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The Hospitalist

VOLUME 21 No. 6 | JUNE 2017

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Leaving Las Vegas:

HM17 delivers record attendance, laughs, learning

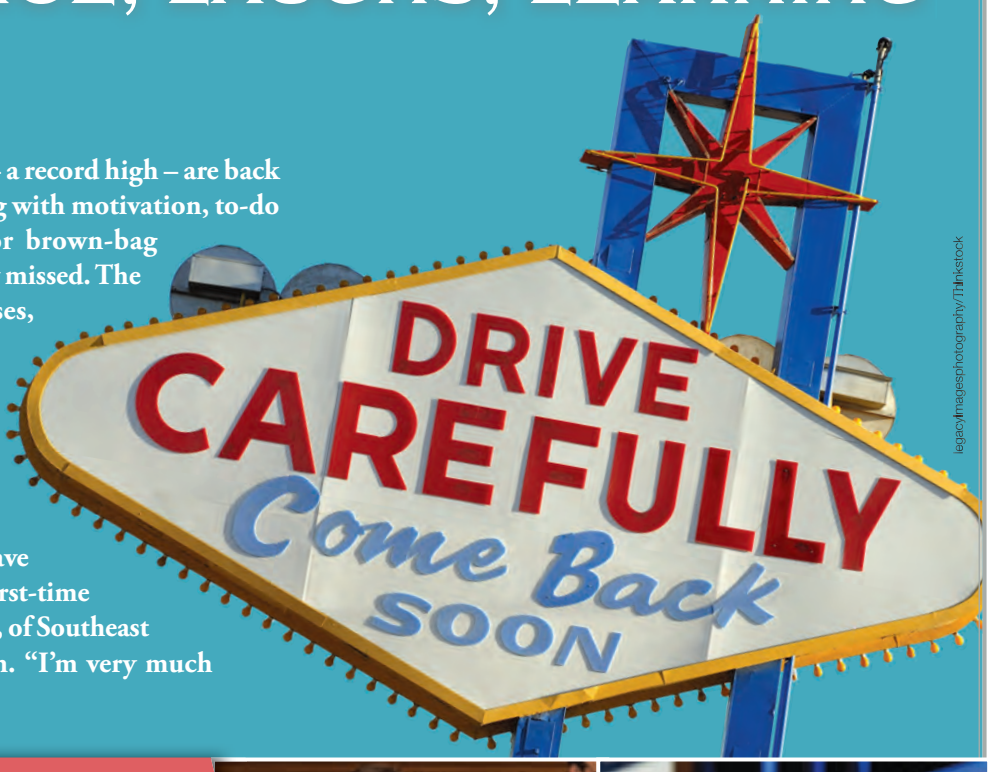
By Richard Quinn

LAS VEGAS – Viva HM17!

Some 4,700 hospitalists and others – a record high – are back home from the SHM annual meeting with motivation, to-do lists, and, most likely, requests for brown-bag sessions to show colleagues what they missed. The list includes three keynote addresses, hundreds of educational courses, and seemingly endless networking.

And, of course, a reminder that HM is a community.

"You're in one part of the country and you have no idea that there's an entire world out there, [that] they have the same issues that you have," said first-time attendee Mohammed N.Y. Shah, MD, of Southeast Alabama Medical Center in Dothan. "I'm very much amazed after coming here.



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SIX PAGES OF HM17 COVERAGE INSIDE:

Q&A SHM MEMBER SPOTLIGHT

Committee and chapter involvement allows SHM member to give back

Paul Grant, MD, SFHM

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Making sense of MACRA:

MIPS and Advanced APMs

By Kelly April Tyrrell

Several months into 2017, physicians around the country are preparing for the first benchmark year of MACRA, the Medicare Access and CHIP Reauthorization Act. Passed in 2015, MACRA is the bipartisan health care law responsible for eliminating the Sustainable Growth Rate, and it promises to continue to fundamentally alter the way providers are paid. This year determines reimbursement in 2019.

Under the law, physicians must report performance under one of two pathways: MIPS, the Merit-Based Incentive Payment System, or participation in a qualified Advanced Alternative Payment Model, or Advanced APM. The first, MIPS, replaces the Physician Quality Reporting System, Meaningful Use, and the Physician Value-Based Payment Modifier and is the track most providers can expect to follow, at least initially, because most will not meet the requirements for Advanced APMs.[1,2]

This is especially true for hospitalists, most of whom are not yet participating in qualifying Alternative Payment Models.[2]

The MIPS track is budget neutral, which means for every physician or physician group that receives a boost in reimbursement, another will receive a cut. Others will receive a neutral adjustment. All physicians see an annual 0.5% increase in payment between 2016 and 2019 and MIPS clinicians receive a 0.25% annual boost starting in 2026. Providers participating in Advanced APMs will also receive

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Improve your glycemic control efforts with SHM's GC eQUIPS program

Inpatient hyperglycemia is a very common condition, affecting approximately 38% of patients in the non–intensive care unit setting.

Enhance the efficiency and reliability of your quality improvement efforts to close the gap between best practices and methods for caring for inpatients with hyperglycemia with SHM's Glycemic Control (GC) Electronic Quality Improvement Program (eQUIPS). The GC eQUIPS program supports the development and implementation of GC programs at hospitals nationwide.

This program offers 2-year access to a data center for performance tracking and benchmarking and aims to support your institution in:

- Gaining understanding in the principles of glycemic control
- Improving glycemic control data collection/analysis/and reporting
- Building and obtaining approval for protocols/policies for glycemic control
- Creating a culture for change and change management

When you enroll in the Glycemic Control eQUIPS, you will receive:

- **Data center for performance tracking.** Helps track performance on project milestones and outcomes, and benchmark performance against comparison groups at your institution and other participating facilities.
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- **Online community and collaborative:**
  - Glycemic Control Library of site-created tools and documents allows you to view sample order sets and protocols, awareness campaigns, patient education materials, and various articles.
  - National Discussion Forum lets you share professional questions and discuss topics related to the planning, implementation, and evaluation of glycemic control interventions.
  - Access to on-demand webinar, facilitated by national experts, topics include IV Insulin Management Strategies, Change Management, and Introduction to Glycemic Control.

Join the webinar on June 28 from 1 to 2 p.m., ET, to receive additional information about SHM's GC programs. Visit hospitalmedicine.org/gc to register or learn more. If you have questions on the program, please email Sara Platt at splatt@hospitalmedicine.org.

Brett Radler is communications specialist at the Society of Hospital Medicine.

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

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SURVEY INSIGHTS

Scheduling patterns: Time for a change?

Dr. Eisenstock is clinical chief, division of hospital medicine, at the University of Massachusetts Memorial Health Care, Worcester.

Editor's note: *Bob Wachter, MD, created buzz in March 2016 when, at the SHM annual meeting in San Diego, he displayed a slide titled "What did we get wrong?" The slide contained the copy, "Hospitalist shifts run 7 a.m.-7 p.m.; 10 a.m.-10 p.m. 7on/7off" circled in bold red.*

Over the last several years, thought leaders in the hospital medicine field have expressed concern that this one-size-fits-all schedule model is a threat to the well-being of many physicians and, by extension, the sustainability of their hospital medicine groups. Despite this, the 2016 State of Hospital Medicine Report reveals relatively little change in the way hospital medicine groups schedule their physicians.

Most groups (69.2%), report the duration of scheduled day shifts to be between 12 and 13.9 hours, similar to the 65.4% reported in the 2014 survey for this same metric. Likely, most of these shifts are the traditional 12-hour shift displayed on Dr. Wachter's slide. Groups reporting shorter shifts tended to be either very large, with the number of bodies needed to develop flexible scheduling, or in academic settings where they could utilize house-staff coverage.

Night shifts echo this trend. There is an even greater number of groups utilizing the 12- to 13.9-hour shift length (79%), which has also varied less at just approximately 5% in either direction over the last two surveys. It is likely very hard to be creative with the shift length for your night physicians when the group is structured predominately around a 12-hour day position.

The 12-hour shift scheduled in long blocks is straightforward to employ for the scheduler, limits handoffs of care, and maximizes number of days off. So, why are Wachter et al. calling for change? Seven-day stretches off may seem attractive when you are just starting out, but, as physicians mature, the very long day competes with family time that cannot be made up on weekday mornings when others are at school and work. Furthermore, the very long hours for 7 days straight lead to burn out and eventually retention issues as well. Some argue that this design promotes disengagement. It sets the expectation that, during "off" weeks, physicians might be unavailable for email responses, committee meetings, or participation in quality improvement initiatives, which disrupts integration into the larger hospital community and perhaps even our own career advancement.

Some groups are trying to address these concerns with innovative approaches to block scheduling. While the hallmark hospital medicine schedule of 7on/7off blocks remains the predominant model – 38.1% of all groups – this represents a drop of approximately 15%, compared with the prior survey. A new large contingent of groups entering the survey this year utilize a Monday-Friday model with rotating moonlighter/weekend coverage. This lifestyle and family-friendly model predominates in the Midwest. It is also found more in smaller groups, which may employ this model to keep the most system-knowledgeable worker around during high volume times, as well as to preserve the well-being and retention of their limited physician work force.

Of note, reconfiguring the 7on/7off model does not necessarily translate into more time off. The median number of shifts per year is also relatively stable at 182 which is the exact number of shifts per year in a strict 7on/7off schedule. This number does not vary by region of the country, group size, or teaching status. Some might argue that working 182 annual shifts is ideal, giving hospitalists a "vacation" every other week. However, this line of thought does not take into account the very long workdays, nor the 52 weekend days spent in the hospital – far more than most specialty peers who serve fewer weekend calls often with more limited in-house hours. In addition, one might argue that defining ourselves as available only during our 182 clinical "on" days is not in our own best interest, as it is the important nonclinical quality and committee service activities that are likely to lead to professional recognition and advancement.

Our hospital medicine group has deviated from this scheduling mainstay and requires only 160 shifts per year. We have set this number based on removal of the number of shifts equivalent to the vacation hours received by our medical group peers. The model poses a challenge in terms of matching our productivity up to benchmarks when talking to system leaders. This challenge pales in comparison to the increased buy-in from our physicians, as they feel equitable vacation time signifies respect from the medical group leadership.

In addition, our group has had success in being flexible around the number of days worked in a continuity stretch. We utilize everything from a 3-day block over holidays to a 7-day block. In general, we allow physicians to select their desired block length. The scheduler then works to accommodate that stretch as much as is feasible. The upfront work in this system is significant, but the downstream effect is decreased turnover costs. Even our own entrenched standard of 7on/7off schedules for house staff services (designed to protect continuity for the learner) have been the target of change. A pilot of alternating 4 and 5 day runs in a 4-week stretch has been implemented over the last few months. The number of days the residents are exposed to a given attending is the same in this model, but there is one additional switch day. The additional switch day puts the residents at risk of managing a change in care plan related to change in attending, but this was mitigated by pairing attendings with very similar teaching and patient management styles. For our group, the extra administrative effort needed to work around the 7on/7off model has always paid off in terms of provider satisfaction and retention.

On the other hand, although I lead a large academic group, we have not yet developed flexibility around the shift length. Only 1 of the 29 roles our providers fill each 24-hour period is not a 12-hour shift. Over the years, I have tried to offer alternative models with shorter shifts to improve flow, reduce burn out, and increase family time. No matter how eloquent the reasoning, the response from the group was always the same: a resounding "no." Most providers felt that they would wind up with a very similar work load and not actually leave the hospital earlier. Other reasons included not wanting to come in more days per month and concerns about increased handoffs/cross coverage.

There is some reason to think change may actually come. For one, burnout is high and may lead physicians to try a new model even with fear of the unknown. Our practice may be reconsidering this one-size-fits-all shift length in the very near future as an increasing percentage of candidates seeking to join our group express a strong interest in finding more accommodating hours.

Overall, I am hopeful that, in the coming years, my hospital medicine group, as well as many others, will heed the thoughts expressed by Dr. Wachter. Finding the flexibility to break out of these rigid scheduling models will be a first step in promoting both physician and system well-being. TH

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Setting discharge goals and visit expectations

By Christine Hrach, MD, SFHM

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

What I say and do

I always ensure at the end of my visit with a patient and their family that they know when to expect me to return to see their child again.

Why I do it

One of the biggest frustrations I hear from families pertains to the discharge process. In talking with families, they want to know the approximate time for discharge. Often, during morning rounds, we mention that the patient may be able to go home later in the day and we say that we will come in again later to check on them. However, unless we give families a time frame for when we will come back and do that check, they are left waiting without any clear expectations.

Dr. Hrach is a pediatric hospitalist at Washington University School of Medicine in St. Louis.

How I do it

One of our goals during morning family-centered rounds is to discuss discharge for every patient, every day. Along with discussing the possibility of going home, we try to give the family goals that they can work on throughout the day that are tied to discharge – for example, the approximate by-mouth intake for a toddler admitted for gastroenteritis and dehydration.

I also give the family an approximate time when either I or the resident team will come back to see if they have achieved this goal. This may be either late afternoon or first thing in the morning if we are planning an early morning discharge before rounds. The families seem to find this helpful because they are not tied to the room all day waiting for the doctor to come back.

I also make sure that the families know they can contact their nurse any time if they need to see any of the doctors sooner than we planned. I let them know that a physician is here on the floor 24 hours a day and that the nurses can easily reach us at any time if they have further concerns. In my experience, this is reassuring to our families. TH

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Q&A

Committee and chapter involvement allows SHM member to give back

Paul Grant, MD, SFHM, contributes to SHM growth

By Felicia Steele

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

This month, The Hospitalist spotlights Paul Grant, MD, SFHM, assistant professor of medicine at the University of Michigan Medical School, Ann Arbor. Dr. Grant is the chair of SHM's Membership Committee and an active member of SHM's Michigan Chapter.

