passion. But it’s not your whole life. Join a system that supports your need to balance work and home life. You can find great dining, art, entertainment, and culture in our cities, as well as peace and quiet in our rural areas. With opportunity for advancement and great schools and colleges nearby, it’s a great place to grow your career and your family.

UPMC Pinnacle — a growing, multisite health system in south central Pennsylvania — can meet your needs at one of our seven acute care hospitals

Join our Hospitalist Team

■ Traditional block and flexible schedules
■ Closed and open ICU environments available with options for procedures and dedicated code teams
■ Competitive salary — above MGMA median salary
■ Additional compensation for nocturnist and ICU coverage
■ Strong advanced practice provider support at all locations
■ Great administrative and clinical leadership support

Schedule a call with our recruiter today!
Wayne Saxton, FASPR
Physician Recruiter
717-231-8383
Saxtondw@upmc.edu

UPMC Pinnacle is an Equal Opportunity Employer.

Employment Opportunity in the Beautiful Adirondack Mountains of Northern New York

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

Come live where others vacation!

■ Convenient schedules
■ Competitive salary & benefits
■ Unparalleled quality of life
■ Family friendly community
■ Excellent schools
■ Nearby Whiteface Mountain ski resort
■ Home of the 1932 & 1980 Winter Olympics and current Olympic Training Center
■ Annual Ironman Competition
■ World Cup Bobsled and Ski Events
■ Abundant arts community

Hike, fish, ski, golf, boat or simply relax and take in the beauty and serenity of the Adirondack Mountains

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

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

• Day, Evening and Nocturnist positions
• 7 on/7 off 10 hour shift schedule
• Previous Hospitalist experience is preferred

Located in Western Massachusetts Berkshire Medical Center is the region’s leading provider of comprehensive health care services

• 302-bed community teaching hospital
• A major teaching affiliate of the University of Massachusetts Medical School
• The latest technology including a system-wide electronic health record
• A closed ICU/CCU
• A full spectrum of Specialties to support the team.

We understand the importance of balancing work with a healthy personal lifestyle

• Located just 2½ hours from Boston and New York City
• Small town New England charm
• Excellent public and private schools
• World renowned music, art, theater, and museums
• Year round recreational activities from skiing to kayaking, this is an ideal family location.

Berkshire Health Systems offers a competitive salary and benefits package, including relocation.

Interested candidates are invited to contact:
Liz Mahan • (413) 395-7866
Emahan@bhs1.org
Apply online at: www.berkshirehealthsystems.org

Where Quality of Life and Quality of Care Come Together

Hospitalist Opportunities Available
The Berkshires ~ Western Massachusetts

TO ADVERTISE
Contact: Heather Gonoroski
973.290.8259
hgonroski@mdedge.com
or
Linda Wilson
973.290.8243
lwilson@mdedge.com
DIVISION CHIEF, HOSPITAL MEDICINE
DEPARTMENT OF MEDICINE
Hershey, Pennsylvania

Penn State Health Milton S. Hershey Medical Center invites applications and nominations for the position of Division Chief, Hospital Medicine. The successful candidate will be a nationally recognized academic leader with a substantial record of leadership, clinical and administrative accomplishments, education scholarship and/or research productivity and teaching experience. We seek candidates with prior administrative and leadership experience gained within a Department of Medicine, strong interpersonal and communication skills and demonstrated ability to effectively inspire, manage, mentor, and develop faculty and staff. Candidates must hold the degree of MD, DO, or equivalent, or MD/PhD, be board certified in internal medicine, and possess qualifications for appointment.

The Division of Hospital Medicine at Penn State Health is made up of five teaching teams, five attending teams, two nocturnists, one consult team and one triage team. Together they provide inpatient care to 140+ hospitalized patients per day. The discipline of hospital medicine grew out of the increasing complexity of patients requiring hospital care and the need for dedicated clinicians to oversee their care. There are plans to further expand the number of providers, presenting a tremendous opportunity for a visionary leader to establish a national presence.

