Danielle Scheurer, MD, MSCR, SFHM, is the chief quality officer and professor of medicine at the Medical University of South Carolina, Charleston. She is the outgoing medical editor of The Hospitalist, and the new president of the Society of Hospital Medicine. She assumes the role from immediate past-president Christopher Frost, MD, SFHM.

As a hospitalist for 17 years, Dr. Scheurer has practiced in both academic tertiary care, as well as community hospital settings. As a chief quality officer, she has worked to improve quality and safety in all health care settings, including ambulatory care, nursing homes, home health, and surgical centers. She brings a broad experience in the medical industry to the SHM presidency.

**At what point in your education/training did you decide to practice hospital medicine?**

I always loved inpatient medicine throughout my entire meds-peds residency training at Duke University, Durham, N.C. I honestly never had a doubt that hospital medicine was going to be my career. What appeals to me is that each hour and each day is different, which is invigorating.

**What are your favorite aspects of clinical practice and of your administrative duties?**

I like doing both administrative work and clinical work because I believe having a view of both worlds helps me to be a better physician and a better administrator. It greatly

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**SURVEY INSIGHTS**

Linda M. Kurian, MD, SFHM, FACP

p9 Latest trends in hospitalist compensation.

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**CEO CORNER**

Laurence Wellikson, MD, MHM

p31 The future of hospital medicine.
Dr. Eric Howell selected as next CEO of SHM

The Society of Hospital Medicine has announced that Eric Howell, MD, MHM, will become its next CEO effective July 1, 2020. Dr. Howell will replace Laurence Wellikson, MD, MHM, who helped to found the society, and has been its first and only CEO since 2000.

“On behalf of the SHM board of directors, we welcome Dr. Howell as the incoming CEO for our organization who, with the mission-driven commitment and dedication of SHM staff, will take SHM into the future,” said Danielle Scheurer, MD, MSRC, SFHM, president-elect of SHM and chair of the CEO search committee. “With his broad knowledge of hospital medicine and extensive volunteer leadership at SHM, Dr. Howell’s experience is a natural complement to SHM’s core mission.”

Dr. Howell has a long history with SHM and has a wealth of expertise in hospital medicine. Since July 2018, he has served as chief operating officer of SHM, leading senior management’s planning and defining organizational goals to drive extensive, sustainable growth. Dr. Howell has also served as the senior physician adviser to SHM’s Center for Quality Improvement, the society’s arm that conducts quality improvement programs for hospitalist teams, since 2015. He is a past president of SHM’s board of directors and currently serves as the course director for the SHM Leadership Academy.

“Having been involved with SHM in many capacities since first joining, I am truly honored to become SHM’s CEO,” Dr. Howell said. “I always tell everyone that my goal is to make the world a better place, and I know that SHM’s staff will be able to do just that through the development and deployment of a variety of products, tools, and services to help hospitalists improve patient care.”

In addition to serving in various capacities at SHM, Dr. Howell has been a professor of medicine in the department of medicine at Johns Hopkins University, Baltimore. He has held multiple titles within the Johns Hopkins medical institutions, including chief of the division of hospital medicine at Johns Hopkins Bayview Medical Center in Baltimore, section chief of hospital medicine for Johns Hopkins Community Physicians, deputy director of hospital operations for the department of medicine at Johns Hopkins Bayview, and chief medical officer of operations at Johns Hopkins Bayview. Dr. Howell joined the Johns Hopkins Bayview hospitalist program in 2000, began the Howard County (Md) General Hospital hospitalist program in 2010, and oversaw nearly 200 physicians and clinical staff providing patient care in three hospitals.

Dr. Howell received his electrical engineering degree from the University of Maryland, which has proven instrumental in his mastery of managing and implementing change in the hospital. His research has focused on the relationship between the emergency department and medicine floors, improving communication, throughput, and patient outcomes.

The search process was led by a CEO search committee, composed of members of the SHM board of directors and assisted by the executive search firm Spencer Stuart. Launching a nationwide search, the firm identified candidates with the values and leadership qualities necessary to ensure the future growth of the organization.

“After a thorough search process, Dr. Eric Howell emerged as the right person to lead SHM,” said SHM board president Christopher Frost, MD, SFHM. “His experience in hospital medicine and his servant leadership style make him an ideal fit to lead SHM to even greater future success.”