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

We are developing ways to reach out to residency program directors – particularly those running a hospital medicine track – to find ways they can benefit from SHM's educational offerings.

—Dr. Paul Grant

During my internal medicine residency, I tried hard to find a subspecialty I could see myself doing for the rest of my career. But I couldn't. What I loved about general medicine was the variety of patients I saw on a daily basis. My next decision was whether to do hospital medicine or ambulatory medicine. This was a tough choice for me, but choosing hospital medicine was one of the best career decisions I've ever made.

After residency, I completed a hospital medicine fellowship at the Cleveland Clinic. During my fellowship, I joined SHM. At that time, I knew nothing about the society, but that soon changed. My fellowship required me to attend the annual meeting and submit an abstract in the RIV competition, which was an extremely valuable experience for me. Not only was I blown away by the meeting, but my poster won the clinical vignette competition, as well! Needless to say, I've been an SHM member ever since.

What prompted you to join the Membership Committee? Can you discuss some of the projects the committee is currently working on?

Because SHM has done so much for my career as a hospitalist, I've tried to give back by volunteering on committees. After

CONTINUED ON PAGE 12

NEWS & NOTES

The latest news about upcoming events, new programs, and SHM initiatives

By Brett Radler

HM17 On Demand now available

➤ Couldn't make it to Las Vegas for SHM's annual meeting, Hospital Medicine 2017? HM17 On Demand gives you access to over 80 online audio and slide recordings from the hottest tracks, including clinical updates, rapid fire, pediatrics, comanagement, quality, and high-value care.

Additionally, you can earn up to 70 American Medical Association Physician Recognition Award Category 1 Credit(s) and up to 30 American Board of Internal Medicine Maintenance of Certification credits. HM17 attendees can also benefit by earning additional credits on the sessions you missed out on.

To easily access content through SHM's Learning Portal, visit shmlearningportal.org/hm17-demand to learn more.

Chapter Excellence Awards

➤ SHM is proud to recognize outstanding chapters for the fourth annual Chapter Excellence Awards. Each year, chapters strive to demonstrate growth, sustenance, and innovation within their chapter activities.

View more at www.hospitalmedicine.org/chapterexcellence. Please join SHM in congratulating the following chapters on their success!

Silver Chapters
Boston Association of Academic Hospital Medicine (BAAHM)
Charlotte Metro Area
Houston
Kentucky
Los Angeles
Minnesota
North Jersey
Pacific Northwest
Philadelphia Tri-State
Rocky Mountain
San Francisco Bay
South Central PA

Gold Chapters
New Mexico
Wiregrass

Platinum Chapters
Iowa
Maryland
Michigan
NYC/Westchester
St. Louis

Outstanding Chapter of the Year
Michigan

Rising Star Chapter
Wiregrass

Student Hospitalist Scholar grant winners

➤ SHM's Student Hospitalist Scholar Grant provides funds with which medical students can conduct mentored scholarly projects related to quality improvement and patient safety in the field of hospital medicine. The program offers a summer and a longitudinal option.

Congratulations to the 2017-2018 Student Hospitalist Scholar Grant recipients:

Summer Program

Anton Garazha
Rosalind Franklin University of Medicine and Science
"Effectiveness of communication during icu to ward transfer and association with medical ICE readmission"

Cole Hirschfeld
Weill Cornell Medical College
"The role of diagnostic bone biopsies in the management of osteomyelitis"

Farah Hussain
University of Cincinnati College of Medicine
"Better understanding clinical deterioration in a children's hospital"

Longitudinal Program

Monisha Bhatia
Vanderbilt university school of medicine
"using electronic medical record phenotypic data to predict discharge destination"

Victor Ekuta
University of California, San Diego School of Medicine
"Reducing CAUTI with noninvasive uc alternatives and measure-vention"

Yun Li
Geisel School of Medicine at Dartmouth
"Developing and implementing clinical pathway(s) for hospitalized injection drug users due to injection-related infection sequelae"

Learn more about the Student Hospitalist Scholar Grant at hospitalmedicine.org/scholargrant.

SPARK ONE: A tool to teach residents

➤ SPARK ONE is a comprehensive, online self-assessment tool created specifically for hospital medicine professionals. The activity contains 450+ vignette-style multiple-choice questions covering 100% of the American Board of Internal Medicine's Focused Practice in Hospital Medicine (FPHM) exam blueprint. This online tool can be utilized as a training mechanism for resident education on hospital medicine.

As a benefit of SHM membership, residents will receive a free subscription. SPARK ONE provides in-depth review of the following content areas:

- Cardiology
- Pulmonary Disease and Critical Care Medicine
- Gastroenterology and Hepatology
- Nephrology and Urology
- Endocrinology
- Hematology and Oncology
- Neurology
- Allergy, Immunology, Dermatology, Rheumatology, and Transitions in Care
- Palliative Care, Medical Ethics, and Decision Making
- Perioperative Medicine and Consultative Comanagement
- Patient Safety
- Quality, Cost, and Clinical Reasoning

"SPARK ONE provides a unique platform for academic institutions, engaging learners in directed learning sessions, reinforcing teaching points as we encounter specific conditions," Rachel E. Thompson, MD, MPH, SFHM said.

Visit hospitalmedicine.org/sparkone to learn more.

Sharpen your coding with the updated CODE-H

➤ SHM's Coding Optimally by Documenting Effectively for Hospitalists (CODE-H) has launched an updated program with all new content. It will now include eight recorded webinar sessions presented by expert faculty, downloadable resources, and an interactive discussion forum through the Hospital Medicine Exchange (HMX), enabling participants to ask questions and learn the most relevant best practices.

Following each webinar, learners will have the opportunity to complete an evaluation to redeem continuing medical education credits.

Webinars in the series include:

- E/M Basics Part I
- E/M Basics Part II
- Utilizing Other Providers in Your Practice
- EMR and Mitigating Risk
- Putting Time into Critical Care Documentation
- Time Based Services
- Navigating the Rules for Hospitalist Visits
- Challenges of Concurrent Care

To purchase CODE-H, visit hospitalmedicine.org/CODEH. If you have questions about the new program, please contact education@hospitalmedicine.org.

Set yourself apart as a Fellow in Hospital Medicine

➤ The Fellow in Hospital Medicine (FHM) designation signals your commitment to the hospital medicine specialty and dedication to quality improvement and patient safety. This designation is available for hospital medicine practitioners, including practice administrators, nurse practitioners, and physician assistants. If you meet the prerequisites and complete the requirements, which are rooted in the Core Competencies in Hospital Medicine, you can apply for this prestigious designation and join more than 1,100 FHMs who are dedicated to the field of hospital medicine. Learn more and apply at hospitalmedicine.org/fellow.

New guide & modules on multimodal pain strategies for postoperative pain management

➤ Pain management can pose multiple challenges in the acute care setting for hospitalists and front-line prescribers. While their first priority is to optimally manage pain in their patients, they also face the challenges of treating diverse patient populations, managing patient expectations, and considering how pain control and perceptions affect Hospital Consumer Assessment of Healthcare Providers and Systems scores. Furthermore, because of the ongoing opioid epidemic, prescribers must ensure that pain is managed responsibly and ethically.

To address these issues, SHM developed a guide to address how to work in an interdisciplinary team, identify impediments to implementation, and provide examples of appropriate pain management. In accompaniment with this Multimodal Pain Strategies Guide for Postoperative Pain Management, there are three modules presented by the authors which supplement the electronic guide.

To download the guide or view the modules, visit hospitalmedicine.org/pain.

Proven excellence through a unique education style: Academic Hospitalist Academy

➤ Don't miss the eighth annual Academic Hospitalist Academy (AHA), Sept. 25-28, 2017, at the Lakeway Resort and Spa in Austin, Tex. AHA attendees experience an energizing, interactive learning environment featuring didactics, small-group exercise, and skill-building breakout sessions. Each full day of learning is facilitated by leading clinician-educators, hospitalist researchers, and clinical administrators in a 1:10 faculty-to-student ratio.

The principal goals of the Academy are to:

- Develop junior academic hospitalists as the premier teachers and educational leaders at their institutions
- Help academic hospitalists develop scholarly work and increase scholarly output
- Enhance awareness of the value of quality improvement and patient safety work
- Support academic promotion of all attendees

Don't miss out on this unique, hands-on experience. Register before July 18, 2017, to receive the early-bird rates. Visit academichospitalist.org to learn more. TH

Crossing the personal quality chasm: QI enthusiast to QI leader

Success in QI begins with a 'bigger pie.'

By Claudia Stahl

Editor's Note: *This new series highlights the professional pathways of quality improvement leaders. This month features the story of Eric Howell, MD, MHM, professor of medicine at Johns Hopkins University, Baltimore.*

For Eric Howell, MD, MHM, the journey to becoming a professor of medicine at Johns Hopkins University, past president of SHM, and director of SHM's Leadership Academies commenced with a major quality improvement (QI) challenge.

Johns Hopkins Bayview Medical Center was struggling with throughput from the emergency department when Dr. Howell began practicing there in the early days of hospital medicine. "The ED said the medicine service was too slow, and the hospitalists said, 'We're working as fast as we can,' " Dr. Howell recalled of his real-world introduction to implementation science. "So, I took on triage oversight in 2000 and began streamlining flow."

Dr. Howell, who enjoys a good process improvement puzzle as much as a clinical challenge, devised a process that would expedite flow among the ED, the ICU, and the department of medicine. The system he implemented, known as Active Bed Management, cut 98 minutes from the ED length of stay to inpatient boarding. Furthermore, the rate of ambulance diversion resulting from overcrowding in the ED decreased by 6%, while diversion linked to ICU overcrowding decreased 27%. Based on its success, multiple hospitals have since implemented an Active Bed Management model.

With a growing reputation for finding solutions to reduce readmissions and improve care transitions, Dr. Howell joined the Better Outcomes by Optimizing Safe Transitions (Project BOOST) project team in 2007 to codevelop one of SHM's most successful programs. He humbly attributes some of this success to luck. "I happened to be at the right place at the right time. There was a problem, opportunity knocked, and I opened the door," he said.


Dr. Howell

After some reflection, he pinpoints more tangible factors – a gift for innovative thinking and finding options that unify, rather than polarize, people and departments.

"I always ensure a solution makes the pie bigger, so that everyone benefits from it," he said. "I don't approach a problem like a sporting event, where one group wins and another loses."

Dr. Howell says that an inclusive mindset is an important characteristic for anyone on a QI track because "it encourages buy-in from everyone who is impacted by a problem, and their investment in making the outcome successful."

Skill development in areas such as leadership principles and processes such as lean will benefit those on a QI pathway, but finding the right mentors is just as critical. Dr. Howell looked to multiple people from diverse backgrounds, none of which included QI, to "help me move my skill set forward," he said. "A clinical educator helped me to interact with other people, learn to facilitate an educational initiative, and lead people to change."

Another mentor, he recalled, was an engineer who helped him figure out how to measure the success of his projects. And a third mentor cleared the pathway of obstructions, providing access to the people who would make his projects successful.

Being able to pivot is also important, Dr. Howell said. "Whether it is looking at data or the people you need to approach to solve a problem, be able to change your approach. Flip-flopping is a good thing in QI, because you're always adjusting your tactics based on new information."

Today, as SHM's senior physician advisor to its Center for Quality Improvement, Dr. Howell holds multiple roles within the Johns Hopkins system and has received numerous awards for excellence in teaching and practice. The core principles that he started with on the path remain the same: "Be humble," he said, "and give away credit. We are often collaborating with other professionals, so shining a light on the great work that they do will make projects more successful and improve the likelihood that they will want to collaborate with you in the future." TH

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

NEWS & NOTES

Choosing Wisely Case Study compendium now available

➤ The Choosing Wisely Case Study Competition, hosted by SHM, sought submissions from hospitalists on innovative improvement initiatives implemented in their respective institutions. These initiatives reflect and promote movement toward reducing unnecessary medical tests and procedures and changing a culture that dictates, "More care is better care."

Submissions were judged by the Choosing Wisely Subcommittee, a panel of SHM members, under adult and pediatric categories. One grand prize winner and three honorable mentions were selected from these categories. The compendium includes these case studies along with additional exemplary submissions.