INQUIRIES, NOMINATIONS AND EXPRESSIONS OF INTEREST, INCLUDING A CURRICULUM
VITAE AND COVER LETTER, SHOULD BE SUBMITTED CONFIDENTIALLY VIA EMAIL TO
Heather Peffley, PHR FASPR: hpeffley@pennstatehealth.psu.edu.

Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.
Hospitalist & Nocturnist Opportunities in SW Virginia & NE Tennessee

Ballad Health, located in Southwest Virginia and Northeast Tennessee, is currently seeking Full Time, BE/BC, Day Shift Hospitalists and Nocturnist Hospitalists to join its team.

Qualified candidates will work within Ballad Health Facilities and will need an active Virginia and/or Tennessee license, depending on facility location.

Facilities:
Ballad Health Southwest Virginia
Johnston Memorial Hospital, Russell County Medical Center, Smyth County Community Hospital, Norton Community Hospital, Mountain View Regional Medical Center, Lonesome Pine Hospital

Ballad Health Northeast Tennessee
Johnson City Medical Center, Holston Valley Medical Center, Bristol Regional Medical Center and Hawkins County Memorial Hospital

Please Contact:
Tina McLaughlin, CMSR
Ballad Health Senior Physician Recruiter
O) 276-258-4580
tina.mclaughlin@balladhealth.org

Join our Academic Hospital Medicine Program with one of the Premier Public Hospitals in the South

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

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

Apply now for immediate openings!
Email your cover letter and CV to:
Dr. Joanna Bonsall, Director
c/o Tomeika Forde’, Program Coordinator
Phone: 404-727-4145
tford@emory.edu

www.medicine.emory.edu/hospital-medicine

Full time positions with the following incentives:
• Hospital Employed (earning potential, exceeding $300K per year)
• Day and Nocturnist Shifts (7 days on – 7 days off)
• Competitive Annual Salary
• Performance Bonus & Production Bonus
• Excellent Benefits
• Generous Sign On Bonus
• Relocation Assistance
• Teaching and Faculty Opportunities with System Residency Programs
• Critical Care Physician Coverage in most of the facilities CCU/PCUs
• Opportunity to Participate in Award-Winning Quality Improvement Projects

A position with our program includes:
• Generous salary and benefits
• Flexible scheduling and time off
• Teaching opportunities (day and night)
• On-site medical director and Sr. Clinical Advisor
• Broad range of clinical, academic, innovation, and research experiences
• Faculty appointments commensurate with experience
• Full malpractice and tail coverage

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

- Hospital Medicine was established at Ochsner in 1992. We have a stable 50+ member group
- 7 on 7 off block schedule with flexibility
- Dedicated nocturnists cover nights
- Base plus up to 40K in incentives
- Average census of 14-18 patients
- E-ICU intensivist support with open ICUs at the community hospitals
- EPIC medical record system with remote access capabilities
- Dedicated RN and Social Work Clinical Care Coordinators
- Community based academic appointment
- The only Louisiana Hospital recognized by US News and World Report Distinguished Hospital for Clinical Excellence award in 3 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

Ochsner Health System is Louisiana’s largest non-profit, academic, healthcare system. Driven by a mission to Serve, Heal, Lead, Educate and Innovate, coordinated clinical and hospital patient care is provided across the region by Ochsner’s 40 owned, managed and affiliated hospitals and more than 100 health centers and urgent care centers. Ochsner is the only Louisiana hospital recognized by U.S. News & World Report as a “Best Hospital” across three specialty categories caring for patients from all 50 states and more than 70 countries worldwide each year. Ochsner employs more than 25,000 employees and over 4,500 employed and affiliated physicians in over 90 medical specialties and subspecialties, and conducts more than 700 clinical research studies. For more information, please visit ochsner.org and follow us on Twitter and Facebook.

Interested physicians should click here to apply online.

Visit ochsner.org/physician Job Number 00022186

Sorry, no opportunities for J1 applications.