In the coming weeks, the SHM board of directors will work with Dr. Howell and Dr. Wellikson on a smooth transition plan to have Dr. Howell assume the role on July 1, 2020.
ELIQUIS:
THE EFFICACY
AND SAFETY*

I WOULD CHOOSE
FOR MYSELF
FOR MY DAD
FOR MY FRIEND
FOR MY PATIENTS

*BASED ON CLINICAL TRIAL DATA VS WARFARIN IN PATIENTS WITH NVAF.

INDICATION
ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF).

SELECTED IMPORTANT SAFETY INFORMATION

WARNING: (A) PREMATURE DISCONTINUATION OF ELIQUIS INCREASES THE RISK OF THROMBOTIC EVENTS,
(B) SPINAL/EPIDURAL HEMATOMA

(A) Premature discontinuation of any oral anticoagulant, including ELIQUIS, increases the risk of thrombotic events. If anticoagulation with ELIQUIS is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant.

(B) Epidural or spinal hematomas may occur in patients treated with ELIQUIS who are receiving neuraxial anesthesia or undergoing spinal puncture. These hematomas may result in long-term or permanent paralysis. Consider these risks when scheduling patients for spinal procedures. Factors that can increase the risk of developing epidural or spinal hematomas in these patients include:

- use of indwelling epidural catheters
- concomitant use of other drugs that affect hemostasis, such as nonsteroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, other anticoagulants
- a history of traumatic or repeated epidural or spinal punctures
- a history of spinal deformity or spinal surgery
- optimal timing between the administration of ELIQUIS and neuraxial procedures is not known

Monitor patients frequently for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary.

Consider the benefits and risks before neuraxial intervention in patients anticoagulated or to be anticoagulated.

CONTRAINDICATIONS

- Active pathological bleeding
- Severe hypersensitivity reaction to ELIQUIS (e.g., anaphylactic reactions)

Please see additional Important Safety Information and accompanying Brief Summary of Full Prescribing Information, including Boxed WARNINGS, on the adjacent pages.
ARISTOTLE study design\(^1,2\)
A phase III, double-blind, randomized trial designed to compare the effects of ELIQUIS 5 mg twice daily\(^*\) (n=9120) and warfarin (n=9081) (target INR range: 2.0-3.0) in reducing the risk of stroke and systemic embolism in 18,201 patients with NVAF and ≥1 additional risk factor for stroke: prior stroke or transient ischemic attack (TIA); prior systemic embolism; age ≥75 years; arterial hypertension requiring treatment; diabetes mellitus; heart failure ≥New York Heart Association (NYHA) Class 2; or left ventricular ejection fraction (LVEF) ≤40%. Patients were followed for a median of 1.7 years. The 2 treatment groups were well balanced with respect to baseline characteristics, including age, stroke risk at entry as measured by CHADS\(_2\) score,\(^3\) and prior vitamin K antagonist (VKA) experience. The primary efficacy endpoint was stroke/systemic embolism, and the primary safety endpoint was major bleeding. Patients who needed aspirin >165 mg/day or needed aspirin plus a thienopyridine (eg, clopidogrel) were excluded from ARISTOTLE.

AVERROES study design\(^1,3\)
AVERROES was a phase III, double-blind, randomized trial designed to compare the effects of ELIQUIS 5 mg twice daily\(^*\) (n=2807) and aspirin (81 mg–324 mg once daily) (n=2791) in reducing the risk of stroke and systemic embolism in 5598 patients with NVAF thought not to be candidates for warfarin therapy, and with ≥1 additional risk factor for stroke: prior stroke or TIA; age ≥75 years of age; arterial hypertension (receiving treatment); diabetes mellitus (receiving treatment); heart failure (≥NYHA Class 2 at the time of enrollment); LVEF ≤35%, or documented peripheral artery disease. Patients could not be receiving VKA therapy (eg, warfarin), either because it had already been demonstrated to be or was expected to be unsuitable for them. The 2 treatment groups were well balanced with respect to baseline characteristics, including age, stroke risk at entry as measured by CHADS\(_2\) score,\(^3\) and prior use of a VKA within 30 days before screening. The mean follow-up period was approximately 1.1 years. The primary efficacy endpoint was stroke/systemic embolism, and the primary safety endpoint was major bleeding.

\(^*\)A dose of 2.5 mg twice daily was assigned to patients with ≥2 of the following characteristics: age ≥80 years, body weight ≤60 kg, or serum creatinine ≥1.5 mg/dL.\(^1\)

\(^3\)Scale from 0 to 6 to estimate stroke risk; higher scores predict greater risk.\(^2\)

SELECTED IMPORTANT SAFETY INFORMATION
WARNINGS AND PRECAUTIONS

- **Increased Risk of Thrombotic Events after Premature Discontinuation:** Premature discontinuation of any oral anticoagulant, including ELIQUIS, in the absence of adequate alternative anticoagulation increases the risk of thrombotic events. An increased rate of stroke was observed during the transition from ELIQUIS to warfarin in clinical trials in atrial fibrillation patients. If ELIQUIS is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant.