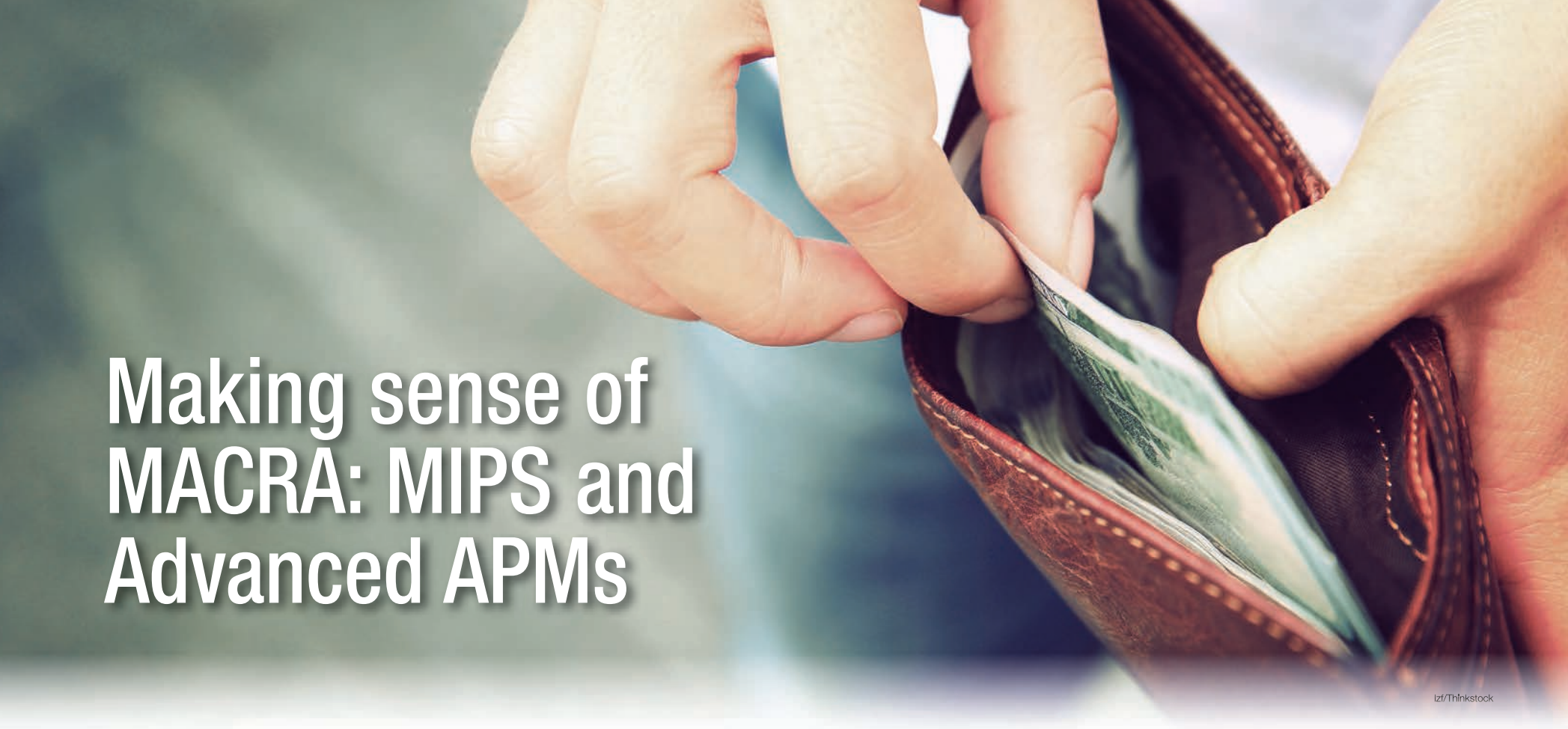
View the Choosing Wisely Case Study Compendium at hospitalmedicine.org/choosingwisely.

Strengthen your interactions with the 5 Rs of Cultural Humility

➤ Look inside this issue for your 5 Rs of Cultural Humility pocket card. It can be easily referenced on rounds and shared with colleagues. We hope to achieve heightened awareness of effective interactions. In addition to the definitions of each of the Rs, the card features questions to ask yourself before, during, and after every interaction to aid in attaining cultural humility.

For more information, visit hospitalmedicine.org/5Rs. TH

Brett Radler is communications specialist at the Society of Hospital Medicine.



Making sense of MACRA: MIPS and Advanced APMs

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an annual 5% payment bonus between 2019 and 2024, and a 0.75% annual increase in payments beginning in 2026.[1]

Both pathways are complex and will affect different clinicians in unique ways, particularly hospitalists.

"A large percentage of hospitalists are actually employed ... and the question is whether there is a change in their compensation structure as a result of a negative score," said Kavita Patel, MD, a practicing internist and nonresident fellow of the Brookings Institution. "That's why MACRA is complicated: It's not just that hospitalists are different, it's that they're compensated differently as well."

Some health policy experts, like Robert Berenson, MD, FACP, Institute Fellow of the Health Policy Center at the Urban Institute, say MACRA could actually drive more hospitalists into employment to avoid the costs associated with complying with the law.

Regardless, there is much about MACRA that hospitalists should familiarize themselves with this year. The Centers for Medicare & Medicaid Services has announced 2018 will also be a transition year and, as such, additional rules are forthcoming.

"It's not an easy piece of legislation to understand, and there are still areas that need to be clarified in the coming months," said Nasim Afsar, MD, SFHM, a hospitalist and member of the Society for Hospital Medicine's Public Policy Committee.

Here is what to know for now:

MIPS

All providers who receive Medicare Physician Fee Schedule payments and do not participate in an Advanced APM will fall into MIPS, and reporting applies to all patients, not just Medicare beneficiaries.[3] There are, however, exemptions: providers in their first year of Medicare, those billing Medicare Part B less than $30,000 annually, and those who see 100 or fewer Medicare patients.[4]

Under MIPS, physicians are scored on a scale from 1 to 100 based on performance across four weighted categories: Quality (60%), Advancing Care Information (25%), Improvement Activities (15%), and Cost (not included for 2017). Hospitalists who provide 75% or more of their services in hospital inpatient or outpatient settings, or in the emergency department, are exempt from Advancing Care Information, which replaced meaningful use. As a result, the Quality category will make up 85% of the overall score in 2017.

"A large percentage of hospitalists are actually employed ... and the question is whether there is a change in their compensation structure as a result of a negative score."

– Dr. Patel

The CMS also announced added flexibility for 2017 with regard to reporting under MIPS, intended to give providers who need it extra time to prepare.[5] Physicians and physician groups can report for a full year, starting Jan. 1, 2017, or report for just 90 days, to be eligible for a positive payment adjustment. To avoid a negative adjustment, they can simply submit more than one quality measure, improvement activity, or advancing care information measure (for those not exempt). Or, providers can choose to report nothing and incur a negative 4% payment.

The approach to MIPS in 2017 will vary widely among SHM members, said Joshua Boswell, SHM's director of government relations.

"Some are looking to do just the bare minimum, not because of their lack of readiness, but for at least this year, to avoid the time, resources, and cost associated with reporting," he said. "Other groups are considering jumping in with both feet and fully reporting, their thinking being that they can't lose, and if there is money on the table for high performers, they might as well go for it."

For 2017, providers who score 70 or more points are eligible for a performance bonus, drawn from a $500 million pool set aside by CMS. The minimum point threshold defined by CMS is three, which a clinician can earn by submitting just one of the six required quality measures.[4]

The CMS has defined 271 total quality measures under MIPS, 13 of which are designated as hospitalist specialty measures. However, SHM believes just seven are appli-

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spending several years on the Early Career Hospitalist Committee, I felt the transition to the Membership Committee was a natural fit. Because SHM membership had been growing every year, our committee felt some pressure to keep this trend going. Thankfully, we have continued to see growth each year in every membership category.

Our committee has been working on several projects. One of the key demographics we have been targeting is the resident member. Residents play a significant role in the future of hospital medicine, as well as SHM membership. We are developing ways to reach out to residency program directors – particularly those running a hospital medicine track – to find ways they can benefit from SHM's educational offerings. Additionally, our committee has been discussing ways to attract international members to SHM. Because hospital medicine is quite developed in the United States, we believe we have much to offer to hospitalists around the world.

Tell TH about your involvement with SHM's Michigan Chapter. What does a typical chapter meeting entail?

A few years ago, at the end of SHM's annual meeting, several of my hospital medicine colleagues in southeast Michigan happened to be on the same flight home. At the departure gate in the airport, we all agreed we should start an SHM chapter. After drawing straws, we decided that I would be chapter president for our inaugural year. In a few short years, our chapter has grown into one of the largest in the country.

As for a typical meeting, each starts with a cocktail hour to encourage our members to network. We have a guest speaker, who presents on a hospital medicine topic, and then, we end the evening with a business meeting. We encourage students and residents to attend. More recently, we've been using interactive technology to broadcast our meetings to large hospital medicine groups in the western and northern parts of the state. Our chapter was thrilled to learn that we'd won the Outstanding Chapter award this year!

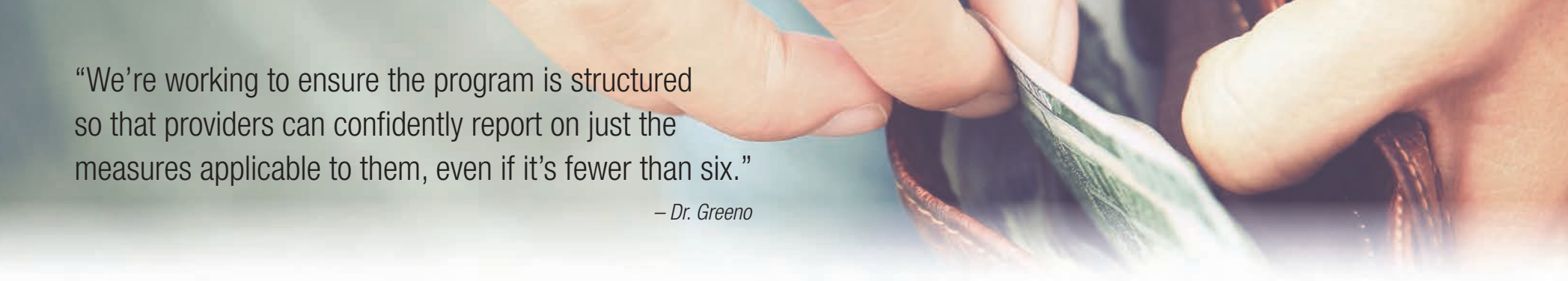
What value do you find in connecting with hospital medicine professionals at the local level?

Whether it's a hospitalist working at a large, tertiary care center or one working in a small rural setting, it seems we all face similar challenges.

As a chapter, we can pull together our resources to address these issues. Furthermore, we have the ability to reach out to more trainees and show them what hospital medicine is all about. Our chapter has been able to partially fund both medical students and residents so they could attend SHM's annual meeting. I'm always amazed at what I can learn from other hospitalists – in the state of Michigan and beyond. TH

Find a chapter near you and get involved at the local level at hospitalmedicine.org/chapters.

Felicia Steele is SHM's communications coordinator.



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cable to hospitalists. Public Policy Committee chair and SHM president Ron Greeno, MD, MHM, says most clinicians will be able to reliably report on only four.

"We're working to ensure the program is structured so that providers can confidently report on just the measures applicable to them, even if it's fewer than six," he said. To ensure physicians are not penalized or disadvantaged for being unable to report the required number of measures, CMS is working to develop a validation test, though it has not yet released details, Dr. Greeno said.

The measures most applicable to hospitalists include two related to heart failure (ACE inhibitor/angiotensin receptor blocker for left ventricular systolic dysfunction [LVSD] and beta-blocker for LVSD), one stroke measure (DC on antithrombotic therapy), advance care planning, prevention of catheter-related bloodstream infection (central venous catheter insertion protocol), documentation of current medications, and appropriate treatment of methicillin-resistant *Staphylococcus aureus* bacteremia.


Dr. Berenson

"This isn't one of those things that will impact everybody equally," said Dr. Afsar. For example, most hospitalists should be able to easily report on advanced care planning and medication documentation, she said, but in some hospitals the stroke measures may be captured in the emergency department; many hospitalists may not achieve enough reportable stroke management cases.

However, Dr. Afsar expects hospitalists will shine in the improvement activities category. "It's part of our DNA," she said. "Improvement activities ... have become part of the core responsibilities for many of us within hospitalist groups, hospitals, and health systems."

In 2017, CMS requires providers to report four improvement activities, which may include – among many other options – implementing antibiotic stewardship programs, connecting patients to community chronic-disease management programs, and integrating pharmacists into a patient care team. Dr. Afsar suggests hospitalists visit SHM's Quality and Innovation guide for ideas, implementation toolkits, and more.

In the cost category, "for the most part, hospitalists aren't acquainted with cost and there is not a lot of cost transparency around what we do ... In general, medical care needs to be discussed between physicians and patients so they can weigh the cost benefit," she said, which includes not just dollars and cents, but the impact associated with procedures, like radiation exposure from a CT scan.

However, Dr. Afsar acknowledges this is challenging, given the overall lack of cost transparency in the American health care system. "It is disjointed, and we don't have any other system where the professionals who do the work are so far removed from the actual cost," she said. "The good thing is, I think we are heading toward an era of more cost-conscious practice."

In addition, hospitalists are poised to help with overall cost reduction in the hospital. "I could imagine something relevant around readmissions and total cost," said Dr. Patel. "But risk adjustment is key."

This category will increase to 30% of a provider's or group's overall score by payment year 2021, CMS says. It will be determined using claims data to calculate per-capita costs for all attributed beneficiaries and a Medicare Spending per Beneficiary measure. The CMS also says it is finalizing 10 episode-based measures determined to be reliable and that will be made available to providers in feedback reports starting in 2018.[4]

Clinicians may report MIPS data as individual providers (a single National Provider Identifier tied to a single Tax Identification Number) by sending data for each category through electronic health records, registries, or qualified clinical data registries. Quality data may be reported through Medicare claims.

Hospitalists who report through a group will receive a single payment adjustment based on the group's performance, using

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The Hospitalist

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group-level data for each category. Groups can submit using the same mechanisms as individual providers, or through a CMS web interface (though groups must register by June 30, 2017).[5]

The SHM has also asked CMS to consider allowing employed hospitalists to align with and report with their facilities, though Dr. Greeno says this should be voluntary since not every hospitalist may be interested in reporting through their hospital. Dr. Greeno says CMS is "very interested and receptive" to how it could be done.