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

To learn more, visit www.the-hospitalist.org and click “Advertise” or contact
Heather Gonroski • 973-290-8259 • hgonroski@mdedge.com or
Linda Wilson • 973-290-8243 • lwilson@mdedge.com
Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. We are seeking IM/FM trained physicians interested in joining the Penn State Health family in various settings within our system.

**What We're Offering:**
- Opportunities for both Community based and Academic settings
- We’ll foster your passion for patient care and cultivate a collaborative environment rich with diversity
- Commitment to patient safety in a team approach model
- Experienced hospital colleagues and collaborative leadership
- Salary commensurate with qualifications
- Relocation Assistance

**What We’re Seeking:**
- Internal Medicine or Family Medicine trained
- Ability to acquire license in the State of Pennsylvania
- Must be able to obtain valid federal and state narcotics certificates
- Current American Heart Association BLS and ACLS certification required
- BE/BC in Family Medicine or Internal Medicine (position dependent)
- No J1 visa waiver sponsorships available

**What the Area Offers:**
Penn State Health is located in Central Pennsylvania. Our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Our surrounding communities are rich in history and offer an abundant range of outdoor activities, arts, and diverse experiences. We’re conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

For more information please contact:
Heather J. Peffley, PHR FASPR, Penn State Health Physician Recruiter
hpeffley@pennstatehealth.psu.edu

Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.

---

**Hospitalist Opportunities with Penn State Health**

Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. We are seeking IM/FM trained physicians interested in joining the Penn State Health family in various settings within our system.

**What We're Offering:**
- Opportunities for both Community based and Academic settings
- We’ll foster your passion for patient care and cultivate a collaborative environment rich with diversity
- Commitment to patient safety in a team approach model
- Experienced hospital colleagues and collaborative leadership
- Salary commensurate with qualifications
- Relocation Assistance

**What We’re Seeking:**
- Internal Medicine or Family Medicine trained
- Ability to acquire license in the State of Pennsylvania
- Must be able to obtain valid federal and state narcotics certificates
- Current American Heart Association BLS and ACLS certification required
- BE/BC in Family Medicine or Internal Medicine (position dependent)
- No J1 visa waiver sponsorships available

**What the Area Offers:**
Penn State Health is located in Central Pennsylvania. Our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Our surrounding communities are rich in history and offer an abundant range of outdoor activities, arts, and diverse experiences. We’re conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

For more information please contact:
Heather J. Peffley, PHR FASPR, Penn State Health Physician Recruiter
hpeffley@pennstatehealth.psu.edu

Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.
Envisioning the future of hospital medicine

By Leslie Flores, MHA, SFHM

I have written frequently over the last few years on topics related to the sustainability of the hospital medicine practice model. I continue to be concerned by what I see as a confluence of significant trends that are conspiring to challenge hospital medicine’s status quo.

On one hand, the financial pressures on U.S. hospitals are unrelenting, and their willingness or even ability to continue providing significant funding to support their hospital medicine groups is in question. Combine this with hospitalists’ rapidly evolving clinical scope and the ever-increasing demands of physicians in other specialties for hospitalist support, and the result is hospital medicine groups that will continue to grow in size, complexity, and the demand for ever more financial support.

On the other hand, the hospitalists interact with in my work all over the country seem more stressed out than ever, and many are questioning whether this is a job that can be satisfying and sustainable for the clinicians while remaining both affordable and viable for the United States, world peace, culture, or other significant public or private endeavors.”

As these trends converge, the hospital medicine practice model as we know it may be facing an existential crisis. If that sounds overly dramatic, let me say instead that the hospital medicine practice model will need to evolve significantly over the next decade in order to continue to meet patient and institutional needs while remaining both affordable and sustainable for the clinicians who work in it.

In September 2019, SHM’s Multi-Site Leaders Special Interest Group met in Chicago for their second annual Multi-Site Leaders Summit to explore the theme of sustainability in hospital medicine. The participants held robust discussions about coping with our changing practice environment, issues relating to hospitalist burnout and resiliency, innovative staffing models, the role of technology in HM sustainability, and financial sustainability.