- **Bleeding Risk:** ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding.
  - Concomitant use of drugs affecting hemostasis increases the risk of bleeding, including aspirin and other antiplatelet agents, other anticoagulants, heparin, thrombolytic agents, SSRIs, SNRIs, and NSAIDs.
  - Advise patients of signs and symptoms of blood loss and to report them immediately or go to an emergency room. Discontinue ELIQUIS in patients with active pathological hemorrhage.
  - The anticoagulant effect of apixaban can be expected to persist for at least 24 hours after the last dose (ie, about two half-lives). An agent to reverse the anti-factor Xa activity of apixaban is available. Please visit www.an dexxa.com for more information on availability of a reversal agent.

- **Spinal/Epidural Anesthesia or Puncture:** Patients treated with ELIQUIS undergoing spinal/epidural anesthesia or puncture may develop an epidural or spinal hematoma which can result in long-term or permanent paralysis. The risk of these events may be increased by the postoperative use of indwelling epidural catheters or the concomitant use of medicinal products affecting hemostasis. Indwelling epidural or intrathecal catheters should not be removed earlier than 24 hours after the last administration of ELIQUIS. The next dose of ELIQUIS should not be administered earlier than 5 hours after the removal of the catheter. The risk may also be increased by traumatic or repeated epidural or spinal puncture. If traumatic puncture occurs, delay the administration of ELIQUIS for 48 hours. Monitor patients frequently and if neurological compromise is noted, urgent diagnosis and treatment is necessary. Physicians should consider the potential benefit versus the risk of neuraxial intervention in ELIQUIS patients.

- **Prosthetic Heart Valves:** The safety and efficacy of ELIQUIS have not been studied in patients with prosthetic heart valves and is not recommended in these patients.

- **Acute PE in Hemodynamically Unstable Patients or Patients who Require Thrombolyis or Pulmonary Embolectomy:** Initiation of ELIQUIS is not recommended as an alternative to unfractionated heparin for the initial treatment of patients with PE who present with hemodynamic instability or who may receive thrombolysis or pulmonary embolectomy.

- **Increased Risk of Thrombosis in Patients with Triple Positive Antiphospholipid Syndrome (APS):** Direct-acting oral anticoagulants (DOACs), including ELIQUIS, are not recommended for use in patients with triple-positive APS. For patients with APS (especially those who are triple positive [positive for lupus anticoagulant, anticardiolipin, and anti–β2-glycoprotein I antibodies]), treatment with DOACs has been associated with increased rates of recurrent thrombotic events compared with vitamin K antagonist therapy.

ADVERSE REACTIONS

- **The most common and most serious adverse reactions reported with ELIQUIS were related to bleeding.**

TEMPORARY INTERRUPTION FOR SURGERY AND OTHER INTERVENTIONS

- **ELIQUIS should be discontinued at least 48 hours prior to elective surgery or invasive procedures with a moderate or high risk of unacceptable or clinically significant bleeding. ELIQUIS should be discontinued at least 24 hours prior to elective surgery or invasive procedures with a low risk of bleeding or where the bleeding would be noncritical in location and easily controlled. Bridging anticoagulation during the 24 to 48 hours after stopping ELIQUIS and prior to the intervention is not generally required. ELIQUIS should be restarted after the surgical or other procedures as soon as adequate hemostasis has been established.

DRUG INTERACTIONS

- **Combined P-gp and Strong CYP3A4 Inhibitors:** Inhibitors of P-glycoprotein (P-gp) and cytochrome P450 3A4 (CYP3A4) increase exposure to apixaban and increase the risk of bleeding. For patients receiving ELIQUIS doses of 5 mg or 10 mg twice daily, reduce the dose of ELIQUIS by 50% when ELIQUIS is coadministered with drugs that are combined P-gp and strong CYP3A4 inhibitors (eg, ketoconazole, itraconazole, or ritonavir). In patients already taking 2.5 mg twice daily, avoid coadministration of ELIQUIS with combined P-gp and strong CYP3A4 inhibitors. Clarithromycin

Although clarithromycin is a combined P-gp and strong CYP3A4 inhibitor, pharmacokinetic data suggest that no dose adjustment is necessary with concomitant administration with ELIQUIS.
A dose of 2.5 mg twice daily was assigned to patients with at least 2 of the following characteristics: age ≥80 years, body weight ≤60 kg, or serum creatinine ≥1.5 mg/dL. Prior stroke or transient ischemic attack (TIA); prior systemic embolism; age ≥75 years; arterial hypertension requiring treatment; diabetes.