"We are trying to create the incentive for everybody to provide care at lower costs," Dr. Greeno said. "There are two goals: Create alignment, and decrease the reporting burden on hospitalist groups."

Additionally, CMS recognizes the potential burden MIPS imposes on small practices and is working to allow individuals and groups of 10 or fewer clinicians to combine to create virtual groups. This option is not available in 2017.[4]

The CMS has also authorized $100 million, dispersed over 5 years, for certain organizations to provide technical assistance to MIPS providers with fewer than 15 clinicians, in rural areas and those in health professional shortage areas.[4]

According to Modern Healthcare, projections by CMS, released last May, show that 87% of solo practitioners and 70% of physician groups with two to nine providers will see their reimbursement rates fall in 2019. Meanwhile, 55% of groups with 25-99 providers and 81% of those with 100 or more clinicians will see an increase in reimbursement.[6]

"It's not an easy piece of legislation to understand, and there are still areas that need to be clarified in the coming months"

– Dr. Afsar

"I think it's going to be pretty tough unless you're big enough to commit the resources you need to do it right," Dr. Greeno said. "If I was just a really small group with very little overhead, no infrastructure to support, I'd consider taking the penalty and just living with it because I don't have many costs and just pay my own salary. But it's still a hard road."

Dr. Afsarm says SHM continues to look across the board and advocate for all its members.

In 2019, physicians reporting under MIPS will see up to a 4% increase and as low as a 4% decrease in reimbursement. This rises to plus-or-minus 5% in 2020, 7% in 2021, and 9% thereafter.[2]

Dr. Patel and many others say it appears to be the intention of CMS to move providers toward alternative payment models. A January 2015 news release from the U.S. Department of Health & Human Services announced a goal of tying 50% of Medicare payments to Accountable Care Organizations (ACO) by the end of 2018 (it's worth noting this was pre-MACRA, and not all ACOs qualify as Advanced APMs).[8]

"The awkwardness and clunkiness of MIPS needs to be addressed in order to make it successful because many people will be in MIPS," Dr. Patel said. "I think it's the intention to move people into Advanced APMs, but how long it takes to get to that point – 3-5 years, it could be 10 – physicians have to thrive in MIPS in order to live."

One of the most important things, she and Dr. Berenson said, is adequately capturing the quality and scope of the care physicians provide.

"I know hospitalists complain how little their care is reflected in HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems) and the quality measures they have now, and readmission rates don't reflect what doctors do inside the hospital. My colleagues are telling me they want something better," Dr. Patel said.

Advanced APMs

Physicians who participate in Advanced APMs are exempt from MIPS. Advanced APMs must use Certified Electronic Health Record Technology (CEHRT) and take on a minimum amount of risk. For 2017 and 2018, providers must risk losing the lesser of 3% of their total Medicare expenditures or 8% of their revenue.[9] They are paid based on the parameters of their particular model.

Additionally, for the 2019 payment year, 25% of a provider's or group's Medicare payments or 20% of their patients must be through the Advanced APM. This increases to 50% of payments and 35% of patients for 2021 and 2022, and in 2023, to 75% of payments and 50% of patients.

In 2017, APMs that meet the criteria for Advanced include Comprehensive End-Stage Renal Disease Care, Comprehensive Primary Care Plus, Next Generation ACO Model, Shared Savings Program Tracks 2 and 3, Comprehensive Joint Replacement Payment Model Track 1, the Vermont Medicare ACO Initiative, and the Oncology Care Model. (APMs that do not qualify must report under MIPS.)[5]

"Anyone who takes care of the patient can take risk or gain share if the episode initiator allows them."

– Dr. Greeno

The CMS also says that services provided at critical access hospitals, rural health clinics, and federally qualified health centers may qualify using patient counts, and medical home models and the Medicaid Medical Home Model may also be considered Advanced APMs using financial criteria.[4]

At this time, SHM is unable to quantify the number of hospitalists participating in Advanced APMs, and some, Dr. Greeno said, may not know whether they are part of an Advanced APM.

Currently, BPCI (Bundled Payments for Care Improvement) is the only alternative payment model in which hospitalists can directly take risk, Dr. Greeno says, but it does not yet qualify as an Advanced APM. However, that could change.

Prior to the passage of MACRA, Brandeis University worked with CMS to create the Episode Grouper for Medicare (EGM), software that converts claims data into episodes of care based on a patient's condition or conditions or procedures. The American College of Surgeons (ACS) has since proposed an alternative payment model, called ACS-Brandeis, that would use the diagnostic grouper to take into account all of the work done by every provider on any episode admitted to the hospital and use algorithms to decide who affected a particular patient's care.

"Anyone who takes care of the patient can take risk or gain share if the episode initiator allows them," said Dr. Greeno.

For example, if a patient is admitted for surgery, but has an internist on their case because they have diabetes and heart failure, and they also have an anesthesiologist and an infectious disease specialist, everybody has an impact on their care and makes decisions about the resources used on the case. The risk associated with the case is effectively divided.

The ACS submitted the proposal to PTAC (the Physician-Focused Payment Model Technical Advisory Committee) in 2016 and SHM submitted a letter of support.

"In this model, everybody's taking risk and everybody has the opportunity to gain share if the patient is managed well," said Dr. Greeno. "It's a very complicated, very complex model ... Theoretically, everybody on that case should be optimally engaged – that's the beauty of it – but we don't know if it will work."

The SHM got involved at the request of ACS, because it would not apply solely to surgical patients. Dr. Greeno says ACS asked SHM to look at common surgical diagnoses and review every medical scenario that could come to pass, from heart failure and pneumonia to infection.

"There's bundles within bundles, medical bundles within surgical bundles," he said. "It's fascinating and it's daunting but it is truly a big data approach to episodes of care. We're thrilled to be invited and ACS was very enthusiastic about our involvement."

Dr. Patel, who sits on PTAC, is heartened by the amount of physician-led innovation taking place. "Proposals are coming directly from doctors; they are telling us what they want," she said.

For Dr. Greeno, this captures the intent of MACRA: "There is going to be a continual increase in the sophistication of models, and hopefully toward ones that are better and better and create the right incentives for everyone involved in the health care system." TH

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7. United States Department of Health & Human Services. Better, smarter, healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursement from volume to value. http://wayback.archive-it.org/3926/20170127185400/https://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html. Published Jan. 26, 2015. Accessed March 6, 2017.

8. B. Wynne. MACRA Final Rule: CMS strikes a balance; will docs hang on? http://healthaffairs.org/blog/2016/10/17/macra-final-rule-cms-strikes-a-balance-will-docs-hang-on/. Published Oct. 17, 2016. Accessed March 6, 2017.

9. United States Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. Documents for Public Comment: Physician-Focused Payment Model Technical Advisory Committee. Proposal for a Physician-Focused Payment Model: CAS-Brandeis Advanced Alternative Payment Model, American College of Surgeons. https://aspe.hhs.gov/system/files/pdf/253406/TheACSBrandeisAdvancedAPM-ACS.pdf. Published Dece. 13, 2016. Accessed March 6, 2017.

IN THE LITERATURE

ITL: Physician reviews of HM-centric research

BY BRYAN J. HUANG, MD, FHM; SARAH HORMAN, MD; LESLIE MARTIN, MD

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IN THIS ISSUE

By Bryan J. Huang, MD, FHM

1 Family reports provide additional information regarding adverse events

CLINICAL QUESTION: Do family reports of adverse events improve incident detection, compared with clinician reports and hospital incident reports?

BACKGROUND: Hospital incident reports, which are voluntary and suffer from underreporting, capture only a fraction of errors and adverse events (defined as errors resulting in harm). Systematic, prospective surveillance by researchers is the gold standard but is time consuming and expensive. The authors hypothesized that family reports would improve error and adverse event detection.

STUDY DESIGN: Prospective cohort study.

SETTING: Four U.S. pediatric hospitals.

SYNOPSIS: The authors developed a Family Safety Interview, administered weekly and on discharge, and compared reporting of errors and adverse events to clinician reports, hospital incident reports, and systematic review of records by researchers. Of 989 hospitalized pediatric patients, 746 parents/caregivers completed interviews between December 2014 and July 2015. From all sources, the authors found a total of 179 errors and 113 adverse events. Families reported a total of 39 of these 179 errors (including 19 unique errors not reported elsewhere) and 33 of 113 adverse events (8 unique).

Overall, error rates with family-reported errors were 15.5% higher (95% confidence interval, 9.0%-22.3%) than without. Adverse event rates with family reporting were 9.8% higher (95% CI, 3.1%-16.9%) than without. Family-reported error rates were 5 times higher (95% CI, 1.9-13.0) than hospital incident report rates.

The study showed that family-reported error and adverse event rates were significantly higher than voluntary, clinician-only hospital incident report rates. The study was limited to pediatric hospitals on general pediatric and subspecialty services, though findings potentially may be applicable more broadly (for example, adult and surgical services).

BOTTOM LINE: Using a structured interview, families report significantly higher rates of errors and adverse events, compared with other sources.

REFERENCE: Khan A, Coffey M, Litterer KP, et al. Families as partners in hospital error and adverse event surveillance. JAMA Pediatrics. Published online Feb 27, 2017. doi: 10.1001/jamapediatrics.2016.4812.

2 Lactulose plus albumin is more effective than lactulose alone for treatment of hepatic encephalopathy

CLINICAL QUESTION: Is the combination of lactulose plus albumin more effective than lactulose alone for treatment of hepatic encephalopathy?

BACKGROUND: Hepatic encephalopathy is caused by the effect of toxins that build up in the bloodstream when the liver is not able to perform its normal functions. Lactulose is primarily directed at the reduction of blood ammonia levels. Albumin is thought to minimize oxidative injury and improve circulatory dysfunction present in cirrhosis.

STUDY DESIGN: Prospective, open-label, randomized controlled trial.

SETTING: Tertiary care centers in India.

SYNOPSIS: 120 patients with overt hepatic encephalopathy were randomized to treatment with lactulose plus albumin (1.5 gm/kg/day; n = 60), versus lactulose alone (n = 60). Patients with serum creatinine greater than 1.5 mg/dL on admission, active alcohol intake less than 4 weeks prior to presentation, other metabolic encephalopathies, or hepatocellular carcinoma were excluded. Treatment was continued up to a maximum of 10 days until complete resolution of hepatic encephalopathy as assessed independently by two expert hepatologists.

Of patients receiving lactulose plus albumin, 75% had complete reversal of hepatic encephalopathy within 10 days, compared with 53% of patients receiving lactulose alone (P = .03). Patients in lactulose plus albumin group had shorter hospital length-of-stay (6.4 vs. 8.6 days; P = .01). There was lower mortality at 10 days in the lactulose plus albumin group (18.3% vs. 31.6%; P = .04).

Limitations of the study include the noted exclusion factors, including presence of alcohol intake, limitation to a single country (India), and a relatively high mortality rate in both groups.

BOTTOM LINE: Combination of lactulose plus albumin is more effective than lactulose alone at reversing hepatic encephalopathy and is also associated with decreased length-of-stay and mortality.

REFERENCE: Sharma BC, Singh J, Srivastava S, et al. A randomized controlled trial comparing lactulose plus albumin with lactulose alone for treatment of hepatic encephalopathy. J Gastroenterol Hepatol. Published online Nov 25, 2016. doi: 10.1111/jgh.13666.

Dr. Huang is associate clinical professor in the division of hospital medicine, department of medicine, University of California, San Diego.

By Sarah Horman, MD

3 2017 GOLD report: Update on COPD management

CLINICAL QUESTION: What medications should be used to treat patients with chronic obstructive pulmonary disease (COPD) who are minimally symptomatic but have severe obstructive defect on spirometry?

BACKGROUND: COPD treatment is geared toward reducing exacerbations and improving quality of life. This report is an updated management guideline based on peer-reviewed evidence published through October 2016.

STUDY DESIGN: The Global Initiative for Chronic Obstructive Lung Disease is an international collaboration of experts that intermittently releases guidelines for the diagnosis and management of COPD.

SETTING: An international committee of experts meets regularly, reviews evidence, and updates the guideline.

SYNOPSIS: The revised ABCD disease severity assessment tool is based on symptoms and exacerbation frequency (rather than spirometry). For patients with mild symptoms and infrequent exacerbations, a short-acting bronchodilator is recommended. For patients with mild to moderate symptoms, a long-acting beta-agonist or long-acting muscarinic antagonist should be prescribed. Dual therapy is the next step if symptoms arenot controlled on single agent. If there are persistent symptoms beyond dual therapy, an inhaled corticosteroid should be added. PDE4 inhibitors may reduce frequency of exacerbations in patients with severe obstructive defect, chronic bronchitis, and severe symptoms.

For acute exacerbations, short-acting bronchodilators and a 5-day course of oral systemic glucocorticoids should be prescribed. Antibiotics are controversial but, in general, recommended for patients who report increased sputum purulence. In acute respiratory failure, noninvasive ventilation is preferred over invasive venti-

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SHORT TAKES

Time to intubation after cardiac arrest: Earlier may not be better

In a retrospective, observational, cohort study of 86,628 adults with in-hospital cardiac arrest, intubation during the first 15 minutes was associated with decreased survival, compared with no intubation.

REFERENCE: Andersen, LW, Granfeldt, A, Callaway, CW, et al. Association between tracheal intubation during adult in-hospital cardiac arrest and survival. JAMA. 2017;317(5):494-506.

DNR orders often not transferred to ED from outside care facilities

Prospective chart review of patients presenting from extended care facilities to an urban trauma center found hospital staff did a poor job of noting do not resuscitate preferences, and extended care facilities were inconsistent in providing their patients' DNR forms.