At the end of the meeting, the group engaged in a visioning exercise designed to move beyond what we are doing today by envisioning what the future of hospital medicine will look like and what interventions will be necessary for us to get from here to there. I’d like to share this visioning exercise with you and encourage you to “play along” by thinking seriously about the questions it poses.

Visioning exercise

Feel free to jot down some thoughts as we go through this exercise. But otherwise, just close your eyes and come along for the ride. Imagine yourself sitting at your desk looking at a desk calendar showing today’s date. Watch the pages flip from today, to tomorrow, to the next day, then to next month, and the next, and then to the next year and so on, until we arrive at December 2029.

Imagine that you look up from your desk, and suddenly realize that you aren’t in your office at all, but instead in a huge auditorium where hundreds are speaking about an award that is going to be announced. People around you are whispering to each other with an air of eager anticipation, their eyes glued to the stage. You realize that the person being introduced up on the podium is the President of the United States, and the award is the Presidential Medal of Freedom, which is awarded to people or groups who have made “an especially meritorious contribution to the security or national interests of the United States, the peace, culture, or other significant public or private endeavors.”

Today, the Medal is being awarded to the Society of Hospital Medicine on behalf of all hospital medicine leaders nationally, for their collective accomplishments in saving the specialty of hospital medicine and, by doing so, ensuring that sick people are able to continue receiving the care they need in our nation’s hospitals – and that the hospitals themselves have become reliably safe, efficient, and effective in achieving high-quality outcomes.

The President says, “At no time in the history of this award until now have we given this, the highest civilian award in the land, to a whole group of physician leaders across an entire specialty. But the achievements of this group of people in preserving and even enhancing the presence of highly energized, dedicated, capable clinicians in our nation’s hospitals against the significant odds they have faced over the last 10 years is nothing short of extraordinary.” There is a standing ovation, as people jump up out of their chairs to cheer and applaud. When the applause finally dies down, the President goes on to list all the accomplishments that made this group of leaders deserving. Listen to what she is saying. What is it that this group has accomplished?

Up on a huge screen beside the stage, a video starts. In it, there are several hospital and physician executives in a focus group, and one executive says, “The thing that is great about what these leaders have accomplished in the field of hospital medicine is...” Fill it in – what did that executive say?

The video then moves on to show a focus group of recent hospital patients. One patient says, “10 years ago when my mom was in the hospital, the poor hospitalists caring for her seemed completely overwhelmed and burnt out, and the whole care system seemed fragmented and inefficient; but my own recent hospital experience was so different because...” Additional patients chime in, talking about how confident they felt about the care they received in the hospital and the reasons for that. What is it these patients are describing?

SHM’s CEO gets up to accept the award and explains that 10 years ago, a group of multi-site hospital medicine leaders from across the country came together to begin addressing the issue of sustainability; this led to a formal process for developing a vision and plan for the future of hospital medicine, and the execution of that plan eventually resulted in the outcomes recognized by this award. She acknowledges that over the years many people questioned whether the hospital medicine model should even continue to exist or whether some other model for inpatient care should be adopted. She talks about all the compelling reasons that supported the continued existence of the specialty of hospital medicine. What are some of the reasons she listed? The SHM CEO goes on to describe some of the key things that were done to address the issues associated with sustainability of the hospital medicine practice model. Listen to what she says; what was it that SHM and the leaders it represents did?

As you leave the auditorium, you overhear a group of mid-career staff hospitalists talking. They are saying that they didn’t originally believe the specialty would actually change, and they weren’t sure if they could do this job for a career – but that it did change. They begin talking about what it feels like to work as a hospitalist.

Take a minute to jot down the specifics that came to mind as you read through this exercise. If you are willing to share your thoughts about sustainability in hospital medicine, I’d love to hear from you. Feel free to email me directly at Leslie.Flores@nelsonflores.com.

Let’s build the foundation for a sustainable future for our specialty.
This advertisement is not available for the digital edition.