A phase III, double-blind, randomized trial designed to compare the effects of ELIQUIS 5 mg twice daily* (n=9120) and warfarin (n=9081) (target INR range: 2.0-3.0) in reducing the risk of stroke and systemic embolism in 18,201 patients with NVAF and ≥1 additional risk factor for stroke: The ARISTOTLE study design 1,2

The most common reason for treatment discontinuation in both ARISTOTLE and AVERROES was bleeding-related adverse reactions; in ARISTOTLE, this occurred in 1.7% and 2.5% of patients treated with ELIQUIS and warfarin, respectively, and in AVERROES, in 1.5% and 1.3% on ELIQUIS and aspirin, respectively.3

Major bleeding was defined as clinically overt bleeding accompanied by ≥1 of the following:1
A decrease in hemoglobin of ≥2 g/dL over 24 hours; transfusion of 2 or more units of packed red blood cells; bleeding that occurred in at least one of the following critical sites: intracranial, intraspinal, intraocular, pericardial, intra-articular, intramuscular with compartment syndrome, retroperitoneal; and fatal bleeding.

**DRUG INTERACTIONS (cont’d)**
- Combined P-gp and Strong CYP3A4 Inducers: Avoid concomitant use of ELIQUIS with combined P-gp and strong CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin, St. John’s wort) because such drugs will decrease exposure to apixaban.
- Anticoagulants and Antiplatelet Agents: Coadministration of antiplatelet agents, fibrinolytics, heparin, aspirin, and chronic NSAID use increases the risk of bleeding. APPRAISE-2, a placebo-controlled clinical trial of apixaban in high-risk postacute coronary syndrome patients treated with aspirin or the combination of aspirin and clopidogrel, was terminated early due to a higher rate of bleeding with apixaban compared to placebo.

**SELECTED IMPORTANT SAFETY INFORMATION**

**pregnancy**
- The limited available data on ELIQUIS use in pregnant women is insufficient to inform drug-associated risks of major birth defects, miscarriage, or adverse developmental outcomes. Please see accompanying Brief Summary of Full Prescribing Information, including Boxed WARNINGS, on the adjacent pages.
Monitor patients frequently for signs and symptoms of neurological impairment (e.g., numbness or paresthesia). When removal of the catheter is indicated, the risk may also be increased by traumatic or repeated epidural or intrathecal catheters should not be removed earlier than 24 hours after the last administration of apixaban. Also, avoid the use of neuraxial anesthesia in patients at risk of developing an epidural or spinal hematoma which can result in long-term or permanent neurological deficits. The maximum duration of exposure was approximately 50 weeks (>3000 patient-years).

The most common reason for treatment discontinuation in both studies was for bleeding-related adverse events. The AE rate was similar in patients treated with ELIQUIS and warfarin, and as per AIREs, in 1.1% and 1.0% on ELIQUIS and apixaban, respectively. Discontinuation in patients with Anticoagulated or to be anticoagulated

Other ICH 15 (0.10) 51 (0.34) 0.29 (0.16, 0.51) -

Fatal ** 10 (0.06) 37 (0.24) 0.27 (0.13, 0.53) -

Clinical Trials Experience

First dose of ELIQUIS 2.5 mg twice daily was administered in Phase II and Phase III studies including 504 patients exposed to ELIQUIS 2.5 mg twice daily undergoing major orthopedic surgery of the lower extremity. As per the protocol, elective knee replacement surgery for up to 30 days. In total, 11% of the patients treated with ELIQUIS 2.5 mg twice daily experienced adverse reactions.

Blood testing results during the treatment period in the Phase II & III studies are shown in Table 3. Blood testing was assessed in early stage with the first dose of dual-blind study drug.

Acute PE in Hemodynamically Unstable Patients or Patients who Require Thrombolysis or Pulmonary Embolectomy

Thrombotic Events associated with each endpoint were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

P-value

ADVANCE-1 Knee Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

p<0.0001

ADVANCE-3 Hr Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

p<0.0001

ADVANCE-2 Knee Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

p<0.0001

ADVANCE-1 Knee Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

p<0.0001

ADVANCE-2 Knee Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

p<0.0001

ADVANCE-1 Knee Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

p<0.0001

ADVANCE-1 Knee Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.