REFERENCE: McQuown CM, Frey JA, Amireh A, Chaudhary A. Transfer of do not resuscitate orders to the emergency department from extended care facilities. Am J Emerg Med. Published on Feb 4, 2017. doi: 10.1016/j.ajem.2017.02.007.

lation. Nonpharmacologic management, including immunization, pulmonary rehabilitation, smoking cessation, oxygen, noninvasive ventilation, surgery, and palliative care, is reviewed. This report encourages consideration of medication de-escalation, treatment of comorbid conditions, and early follow-up after hospitalization.

BOTTOM LINE: COPD management should follow a step-wise escalation of therapy based on individual patient characteristics, including symptom severity, exacerbation frequency, comorbid conditions, and goals of care.

REFERENCE: Vogelmeier CF, Criner GJ, Martinez FJ, et al. Global strategy for the diagnosis, management and prevention of chronic obstructive lung disease 2017 Report. Am J Respir Crit Care Med. 2017;195(5):557-82.

4 Resumption of warfarin after intracranial hemorrhage

CLINICAL QUESTION: In patients with atrial fibrillation and intracranial hemorrhage (ICH) who are restarted on warfarin, is bleeding risk dependent on etiology of ICH (traumatic vs. hemorrhagic stroke)?

BACKGROUND: Patients with a history of atrial fibrillation who take warfarin and suffer from an ICH remain at risk for future ischemic strokes without anticoagulation. This study examines if the rebleeding risk is different for patients who have had a traumatic ICH or a hemorrhagic stroke after being restarted on warfarin.

STUDY DESIGN: Retrospective observational cohort study of 2,415 patients.

SETTING: Denmark national registry–based study.

SYNOPSIS: Using national registry databases, investigators linked patients admitted with atrial fibrillation on warfarin with diagnosis codes of traumatic ICH and hemorrhagic stroke. Prescription claim data were used to track resumption of warfarin after discharge.

For patients with traumatic ICH, the warfarin treatment group had a lower (but not significant) rate of ischemic stroke and recurrent ICH. For patients with hemorrhagic stroke, the warfarin treatment group had a lower (but not significant) rate of ischemic stroke and a higher rate of recurrent ICH. Rate of recurrent ICH with warfarin was higher in the hemorrhagic stroke group than it was in the traumatic ICH group. All-cause mortality rate was lower for patients taking warfarin than in patients not on anticoagulation in both hemorrhagic stroke and ICH groups. This study was limited by lack of direct assessment of bleed severity, intensity of warfarin treatment, and potential inaccuracy of the prescription database.

BOTTOM LINE: Spontaneous hemorrhagic stroke and traumatic ICH may confer a different risk and benefit profile with resumption of anticoagulation, but more studies are needed to further guide practice.

REFERENCE: Nielsen PB, Larsen TB, Skjoth F, Lip GY. Outcomes associated with resuming warfarin treatment after hemorrhagic stroke or traumatic intracranial hemorrhage in patients with atrial fibrillation. JAMA Intern Med. 2017;177(4):563-70.

Dr. Horman is assistant clinical professor in the division of hospital medicine, department of medicine, University of California, San Diego.

SHORT TAKES

Community-based palliative care reduces emergency department visits

Retrospective cohort study showed that patients receiving community-based palliative care were less likely to seek ED care. The reduction was greater for older patients and for patients living in areas of higher socioeconomic status.

REFERENCE: Spilsbury K, Rosenwax L, Arendts G, Semmens JB. The association of community-based palliative care with reduced emergency department visits in the last year of life varies by patient factors. Ann Emerg Med. 2017;69(4):416-25.

By Leslie M. Martin, MD

5 Sooner may not be better: Study shows no benefit of urgent colonoscopy for lower GI bleeding

CLINICAL QUESTION: In patients hospitalized for a lower gastrointestinal bleeding (LGIB), does an urgent colonoscopy (less than 24 hours after admission) result in any clinical benefits, compared with waiting for an elective colonoscopy?

BACKGROUND: LGIB is a common cause of morbidity and mortality, often requiring hospitalization. While colonoscopy is necessary for appropriate work-up and treatment, it remains unclear if time to colonoscopy (urgent vs. elective) confers any clinical benefit in hospitalized patients.

STUDY DESIGN: Systematic review and meta-analysis.

SETTING: Twelve studies meeting inclusion criteria.

SYNOPSIS: Computerized bibliography databases were searched for appropriate studies, and 12 met inclusion criteria, resulting in a total sample size of 10,172 patients in the urgent colonoscopy arm and 14,224 patients in the elective colonoscopy.

Outcome measures included bleeding source identified on colonoscopy, therapeutic endoscopic interventions performed, patients requiring blood transfusions, rebleeding, adverse events, and mortality.

Urgent colonoscopy was associated with increased use of endoscopic therapeutic intervention (relative risk, 1.70; 95% CI, 1.08-2.67). There were no significant differences in bleeding source localization (RR, 1.08; 95% CI, 0.92-1.25), adverse event rates (RR, 1.05; 95% CI, 0.65-1.71), rebleeding rates (RR, 1.14; 95% CI, 0.74-1.78), transfusion requirement (RR, 1.02; 95% CI, 0.73-1.41), or mortality (RR, 1.17; 95% CI, 0.45-3.02) between urgent and elective colonoscopy.

Limitations of the study comprise of inclusion of small number of studies, underpowered statistical analysis, and possible variation in quality assessment of articles evaluated.

BOTTOM LINE: Urgent colonoscopy is safe and usually well tolerated in hospitalized patients with LGIB, but, compared with elective colonoscopy, there is no clear evidence it alters important clinical outcomes.

REFERENCE: Kouanda AM, Somsouk M, Sewell JL, Day LW. Urgent colonoscopy in patients with lower GI bleeding: A systematic review and meta-analysis. Gastrointest Endosc. Published online Feb 4, 2017. doi: 10.1016/j.gie.2017.01.035. TH

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ADDITIONAL REVIEWS AT THE-HOSPITALIST.ORG

- Use of probiotics in hospitalized adults to prevent *Clostridium difficile* infection
- Application of the MASCC and CISNE risk-stratification scores to identify low-risk febrile neutropenic patients in the emergency department
- Assessing the risks associated with MRI patients with a pacemaker or defibrillator
- Sodium bicarbonate versus sodium chloride for preventing contrast-associated acute kidney injury in critically ill patients
- Recurrence and mortality after first venous thromboembolism in a large population-based cohort

For more physician review of HM-relevant research, visit the-hospitalist.org.

Plenaries: HM leading health care shift to value, quality

By Richard Quinn

LAS VEGAS – The path to improved health care in the United States may never be straight – and it certainly won't be easy – but the three plenary speakers at HM17 think its destination is pretty clear: a system that increasingly rewards quality care delivered at lower costs.

And the three experts agreed that there may be "no finer group" than hospitalists to continue leading the charge.

Hospitalists "have been at the center of change, not only in building a new field and showing us that medicine doesn't have to be the way it always was," said Karen DeSalvo, MD, MPH, MSc, former acting assistant secretary for health in the U.S. Department of Health & Human Services. "You have been at the forefront of seeing that we're getting better value out of our health care system."

Dr. DeSalvo believes HM's scope of practice must evolve to include a focus on social determinants – such as economic stability, neighborhood and physical environment, education, and access to healthy options for food – because they have "direct relationships with mortality and morbidity and cost."

In other words, Dr. DeSalvo wondered aloud, what good is treating a grandmother's heart failure over and over if she's always going to return to the hospital because her home, her neighborhood, or her finances mean she is unable to prevent recurring issues?

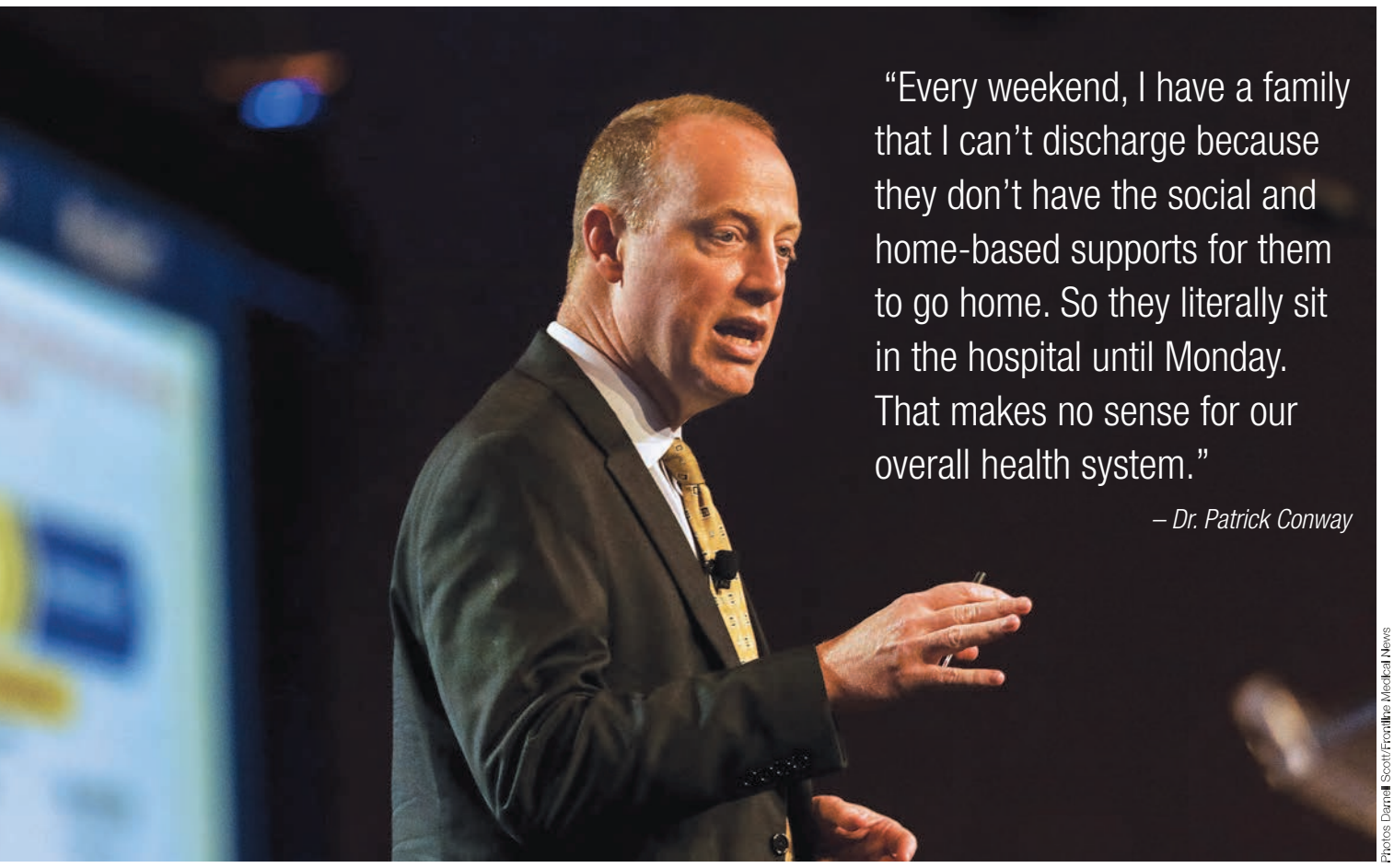
"If you listen to the hoof-beats that are coming, there is definitely a financial imprimatur to do this," Dr. DeSalvo said. "There is going to be an expectation from public and private payers ... that we are going to be taking into account and addressing social factors. Just look at the data from the people of this country – they are shouting loudly to you that they need help."

Patrick Conway, MD, MSc, MHM, deputy administrator for innovation and quality at the Centers for Medicare & Medicaid Services and director of its Center for Medicare and Medicaid Innovation, echoed Dr. DeSalvo's idea that HM needs to look at health care more holistically to help work on social issues. Dr. Conway, who still moonlights as a pediatric academic hospitalist on weekends, knows the problem firsthand as he often sees children on Medicaid who have multiple chronic conditions.

"I can tell you our system still does not have a highly reliable, whole health system for those children and their families," he said. "Every weekend, I have a family that I can't discharge because they don't have the social and home-based supports for them to go home. So they literally sit in the hospital until Monday. That makes no sense for our overall health system."

Dr. Conway assured attendees that health system transformation is a bipartisan ideal and that, for all the tumult in Washington, the progress of testing new payment- and service-delivery models will move forward.

Dr. Brian Harte conducts an interview with Dr. Karen DeSalvo during the opening plenary Tuesday at HM17.



Photos Darnell Scott/Frontline Medical News

Dr. Patrick Conway delivers the day 3 keynote on "Health Care System Transformation" during the Wednesday morning plenary at HM17.

The work "on value, the work on accountability, the work on bundled payments ... will continue and will continue to be important to you and the patients you serve," he said.

Robert Wachter, MD, MHM, concluded the meeting – as is tradition – by telling hospitalists the field remains positioned to take the lead for hospital transformation. And technology, despite its myriad frustrations, is still the tool that will get the field there.

"Digital is really important here, because it becomes an enabler for those stakeholders who care about what we do to measure what we do, and our ability to change what we do in a far more robust way than we could ever do before, if we get our acts together," Dr. Wachter said. "We're well past the time where you can nibble around the edges here, you can get this done with little mini projects. You really have to remake your whole delivery system, the way you do your work in order to succeed in this environment."