Table 1: Bleeding Events in Patients with Nonvalvular Atrial Fibrillation in ARISTOTLE

Bleeding endpoints

p<0.0001

ADVANCE-1 Knee Replacement Surgery

1st dose (21.4%)

F (0.07)

Bleeding events occurring within subcategories were counted once per subject, but subjects may have contributed to more than one bleeding event. For the safety population, compared to ITT analysis presented in Table 1.
The mean duration of exposure to ELIQUIS was 154 days and to enoxaparin/warfarin was 840 patients exposed to ELIQUIS 2.5 mg twice daily.

Common adverse reactions (≥1%) were gingival bleeding, epistaxis, contusion, hematuria, twice daily, and 840 patients exposed to ELIQUIS 2.5 mg twice daily.

Injury, poisoning, and procedural complications: wound secretion, incision-site hemorrhage, conjunctival hemorrhage, retinal hemorrhage, eye hemorrhage

Eye disorders:

Blood and lymphatic system disorders: thrombocytopenia (including platelet count decreases)

Gastrointestinal disorders:

gastrointestinal hemorrhage (including hematemesis and melena).

Hypotension (including procedural hypotension)

thrombocytopenia (including platelet count decreases)

surgery occurring at a frequency of ≥0.1% to <1%:

Serious adverse reactions that contributed events to multiple endpoints.

Laboratory data

maximal milk concentrations were observed within 6 hours of dosing. After the milk to plasma AUC (0-24 h) ratio is 0.31 indicating that vancomycin can accumulate to a risk. The concentrations of vancomycin in animal milk does not necessarily predict the concentration of drug in human milk.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

All patients receiving anticoagulants, including pregnant women, are at risk for bleeding.

Anticoagulants and Antiplatelet Agents

No dose adjustment is recommended for patients with renal impairment, including those with ESRD on dialysis (see Dosage and Administration (2.3) in full Prescribing Information). Clinical efficacy and safety studies with ELIQUIS did not enroll patients with ESRD on dialysis or patients with a GFR <15 mL/min. Therefore, dosage recommendations are based on pharmacokinetic and pharmacodynamic (anti-FXa activity) data in subjects with ESRD maintained on dialysis (see Clinical Pharmacology (12.3) in full Prescribing Information). ELIQUIS is not recommended in patients with severe hepatic impairment (Child-Pugh class C) (see Clinical Pharmacology (12.5) in full Prescribing Information).

OVERDOSAGE

Overshoot of ELIQUIS increases the risk of bleeding (see Warnings and Precautions).

In controlled clinical trials, elderly administered anticoagulant in healthy subjects of doses up to 50 mg daily for 2 to 7 days (2 mg twice daily for 7 days to 50 mg once daily for 3 days) had no clinically relevant adverse effects.

In healthy subjects, administration of activated charcoal 2 and 6 hours after ingestion of a 20 mg dose ofapixaban reduced mean AUC by 50% and 27%, respectively. Thus, administration of activated charcoal can be considered in patients who overdose and manifest significant adverse reactions.

For patients receiving ELIQUIS 5 mg or 10 mg twice daily, the dose of ELIQUIS should be reduced from 1.0 to 0.5 mg in patients with moderate hepatic impairment (Child-Pugh class B). Because patients with moderate hepatic impairment (Child-Pugh class B) may have altered pharmacokinetics, dosing recommendations cannot be provided (see Clinical Pharmacology (12.2) in full Prescribing Information). It is not known whether these alterations will lead to similar stroke reduction and bleeding risk in patients with ESRD on dialysis as was observed in the AMPLIFY-EXT study.

Prophylaxis of Deep Vein Thrombosis Following Hip or Knee Replacement Surgery, and Treatment of DVT and PE in the AMPLIFY-EXT Study

To tell their physicians and dentists they are taking ELIQUIS, and/or any other product known to effect bleeding (including nonsteroidal antiinflammatory drugs, such as aspirin or NSAIDs), before any surgery or dental procedure is scheduled and before any new drug is taken.

If the patient is having unusual sweating or special urination, inform the patient to withhold the tablet.

Risk Summary

There are data on the presence of apixaban or its metabolites in human milk, the effects on the breastfed infant, or the effects on milk production. Apixaban and/or its metabolites were present in the milk of lactating women in one study (see Milk and Breastfeeding Nursing (8.3) in full Prescribing Information). Because human milk through which breastfeeding is known is not recommended for treatment with ELIQUIS (see Drug Interactions (7.2)).

Data

Maximum plasma concentrations were observed after 30 minutes following a single oral administration of a 5 mg dose taken at 5 AM. Mean peak concentration occurred at 2.6 hours after dosing. During the milk to plasma AUC (0-24 h) ratio is 0.31 indicating that apixaban can accumulate to a risk. The concentrations of apixaban in animal milk does not necessarily predict the concentration of drug in human milk.

Patients with End-Stage Renal Disease on Dialysis

Clinical efficacy and safety studies with ELIQUIS did not enroll patients with end-stage renal disease (ESRD) or patients on dialysis. In ESRD maintained on dialysis (see Dosage and Administration (2.3) in full Prescribing Information) with regard to concentrations of apixaban and pharmacodynamic activity similar to those observed in the AMPLIFY-EXT study (see Clinical Pharmacology (12.3) in full Prescribing Information), it is not known whether these concentrations will lead to similar stroke reduction and bleeding risks in patients on ESRD on dialysis.

Reduction of Risk of Stroke and Systemic Embolism in Patients with Nonvalvular Atrial Fibrillation

The recommended dose is 2.5 mg twice daily in patients with at least two of the following characteristics (see [Drug Dosage and Administration (2.1) in full Prescribing Information]):

• age greater than or equal to 65 years;

• body weight less than or equal to 60 kg;

• serum creatinine greater than or equal to 1.5 mg/dL.
Vineet Chopra, MD, MSc, FHM, is associate professor of medicine and chief of the Division of Hospital Medicine at Michigan Medicine and the VA Ann Arbor (Mich.) Health System. A career hospitalist, Dr. Chopra’s research is dedicated to improving the safety of hospitalized patients through prevention of hospital-acquired complications. His work has been focused on identifying and preventing complications associated with central venous catheters with a particular emphasis on peripherally inserted central catheters (PICCs).

Dr. Chopra is the recipient of numerous teaching and research awards, including the 2016 Kaiser Permanente Award for Clinical Teaching, the Jerome W. Conn Award for Outstanding Research in the Department of Medicine, the 2016 Society of Hospital Medicine Award for Excellence in Research, and the 2014 MDevitt Award for Research Excellence. He has published more than 100 peer-reviewed articles and has served as associate editor for the American Journal of Medicine and Journal of Hospital Medicine.

At what point in your education/training did you decide to practice hospital medicine? What about hospital medicine appealed to you?

I think I knew very early – toward the middle of my intern year – that I wanted to be a hospitalist. There was much that drew me to the field. First, I loved being in the inpatient setting. The tempo of work, the unexpected nature of what may come next, and the opportunity to truly have an impact on a patient’s life at their time of greatest need appealed to me. I wasn’t as inclined toward the procedural fields and also loved the cognitive aspects of general medicine – doing the workup on a difficult diagnosis or medically managing a patient with acute coronary syndrome came naturally. I found myself loving the work so much so that it didn’t feel like work. And the rest was history!

What is your current role at Michigan Medicine?

I started at Michigan Medicine in 2008 as a full-time clinician taking care of patients on direct care and resident services. After 3 years of clinical work, I decided it was time to hone in on a specific skill set and went back to a research fellowship.

I became Michigan’s first fellow in hospital medicine – the guinea pig – for what would turn out to be one of the best decisions in my life. After finishing fellowship, I switched my focus from clinical work to research and rose up the ranks to receive tenure as an associate professor of medicine. After attaining tenure, I was among a handful of people in the nation who had success in both the research and the clinical arenas and leadership opportunities began to come my way.

I was fortunate to be recruited as the inaugural division chief of hospital medicine at Michigan Medicine in 2017. The Division of hospital medicine is the 13th in the department of medicine and the first one to be created in over 60 years. As division chief, I oversee all of our clinical, academic, research, and educational endeavors. Currently, we have approximately 130 hospitalists in our group and about 30 advanced practice providers (APPs) with a support and research staff of about 15 individuals. So I like to say we have a big family!

What are your favorite areas of clinical practice and/or research?

I am fortunate to have the ability to enjoy all that hospital medicine has to offer. I still appreciate the challenges that direct care brings, and I continue to do as much as I can in this area. I also enjoy working with residents and medical students at the university and at our VA site – where much of my focus is devoted to making sure all learners on the team are growing while they provide excellent patient care. To meet a new patient and work to develop a therapeutic relationship with them such that we can make positive changes in their disease trajectory remains my favorite part of clinical work.