Dr. Wachter agreed that social determinants must be addressed. He said HM might do better to partner with folks handling those issues, rather than tackling them head on. Instead, HM needs to be "focusing on the right things" amid mounting pressures from digitization, consolidation of everything from health systems to insurance companies to HM companies, and the gravitation toward population health.

"We have successfully positioned ourselves as the people who are leaders in this work," Dr. Wachter said, "and it is increasingly important that we continue to do that as we go forward." TH

Grassroots policy demands that hospitalists team up

By Richard Quinn

LAS VEGAS – Alla Zilbering, MD, sat at attention for hours during HM17, jotting notes like a scribe about the myriad of federal rules that are pretty rapidly pushing hospitalists and health care as a whole away from fee-for-service payments to a world where doctors are paid for quality.

So, why did she do it? Why all that time on policy, instead of practice?

Because Dr. Zilbering felt compelled to get more involved. As a lead hospitalist at Cigna-HealthSpring, a Medicare Advantage program in Philadelphia, she's already part of initiatives to improve transitions of care and reduce readmissions.

However, she said she wants to do more. "I'm feeling like, unless you actually address the policy, you can't get that far in terms of what you can physically do with a patient."

SHM, this year, unveiled its first Health Policy Mini Track, dedicated to updating attendees on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Bundled Payments for Care Improvement initiative, and a host of other federal programs. Hospitalists were updated on a litany of advocacy efforts, including observation status, interoperability of electronic health records systems, and the recent launch of the first hospitalist billing code.

Two of the meeting's three keynote speakers were Washington veterans who confirmed that, while nightly news reports may suggest that health care reforms contained in the Affordable Care Act are constantly in flux, the trajectory toward paying for higher quality care at lower costs shows no signs of abating.

"There is no appetite, I'm telling you, on either side of the aisle to move away from the plan to create tremendous incentives, to have us move away from fee-for-service and move into alternative payment models," said new SHM president Ron Greeno, MD, MHM, who also chairs the society's Public Policy Committee.

Plenary speaker Patrick Conway, MD, MSc, MHM, deputy administrator for innovation and quality at the Centers for Medicare & Medicaid Services and director of its Center for Medicare and Medicaid Innovation, noted that the proposed American Health Care Act doesn't have a "single word dealing with the Innovation Center," which is the government agency tasked with supporting the development and testing of new payment and service delivery models.

He added that the policy's gravitation away from fee-for-service toward alternative payment models will ideally lead to better patient outcomes, more coordinated care, and financial savings.

M.A. Williams, MD, FHM, the medical director of perioperative services at Porter Adventist Hospital in Denver, said that the way to help design those systems is to get involved. Individual practitioners can make more impact than they think.

"Learn enough to be dangerous and go to your [Chief Medical Officer or] whoever you can get a meeting with because MACRA is going to affect all physicians in the organization, even if the system is not doing anything active about it," Dr. Williams said.

And that traction isn't just within the walls of a given institution, Dr. Greeno said. He wants more hospitalists involved in the society's overall advocacy efforts. That includes lobbying Congress both in person and with phone calls, letters, and emails and pressuring people at home via conduits like SHM's Grassroots Network, which has nearly 1,200 members from 490 states.

Don't think those things work? Dr. Greeno said, one need look no further than the new C6 Medicare billing code for hospitalists that went live in April. That didn't come to pass without a concentrated effort.

The code will help differentiate hospitalists at a time when MACRA will force changes in how hospitalists are paid. But, it will also define the specialty in a way that has never before been accomplished.

"It is an identity within Medicare," said Josh Boswell, SHM's director of government affairs.

While the ACA and the potential repeal of its insurance reforms have taken center stage in the media, Dr. Greeno urged hospitalists to focus more on the implementation and rule-making via MACRA.

The bill, which eliminated the Sustainable Growth Rate formula, states that, starting in 2019, Medicare payments will be provided through one of two pathways. The first is the Merit-Based Incentive Payment System that combines the Physician Quality Reporting System, the Physician Value-Based Modifier, and Meaningful Use into a single performance-based payment system.

The second option is Alternative Payment Models, which is meant to incentivize the adoption of payment models that move physicians away from fee-for-service models more quickly. For this pathway, the criteria require elements of "upside and downside financial risk," as well as meeting threshold requirements for either patients or payments. Those physicians that meet the criteria qualify for a 5% incentive payment.

The first payments in 2019 are based on performance data for 2017. As most hospitalists won't quality for APMs in the first year, they will default to the MIPS pathway, Dr. Greeno said.

"This bill will have a greater impact on ... providers than any piece of legislation in our lifetime," he noted. "Now, the ACA had a bigger impact on consumers, but, in terms of us as providers, MACRA is a sea change."

The topic is so important, SHM has created a website at www.macraforhm.org that is meant to serve as a tutorial to the law's basics. The guide is intended to educate hospitalists and to motivate them to get involved in the policy work that affects them all, Dr. Greeno said. TH

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– Dr. Ron Greeno

RIV spotlights HM-focused research in real time

By Richard Quinn

LAS VEGAS – Masih Shinwa, MD, stood beside a half-circle of judges at SHM's annual Research, Innovations, and Clinical Vignettes poster competition and argued why his entry, already a finalist, should win.

To think, his work, "Please 'THINK' Before You Order: A Multidisciplinary Approach to Decreasing Overutilization of Daily Labs," was borne simply of a group of medical students who incredulously said that they were amazed patients would be woken up in the night for tests.

Now it was a poster at RIV, one of the biggest highlights of SHM's annual meeting. The Scientific Abstracts Competition – the event's formal name – has exploded in popularity over the past few years. Submissions for posters rose from 634 in 2010 to 1,712 this year, and presenters ranged from first-year residents to a former SHM president.

Dr. Shinwa's project shows just how an idea can blossom into a recognized poster.

Some 18 months ago, the students he works with at Mount Sinai Hospital in New York just couldn't understand why so many tests had to be done overnight while a patient slept. So, Dr. Shinwa and his colleagues looked at ways to reduce unnecessary lab tests and chemistry testing.

Now, Dr. Shinwa was humbled to think his work and that of his colleagues could be a pathway to eliminating tests that don't need to happen across the country, a focal point of SHM and the American Board of Internal Medicine Foundation's Choosing Wisely Campaign.

Darnell Scott/Frontline Medical News

Dr. Benji Mathews (left), assistant professor of medicine at the University of Minnesota, explains his poster on point of care ultrasound to the judges during the Tuesday evening RIV poster session at HM17.

"This is a way to make it national," he said. "You may have affected the lives of the patients in your hospital, but, unless you attend these types of national meetings, it's hard to get that perspective across (the country)."

That level of personal and professional collaboration is the purpose of the RIV, said Margaret Fang, MD, MPH, FHM, program chair for the HM17 competition.

"One of the amazing things is, everyone has their own poster. They're doing their work," she added. "But then they start up conversations with the people next to them. ... Seeing the organic networking and discussion that arise from that is really exciting. RIV serves as a way of connecting people who might not have known the other person was doing that kind of work."

Dr. Fang said that the intergenerational aspect of the RIV, where early-career hospitalists mingle with the field's founders and leaders, creates an environment where research is encouraged.

"Just seeing the intense interest that more senior hospitalists have in mentoring and guiding the next generation is delightful," she added.

Dr. Shinwa said that the specialty's focus on both clinical research and systems-level change is important, as the work positions the field to be leaders not just in patient care but for hospitals as a whole.

"We are physicians," he said. "Our role is taking care of patients. Knowing that there are people who are not just focusing on taking care of specific patients but are actually there to improve the entire system and the process – that's really gratifying."

That's the word that Merideth Prevost, MD, of New Mexico VA Health Care System, Albuquerque, also used to describe presenting her poster, "Improving Accuracy in Measuring Fluid Balance on a General Medicine Ward."

"If we can improve our little microcosm, then spread it to other folks, then patients all over the country can be helped by what we do," she said. "And that's a really cool thought."

The RIV also has the unique advantage of letting people have immediate and direct access to lead researchers at the exact moment of reading their research. HM17 attendees had conversations that usually went beyond just the results, which can be downloaded at www.shmabstracts.com.

Dr. Prevost believes that the chats can helpfully highlight the behind-the-scenes pitfalls and mistakes of research that can sometimes be just as valuable as the published results.

"The things that don't make it to the posters are all the challenges that people experienced on the way to get to this particular work," she added. "You can brainstorm with every poster that you're interested in, which is really exciting." TH

For a complete list of RIV winners, visit www.the-hospitalist.org.

Hospitalists share strategies to secure, excel at jobs

By Richard Quinn

LAS VEGAS – In the view of academic hospitalist Alfred Burger, MD, SFHM, portability was long a dirty word in HM circles. But not anymore.

"My good friends in law and business do this all the time," said Dr. Burger, associate program director of the internal medicine residency program at Mount Sinai Beth Israel in New York. "You're not going to make partner in city X, but they've got an opening to be partner in city Y if you go there and perform for a year. People up and leave coasts, people up and leave states, people have up and left the country. ... Doctors are starting to view it the same way."

The lessons of career development were a focal point of HM17, particularly for younger physicians who could take advantage of the Early-Career Hospitalists mini-track. But Dr. Burger said that those strategies of upward mobility can apply whether someone is chasing their first job or their fifth.

First, identify one's strengths and play to those. Then identify the skills you don't have or don't excel at, and address those deficiencies.

"How can you acquire the skills to put yourself in the best position to move up, if you wish to develop your career as a leader?" Dr. Burger said. "If you wish to be the best clinician, you still need to stay on top of the game. Things like coming to SHM, staying on top of the content. That's important."

Another skill set is self-advocacy.

"Be your own champion," said Brian Markoff, MD, SFHM, chief of hospital medicine at Mount Sinai St. Luke's in New York. "Many of us are very good at this and many of us are terrible at this. You may fall somewhere in between, but you do have to be your own champion."

Dr. Burger said that he understands that there is a fine line between too much self-promotion and too little. But he urged hospitalists at all career points to take responsibility for marketing themselves.

"Nobody is going to invest in your career unless you yourself invest in it," he added. "You have to put it as a priority, and not in a selfish way, but in a way [that,] if you wish to move forward and move up, you've got to put the time in. It's not a natural assumption anymore that, if you are the best and brightest of a group of doctors, you will just be chosen to lead."

In a similar vein, networking is a major boon to career development that can be a double-edged scalpel.

"Having a great 'social game' is important, but if all you bring to the table is a social game, you'll find yourself out of a job just as quickly as you found that job," Dr. Burger said. "Meaning, you might be able to get it based on that, but you're not going to be able to sustain it. At the same time, being highly accomplished and having no social graces is also a killer. So, you need to be sort of strong in both areas."

Many of the meeting's opportunities for tips on professional development are personal, but HM group leaders have to consider developing the careers of their employees. One of the main planks of that is physician engagement, said Flora Kisuule, MD, MPH, SFHM, of Johns Hopkins University, Baltimore.

"I don't believe your institution or your organization can go anywhere if your employees are not engaged or if the people you work with are not engaged," she said, adding that disengaged employees "are actively working against you. You don't want that. You can't go in any direction when there are people rowing in the opposite direction. At best, you stay in one place. At worst, you can end up losing ground."

Hospitalist Christie Masters, MD, MBA, MHA, who practices at UCLA, disclosed during a session that she also runs a wellness coaching firm. She added that a focus on personal wellness and well-being is its own form of career development. It works in tandem with engagement, morale, and professional growth.

"If you're only focusing on wellness and you don't have hospitalists or a group that's engaged or with high morale, they're going to burnout or they're going to leave," Dr. Masters said. "And nobody wants that for their group. So, if we surround ourselves with people who feel well and feel whole, that's going to have intangible benefits ... that affect the bottom line." TH

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Attendees Dr. Scott Kaatz, right, of Hurley Medical, and Dr. Prakash Acharya address speakers in a Q&A during the "Best Research/Innovations of 2017" plenary at HM17 in Las Vegas.

Hospitalists' EMR frustrations continue: SHM report

By Richard Quinn

LAS VEGAS – Ronald Schaefer, MD, a hospitalist with Hawaii Pacific Health who also works on creating digital templates for his hospital, can't input hemoglobin $A1_c$ levels from three different labs into his electronic medical records (EMR) system the same way.

Hospitalist George Dimitriou, MD, FHM, who splits his time at Allegheny Health Network in Pittsburgh between clinical work and medical informatics, worries there are so many fields in his EMR that physicians can get distracted.

Yevgeniy "Eugene" Gitelman, MD, a clinical informatics manager at the Perelman School of Medicine at University of Pennsylvania Health in Philadelphia, wonders how good any systems can be with the privacy concerns related to HIPAA.

This was the nexus of IT and HM17, a time when hospitalists said they are stymied and frustrated by continuing issues of interoperability, functionality, and access. The meeting highlighted new smartphone and tablet applications, as well as medical devices available to hospitalists, but tech-focused physicians say the biggest issue remains the day-to-day workings of EMR.

"If you build something really good, people will use it. If you build something that makes their documentation process a lot easier and a lot faster and a lot better, they'll use it," said Dr. Schaefer. "The tools aren't there yet. I don't think the technology is mature enough."

If the tech hasn't yet come of full age, the concerns surely have. SHM unveiled a white paper at HM17 that codified hospitalists' worries about the current state of IT. The report, "Hospitalist Perspectives on Electronic Medical Records," (hospitalmedicine.org/ITEHR) found that "a staggering" 85% of providers said they actually spend more time interacting with their inpatient EMR than their inpatients.