My research work remains closely linked to my clinical interests around preventing patient harm and improving patient safety – so studying hospital-acquired infections, coming up with new ideas and strategies, and then implementing them on clinical service represents the perfect blend of the two. My research is largely focused on intravenous devices and catheters, and I focus my work on preventing harms such as bloodstream infection, venous thrombosis, and related adverse events. I have been fortunate to receive national and international attention for my research, including adoption of my work into guidelines and changes to national policies. I am honored to serve on the most important federal advisory committee that advises the government on health care infections (the committee is called HICPAC – Healthcare Infection Control Practice Advisory Committee).

What are the most challenging aspects of practicing hospital medicine? What are the most rewarding?

For me, the most challenging aspects are also the most rewarding. First and foremost, making a connection with a patient and their family to understand their concerns and define a therapeutic alliance is both challenging and rewarding. Second, ensuring that we have the ability to work efficiently and effectively to manage patient care is sometimes challenging but also the most rewarding aspect of the job. I am fortunate to work in a health system where I am surrounded by smart colleagues, important resources, advanced technology, and the support of nurses and advanced practice providers who share this zeal of patient care with me.

Finally, one the greatest challenges and rewards remains time. Our work is hard and grueling, and it is often very challenging to get things done at different times of the day. But the ability to make a diagnosis or see a patient improve makes it all worth it!

How will hospital medicine change in the next decade or two?

I predict our work will shift from a model that is reactive – taking care of patients that are sick and need hospitalization – to a proactive approach where the focus will remain on keeping people out of the hospital. This doesn’t necessarily mean that we will be out of a job – but I see the model of our work shifting to ensure that patients who are discharged remain healthy and well. This means we will need to embrace extensivist models, hospital-at-home care, and aspects such as bridge clinics.

I also think our work will evolve to harness some of the incredible technology that surrounds us outside health care, but has not yet permeated our work flow. To that end, aspects such as virtual consultations and patient assessments, and remote monitoring that includes biometrics, will all fall into our workflow. And of course, lets not forget about the mighty electronic medical record and how that will affect our experience and work. I see much more of our work shifting toward becoming digital experts, harnessing the power of big data and predictive analytics to provide better care for patients. These skills that are emerging in our field, but we have not yet mastered the art of managing data.

Do you have any advice for students and residents interested in hospital medicine?

I would highly recommend taking on a rotation with a hospitalist, carrying the pager and working side-by-side with someone who truly loves what they do. Many students and residents just see the on/off nature of the work, but that is truly skin deep in terms of attraction.

The beauty of hospital medicine is that you can be everything for a patient – their doctor, their health care navigator, their friend, and their partner during their hospital stay. Find that joy – you will not regret it!
What’s in your wallet?
Trends in hospitalist compensation

By Linda M. Kurian, MD, SFHM, FACP

Ever wonder how your hospitalist group’s compensation stacks up? Whether you’re a practicing hospitalist curious about how competitive your compensation package is or a hospital medicine group leader performing an appraisal of your group’s salary structure, chances are you’re looking for fair-market benchmarks for hospitalist compensation. In the 2018 State of Hospital Medicine (SoHM) report, the Society of Hospital Medicine partnered with the Medical Group Management Association to provide data on hospitalist compensation. In the 2018 SoHM survey, the median employer contribution to retirement plans was reported to be $19,875, with respondents in the Midwest receiving the highest retirement benefit of $28,340.

The good news is that hospitalist physician compensation has continued to rise, compared with previous years (see Figure 2), despite the relative flat trends in wRVUs and encounters. Among other reasons, this may reflect a shift from compensating hospitalists for volume toward productivity. De-

Figure 1. Average hospitalist compensation per wRVU

Source: 2018 State of Hospital Medicine report

when considering productivity, but nonacademic pediatric hospitalists earned significantly more per wRVU. From this perspective, pediatric hospitalists appear to be similarly compensated, if not better, than their adult hospitalist colleagues.

While differences in compensation per wRVU may be minimal between nonacademic and academic hospitalists, there remains a significant difference in total compensation. Median compensation for nonacademic internal medicine hospitalists was approximately $63,000 more than that reported for academic internal medicine hospitalists. This doesn’t come as a surprise since compensation tends to be lower in academic settings across all specialties. It could be valuable for future compensation and productivity assessments to define and measure academic and other forms of nonbillable hospitalist productivity. Development of national standards for nonbillable productivity units could help create a more comprehensive model for structuring hospitalist compensation.