Rupesh Prasad, MD, MPH, SFHM, chair of SHM's Health IT Committee, says the report is meant to foster discussion about the issues surrounding EMRs. The data points, generated from 462 respondents, are stark. Just 40% said they were happy with their EMR. Some 52% would change vendors if they could. One-quarter of respondents would revert to using paper if given the option.

"By sharing these results, we hope to raise awareness of the unacceptable performance of existing systems," the report states. "This continues to contribute to our slower than desired improvement in quality and safety, as well as increasing provider frustration. We strongly believe that we need a renewed focus on initial goals of technology adoption in health care."

Dr. Prasad said that he hopes hospitalists heed that call to action and use the report in discussions with various stakeholders, including vendors, public policy officials, and their own bosses.

> "As end users of technology, we understand the problems better than anybody else. Obviously, the next step would be try to solve the problems. And what better way than to get involved and become experts in what you do?"
>
> *– Dr. Rupesh Prasad*

"We want to give hospitalists ammunition to go back to their systems and talk to their administrators to see if they can influence [it]," he said.

Dr. Prasad is pleased that the society is sensitive to the issues surrounding technology. He encourages hospitalists to actively participate in HMX, SHM's online portal to discuss health IT issues and crowd-source potential solutions. Patrick Vulgamore, MPH, SHM's director of governance and practice management, said the society is formulating a potential special-interest working group to further seek to solve problems.

Hospitalists were also urged to apply for American Board of Medical Specialties (ABMS) certification in clinical informatics. Physicians can grandfather into eligibility via the "practice pathway" through the end of the year, if they've been working in informatics professionally for at least 25% of their time during any three of the previous 5 years. Next year, only graduates of 2-year Accreditation Council for Graduate Medical Education–accredited fellowships will be board eligible.

"As end users of technology, we understand the problems better than anybody else," Dr. Prasad said. "Obviously, the next step would be try to solve the problems. And what better way than to get involved and become experts in what you do?"

While much of the meeting's tech talk was frustration, both former National Coordinator for Health IT Karen DeSalvo, MD, MPH, MSc, and HM Dean Robert Wachter, MD, MHM, forecast a future when artificial intelligence and intuitive computers work alongside physicians. Imagine the user-friendliness of Apple's Siri or Google's Alexa married to the existing functionalities provided by firms such as Epic or Cerner.

But that's years away, and hospitalists like Dr. Dimitriou want help now.

"The speed of medicine, the speed of what's happening in real time, is still faster than what our electronic tools seem to be able to keep up with," he said. "There are encouraging signs that we've moved in the right direction. We've come a long way ... but we aren't keeping up. We've got to do more." TH

Practice management skills more relevant than ever

By Richard Quinn

LAS VEGAS – Babatunde Akinsete, MD, took a new job about 18 months ago as a lead hospitalist within Adventist Health System of Florida. The role has the expected leadership responsibilities, but those folks he's now partly supervising are the same ones who used to be his peers.

The same people he spent time "in the trenches" with, complaining about the problems they saw – issues that are now partly his job to help fix.

"It's tough," Dr. Akinsete said at the annual meeting of the Society of Hospital Medicine. "How do you motivate people?"

Welcome to managing a practice, circa 2017. The day-to-day doings of an HM group – recruiting, retention, compensation, scheduling, and more – are the backbone of the specialty. And SHM's annual meeting makes the topics a principal point, from a dedicated precourse to dozens of presentations to networking opportunities introducing experienced leaders to nascent ones.

The subject is more relevant than ever these days as the maturing specialty now has three generations of hospitalists practicing side by side, including those who founded the society and laid the groundwork for the specialty some 20 years ago and those who will now infuse it with new blood for the next 20 years, said Jerome Siy, MD, SFHM, an HM17 faculty member and chair of SHM's Practice Management Committee.

"We're heading into a cycle of a lot of change," he said. "Being able to manage change is going to be pretty key."

The first step in building or bettering a "healthy practice" is building a "culture of ownership," Dr. Siy said.

"You must have the right culture first if you're going to tackle any of these issues, whether it's things like schedules to finances to negotiations," he added. "Second is this openness and innovation to think outside the box and to allow yourself to hear things that might not work for you. Be open to it because whether you hear something that doesn't work or not, it may inspire you to figure out … what is the key element you were missing before."

That's what Liza Rodriguez Jimenez, MD, is taking away from the meeting. She is moving into a codirector position for her medical group at St. Luke's in Boise, Idaho. A crash course in alternative-payment models, full-time equivalents (FTEs), relative value units (RVUs) and scheduling was an eye-opener for her.

But to Dr. Siy's point, it wasn't the specific examples of how other people do what they do that intrigued Dr. Rodriguez Jimenez. It was more so that people just did it differently.

"It's just helpful to know that there are other choices," Dr. Rodriguez Jimenez said. "In other words, why do we do 7 on, 7 off? I don't know. We just do. If you don't know that you don't know, then how do you know to change it? You get exposed to so much stuff here now that you can theoretically go back and say, 'why do we do 7 on, 7 off? … And then let the group say we want 5 on, 10 off, 4 on, 3 off. Whatever people decide."

Nasim Asfar, MD, SFHM, chief quality officer of the department of medicine at UCLA Health in Los Angeles, said that idea of just framing the question differently is a big deal, and a leadership skill in and of itself. For example, say a hospital medicine group's leaders are trying to discuss whether the practice should continue its comanagement focus.

"If you frame a decision as, 'We are going to lose this comanagement,' there's just something, like a gut feeling. You don't want to lose stuff," she said. "As opposed to, if you say, 'Gosh, think about the gains. That we will have all this free time that we now have where we can develop other aspects of our hospital medicine group.' So when you frame the same exact thing in terms of loss, it becomes so much more difficult for us to actually let go of that."

Leadership is more than just framing, of course. Dr. Asfar and former SHM president Eric Howell, MD, MHM, said that leadership traits include using standardized processes to make decisions, as well as getting group members involved in those decisions when necessary and using feedback and motivation properly.

But, at day's end, practice management is managing the needs of your practice.

For Abdul-Hady Kheder, MD, of Hamilton Hospitalists in Central New Jersey, the meeting opened his eyes to techniques he could use to deal with lower reimbursement figures and less patients.

"What can help my situation will be increasing the volume of the practice," he said. "Right now, we admit 30%-40% of the patients ... into the hospital. National average is 60%-90% of total hospital admissions. I think that most probably will balance my financial dilemma."

For Rodney Hollis, practice administrator for Eskenazi Health of Indianapolis, the meeting was a way to glean tips on improving his practice. One nugget he's excited about: pairing an experienced hospitalist with a new hire for a year. As a nonclinical administrator, Mr. Hollis said he views his role as helping clinicians work on the things they are best at, while he handles the rest.

"The more clinical time that the clinical directors can spend, that's more advantageous to the group," Mr. Hollis said. "Allowing the nonclinical activities to be done by an administrator helps. We want more responsibility and if there's something that our clinical is doing that I can do, why not have me do it?"

For Dr. Rodriguez Jimenez, open-ended questions like that one are among the most "insightful" takeaways from the meeting.

"There is no right or wrong way, so maybe we've been doing it this way 'just because,' " she said. "Now we need to look at it and say, 'Can we do it a different way? Can we adapt it? Can we change it?' "

She's starting to sound like a practice manager already. TH

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>
> – Dr. Nasim Asfar

HM17 session summaries

Building a practice that people want to be part of

By Miguel Villagra, MD, FACP, FHM

Presenters
Roberta Himebaugh MBA, SHM; John Nelson, MD, FACP, MHM; Jerome Siy, MD, SFHM

Session summary
Creating a "culture of ownership" by recruiting the right people, promoting physician leadership, and improving structural elements such as compensation model and schedule were topics discussed in this practice management precourse at HM17.

The presenters said leaders must reduce hierarchy and promote shared decision making among the group, while instilling a "thank you culture" that recognizes motivations such as autonomy, mastery, and purpose.

Current challenges related to most hospitalist groups include excessive documentation, clerical and administrative duties, and frequent low-value interruptions. One potential solution discussed was delegation of some of these duties to registered nurses, medical assistants, and possibly scribes, although the latter is currently in early adoption stages.


Dr. Villagra

Leaders must also consider current changes in health care payment models, such as MIPS (Merit-Based Incentive Payment System), bundled payments, and Hospital Value-Based Purchasing. Hospitalist groups must be prepared for these changes by learning about them and looking for potential cost reduction opportunities (e.g., reducing the number of patients going to skilled nursing facilities after joint replacement by sending patients home whenever possible).

Promoting a culture of engagement might include the development of interpersonal support strategies (e.g., meditation and mindfulness), innovative staffing (is 7 on/7 off right for everyone?), and comprehensive support for career and leadership development.

Finally, hospitalists should give special attention to the value formula by focusing on improving patient outcomes and experience, but also reducing direct and indirect costs. This is crucial for the sustainability of any hospitalist group.

Key takeaways for HM
- Create a culture of ownership to promote engagement and job satisfaction.
- Make adjustments to schedule and workflow to improve efficiency.
- Prepare for evolving pay-for-performance programs.
- Demonstrate the value of the group by setting expectations with key stakeholders, developing a practice score, and providing effective feedback to providers. TH

Dr. Villagra is a chief hospitalist in Batesville, Ark., and an editorial board member of The Hospitalist.

The art of story in delivering memorable lectures

By James Kim, MD

Presenter
Ethan Cumbler, MD, FACP, FHM

Session summary
This session was designed to give learners a different paradigm in thinking about the structure and organization of presentations, for a more dynamic and engaging lecture.


Dr. Kim

Memorable teaching points are tied to a narrative with emotional impact. One study of surgery residents immediately after finishing grand rounds found that learners only remember approximately 10% of the material embedded in a lecture. Therefore, the lecture should not necessarily include a comprehensive amount of information, but make major points as "sticky" as possible.

One must be familiar with the topic, but it is important to empathize with the audience and ask oneself "what do they want out of this?"

This will help anchor your presentation and will hopefully assist in creating an organizational framework. Think about a real patient case to keep the audience engaged. You can add drama and suspense as the audience and the speaker work through the case together.

One should have a "hook" as an analogy to engage with the audience while reinforcing the central message.

Dr. Cumbler recommends thinking of slides from a design perspective. In order to provide more content while not burdening slides with more text, consider handouts to provide information that one cannot show during the presentation.

It is incredibly difficult to stay engaged in a lecture delivered at the same pace and in a monotone. One should vary the volume and tempo during the talk and allow for pauses when appropriate.

A good talk is not only the information itself, but a presenter's presence, so think of body language and positioning. Use hand gestures to emphasize points in the lecture and draw the learners in. Make eye contact with individuals periodically. Move across the stage or walk through the audience with a wireless microphone to liberate oneself from the podium.

Key takeaways for HM
- Consider the stand-up comedy concept of the "call-back." Start with a concept, and then return to this concept in different forms through the presentation. One can return to another variation of this for a surprise at the end. One can make a key point memorable by using a theme with multiple variations.
- Think about structure in order to draw listeners into a talk and keep them invested (organizational framework centered around a patient); create a "hook"; think about slides visually, not from a content perspective; keep the tempo, timing, and volume dynamic; and use body language and presence to engage the room.
- If one would like to learn more, consider reading the book Presentation Zen; watch TED talks; practice multiple times to hone various aspects of the talk; give the talk multiple times for iterative improvement; always ask for feedback and try to change at least one thing from one talk to another to continuously improve. TH

Dr. Kim is a hospitalist who works at Emory University Hospital in Atlanta, and is an editorial board member of The Hospitalist.

Focus on POCUS: Introduction to Point-of-Care Ultrasound for pediatric hospitalists

By Weijen W. Chang, MD, SFHM, FAAP

Presenters
Nilam Soni, MD, FHM; Thomas Conlon, MD; Ria Dancel, MD, FAAP, FHM; Daniel Schnobrich, MD

Summary
Point-of-care ultrasound (POCUS) is rapidly gaining acceptance in the medical community as a goal-directed examination that answers a specific diagnostic question or guides a bedside invasive procedure. Adoption by pediatric hospitalists is increasing, aided by multiple training pathways, opportunities for scholarship, and organization development.

The use of POCUS is increasing among nonradiologist physicians because of the expectation for perfection, desire for improved patient experience, and increased availability of ultrasound machines. POCUS is rapid and safe, and can be used serially to monitor, provide procedural guidance, and lead to initiation of appropriate therapies.


Dr. Chang

Training in POCUS in limited applications is possible in short periods of time. One recent study showed that approximately 40% of POCUS cases led to new findings or alteration of treatment. However, POCUS requires training, monitoring for competence, transparency of training/competence, and a QA process.

Pediatric applications include guidance of bladder catheterization, identifying occult abscesses, diagnosis of pneumonia and associated parapneumonic effusion, and IV placement. More advanced applications include diagnosis of appendicitis, intussusception, and increased intracranial pressure. Novel applications have included sinus ultrasound.

Key takeaways for HM
- Point-of-care ultrasound (POCUS) is rapidly being adopted by pediatric hospitalists.
- Pediatric applications are still being developed, but include guidance of bladder catheterization, identifying occult abscesses, diagnosis of pneumonia, and IV placement.
- Initial training can be provided by pediatric ED physicians/pediatric ICU physicians or an on-site commercial course for larger groups.
- Relationships with radiologists should be established at the outset to avoid misunderstanding of POCUS. TH

Dr. Chang is a pediatric hospitalist at Baystate Children's Hospital and is the pediatric editor of The Hospitalist.

To read more HM17 session summaries, visit www.the-hospitalist.org.

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

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For additional information, please contact:

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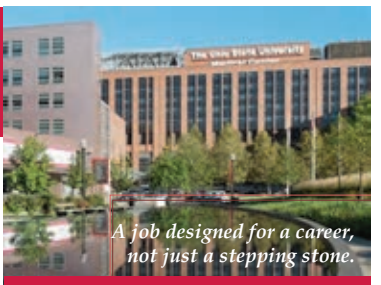

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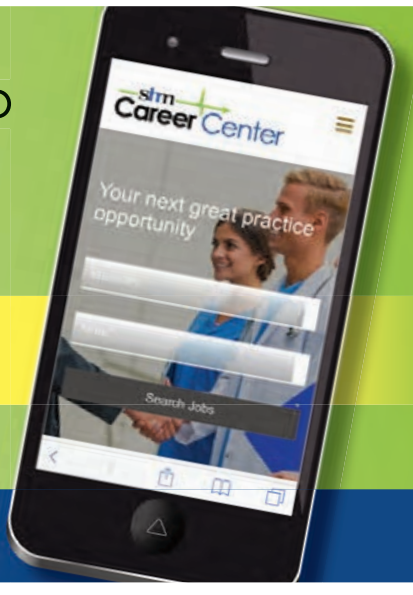

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- Michigan license
- Current CV
- Board certification or board eligibility

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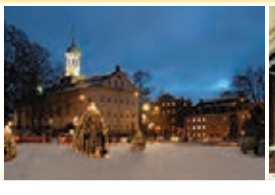


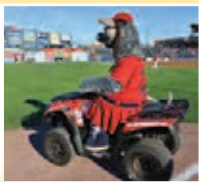

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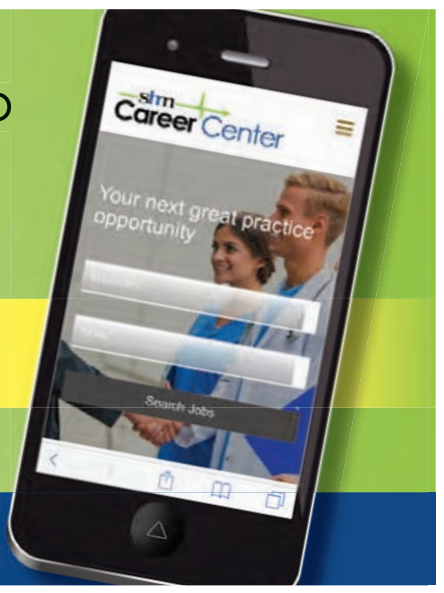

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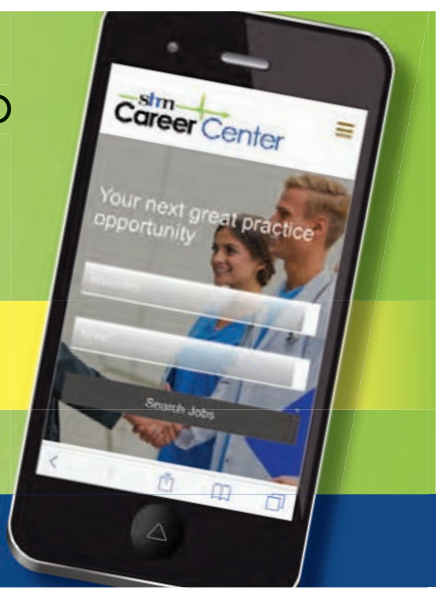

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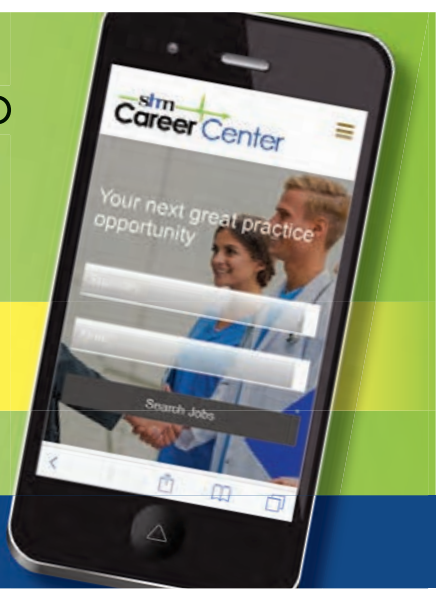

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A case for building our leadership skills

Dr. Afsar is an assistant clinical professor in the departments of medicine and neurosurgery and the associate chief medical officer at UCLA Hospitals.

Let me ask you a question: When was the last time you used the Krebs cycle in the hospital?

Now another question: When did you last have to persuade your boss to give you additional resources?

My guess is that your need for additional resources comes up more frequently than the Krebs cycle. It's interesting that we spent so much time in our training focused on biochemical pathways and next to nothing on leadership skills, such as ways to motivate our health care teams or the most effective way to provide feedback – skills that we use on a regular basis. Yet, these skills are just as critical as understanding the science behind our daily work.

I'll give you an example. I've been involved in quality improvement and operational work for a decade, so I often find myself in front of groups of health care professionals convincing them to implement new pathways and protocols.

In the past, I would present my case in the following way:

1. Highlight the importance of the ask.
2. Leverage data to prove the point.
3. Illustrate large-scale implications of the ask.
4. Make the ask.

I'll use a project to increase deep vein thrombosis prophylaxis (DVT) rates to illustrate this point:

1. Highlight the importance of DVT prophylaxis: I would focus on statistics that would surprise the audience, such as "Hospital acquired venous thromboembolism leads to significant morbidity and mortality, including more than 100,000 deaths."[1]
2. Leverage data to prove the point: "Worldwide, only 40%-60% of patients who require DVT prophylaxis actually receive it in the hospital.[2] Our performance leaves tremendous room for improvement – we're currently at 68%."
3. Illustrate large-scale implications of the ask: "If we do this, it enhances our reputation as a group, and it will improve hospital revenues."
4. Make the ask: "I have an evidence-based protocol that we need to implement to achieve results."

Through leadership courses over the past couple of years, I've changed my approach significantly. By leveraging concepts from behavioral economics, we can significantly improve the effect of our work. Here's how I would conduct that same meeting:

1. **Connect with the audience in a genuine way:** Start off with "You are quality-minded providers who have taken on major challenges in the past and successfully delivered results, like the time you reduced the rates of catheter-associated urinary tract infections."
2. **Make the ask:** "I'm here to talk to you about improving our DVT prophylaxis rates. Here's the protocol we need to implement."
3. **Leverage data to prove the point:** "DVT prophylaxis rates at the hospital across town (or at another unit in the hospital) are at 82%. What do you think our numbers are? We're actually at 68%!"
4. **Illustrate large-scale implications of the ask:** "We all know this. Patients under our care will die or be seriously harmed if we don't improve our practice. The hospital will also lose money, which will ultimately impact us. So, we have two options: a) We can continue what we've been doing – work as hard as we can and our practice will not improve. b) Or we can decide today to pilot this new protocol and change our practice and performance."

Let's look at the changes above in greater detail:

Connect with the audience in a genuine way: Instead of highlighting the importance of the ask with statistics, use an attention getter to connect with the group. Highlighting the fact that the group is "quality-minded" and has surmounted challenging obstacles in the past reinforces the providers' sense of identity.[3] This helps the group think more openly about the proposal.

Make the ask: Now that you've captured their attention, make your ask, clearly and concisely, upfront. Remember, in today's health care settings, we have short attention spans. You're minutes away from someone getting paged away from the meeting or people checking their emails or the latest Facebook post. Don't schedule the protocol review as the last item on the agenda.

Leverage data to prove your point: Data are powerful, but only if presented in the right way. Use questions to keep your audience engaged ("What do you think our numbers are?"), particularly around data, where most people decide to switch their attention to their smartphones. Based on your access to data sources, find another unit or institution with a higher performance than yours. State that upfront. It anchors the group to a higher number, so, when you reveal your current performance, the gap is highlighted.[3,4] In the first case, when the lower national average of 40%-60% is presented initially, the group will be happy that their performance is in fact better at 68%.

> Emphasizing that a decision has to be made today, and giving the group a choice around it, increases the likelihood of walking out of the meeting with a decision.

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Illustrate large-scale implications of the ask: There are two concepts at work here: First, loss aversion.[3,4] We tend to experience greater psychological burden with losses versus gains. Changing the framing from the fact that the hospital will lose money, versus making money in the first case, changes how we perceive the information. Second, active choice.[3] Emphasizing that a decision has to be made today, and giving the group a choice around it, increases the likelihood of walking out of the meeting with a decision.

With some simple, yet thoughtful, modifications, the message takes on a more effective tone, and, based on my experience, it is significantly more impactful.

So, while I'm a fan of biochemical pathways that enable us to generate energy, I also hope we can integrate leadership lessons into our day-to-day learning and life. TH

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

Will artificial intelligence make us better doctors?

Gating factors: Data availability, signal, noise.

Given the amount of time physicians spend entering data, clicking through screens, navigating pages, and logging in to computers, one would have hoped that substantial near-term payback for such efforts would have materialized.

Many of us believed this would take the form of health information exchange – the ability to easily access clinical information from hospitals or clinics other than our own, creating a more comprehensive picture of the patient before us. To our disappointment, true information exchange has yet to materialize. (We won't debate here whether politics or technology is culpable.) We are left to look elsewhere for the benefits of the digitization of the medical records and other sources of health care knowledge.

Lately, there has been a lot of talk about the promise of machine learning and artificial intelligence (AI) in health care. Much of the resurgence of interest in AI can be traced to IBM Watson's appearance as a contestant on Jeopardy in 2011. Watson, a natural language supercomputer with enough power to process the equivalent of a million books per second, had access to 200 million pages of content, including the full text of Wikipedia, for Jeopardy.[1] Watson handily outperformed its human opponents – two Jeopardy savants who were also the most successful contestants in game show history – taking the $1 million first prize but struggling in categories with clues containing only a few words.

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MD Anderson and Watson: Dashed hopes follow initial promise

As a result of growing recognition of AI's potential in health care, IBM began collaborations with a number of health care organizations to deploy Watson.

In 2013, MD Anderson Cancer Center and IBM began a pilot to develop an oncology clinical decision support technology tool powered by Watson to aid MD Anderson "in its mission to eradicate cancer." Recently, it was announced that the project – which cost the cancer center $62 million – has been put on hold, and MD Anderson is looking for other contractors to replace IBM.

While administrative problems are at least partly responsible for the project's challenges, the undertaking has raised issues with the quality and quantity of data in health care that call into question the ability of AI to work as well in health care as it did on Jeopardy, at least in the short term.

Health care: Not as data rich as you might think

"We are not 'Big Data' in health care, yet." – *Dale Sanders, Health Catalyst.*[2]

In its quest for Jeopardy victory, Watson accessed a massive data storehouse subsuming a vast array of knowledge assembled over the course of human history. Conversely, for health care, Watson is limited to a few decades of scientific journals (that may not contribute to diagnosis and treatment as much as one might think), claims data geared to billing without much clinical information like outcomes, and clinical data from progress notes (plagued by inaccuracies, serial "copy and paste," and nonstandardized language and numeric representations), and variable-format reports from lab, radiology, pathology, and other disciplines.

> While machine learning has had mixed results in predicting future clinical events, this is likely to change as data integrity and algorithms improve.

To articulate how data-poor health care is, Dale Sanders, executive vice president for software at Health Catalyst, notes that a Boeing 787 generates 500 GB of data in a 6 hour flight while one patient may generate just 100 MB of data in an entire year.[2] He said that AI platforms like Watson currently do not have enough data substrate to impact health care as many hoped it would. Over the longer term, he says, if health care can develop a coherent, standard approach to data content, AI may fulfill its promise.

What can AI and related technologies achieve in the near-term?

"AI seems to have replaced Uber as the most overused word or phrase in digital health." – *Reporter Stephanie Baum, paraphrasing from an interview with Bob Kocher, Venrock Partners.*[3]

My observations tell me that we have already made some progress and are likely to make more strides in the coming years, thanks to AI, machine learning, and natural language processing. A few areas of potential gain are:

Clinical documentation

Technology that can derive meaning from words or groups of words can help with more accurate clinical documentation. For example, if a patient has a documented UTI but also has in the record an 11 on the Glasgow Coma Scale, a systolic BP of 90, and a respiratory rate of 24, technology can alert the physician to document sepsis.

Quality measurement and reporting

Similarly, if technology can recognize words and numbers, it may be able to extract and report quality measures (for example, an ejection fraction of 35% in a heart failure patient) from progress notes without having a nurse-abstractor manually enter such data into structured fields for reporting, as is currently the case.

Predicting readmissions, mortality, other events

While machine learning has had mixed results in predicting future clinical events, this is likely to change as data integrity and algorithms improve. Best-of-breed technology will probably use both clinical and machine learning tools for predictive purposes in the future.

In 2015, I met Vinod Khosla, cofounder of SUN Microsystems and venture capitalist, who predicts that computers will largely supplant physicians in the future, at least in domains relying on access to data. As he puts it, "the core functions necessary for complex diagnoses, treatments, and monitoring will be driven by machine judgment instead of human judgment."[4]

While the benefits of technology, especially in health care, are often oversold, I believe AI and related technologies will some day play a large role alongside physicians in the care of patients. However, for AI to deliver, we must first figure out how to collect and organize health care data so that computers are able to ingest, digest, and use it in a purposeful way. TH

Disclosures: Dr. Whitcomb is founder and adviser to Zato Health, which uses natural language processing and discovery technology in health care.

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