While it’s important to understand compensation benchmarks in order to remain competitive as a hospital medicine group, money isn’t everything. Group culture, professional development and growth opportunities, and schedules that afford better work-life integration are important factors that contribute to hospitalist “compensation” valuations. Arguably these factors are more valuable than any compensation package, but it’s not easy to quantify their weight. Some indirect forms of compensation include paid time off, paid sick days, and support for professional development through allowances and protected time off for CME. Other indirect compensation includes tuition benefits for hospitalists and their family, retirement benefits programs, and the unicorn of benefits — pension plans. In the 2018 SoHM survey, the median employer contribution to retirement plans was reported to be $19,875, with respondents in the Midwest receiving the highest retirement benefit of $28,340.

The not-so-good news? In contrast to prior SoHM Surveys reporting compensation differences that increased at a rate of 8%-10% every 2 years, the difference in median compensation between 2016 and 2018 was 37%. Several factors could play into the slower acceleration rate, including differences in respondent groups between 2016 and 2018. It will be more intriguing to know whether we’re starting to see hospitalist compensation leveling off.

As the 2020 SoHM surveying period just concluded, it remains to be seen how compensation has changed in the past 2 years and whether hospitalist compensation is starting to plateau. Stay tuned for the 2020 SoHM Report available later this year, which will offer invaluable insights into hospitalist compensation trends. You can sign up to be notified when it becomes available at www.hospitalmedicine.org/SoHM.

Figure 2. Trend in hospitalist physician compensation

Source: 2018 State of Hospital Medicine report

Group Management Association to provide data on hospitalist compensation and productivity. In 2018, the median compensation for adult hospitalist respondents was $289,151, an increase of over $10,000 from 2016. When comparing compensation across different regions, there appear to be remarkable differences across the nation. Not surprisingly, hospitalists in the South fare better than their colleagues in the East, with a reported median compensation difference of nearly $33,000. Does that make you want to move to Texas? What about the even more striking difference between adult hospitalists and pediatric hospitalists, whose median compensation was reported to be $205,342 in 2018?

A common pitfall in compensation analysis is comparing wages across regions and specialties without taking productivity into consideration. Reviewing compensation per work relative value units (wRVU) and compensation per encounter offer additional insight for a more comprehensive assessment of compensation.

A regional comparison of compensation per wRVU reveals that hospitalists in the West earn more per wRVU than their colleagues in other parts of the country, including the South. Specifically, compensation per wRVU in the West is $86.57; in the South, $59.38; in the East, $65.74; and in the Midwest, $73.08. A similar comparison of compensation per wRVU (see Figure 1) suggests that academic adult, academic pediatric, and nonacademic adult hospitalists are fairly evenly compensated relative value units (wRVU) across the nation.

SoHM Analysis Committee.

Dr. Kurian is chief of the academic division of hospital medicine at Northwell Health in New York. She is a member of the SHM Practice Analysis Committee.
The wide-ranging impact of hospital closures

Clinicians struggle to balance priorities

By Jeff Craven

On June 26, 2019, American Academic Health System and Philadelphia Academic Health System announced that Hahnemann University Hospital, a 496-bed tertiary care center in North Philadelphia in operation for over 170 years, would close that September.

The emergency department closed 52 days after the announcement, which ended up leaving little time for physicians and staff to coordinate care for patients and secure new employment. The announcement was also made right at the beginning of the new academic year, which meant residents and fellows were forced to find new training programs. In total, 2,500 workers at Hahnemann, including more than 570 hospitalists and physicians training as residents and fellows, were displaced as the hospital closed – the largest such closing in U.S. history.

For most of its existence, Hahnemann was a teaching hospital. While trainees were all eventually placed in new programs thanks to efforts from the Accreditation Council for Graduate Medical Education, some of the permanent staff at Hahnemann weren’t so lucky. A month after the announcement, Drexel University’s president said residents during Hahnemann’s closure were essentially teaching themselves how to swim. “There were just no laws, no rules,” he said. The vast majority of programs accepting applications from residents at Hahnemann were sympathetic and accommodating, he said, but a few programs applied “pressure tactics” to some of the residents offered a transfer position, despite graduate medical education rules in place to prevent such a situation from happening. The resident says: ‘Oh, well, I’m waiting to hear from this other program,” said Dr. D’Mello. ‘They’d say: ‘Okay, well, we’re giving you a position now. You have 12 hours to answer.”

Decision makers at the hospital also were not very forthcoming with information to residents, fellows and program directors, according to a recent paper written by Thomas J. Nasca, MD, current president and CEO of ACGME, and colleagues in the journal Academic Medicine (2019 Dec 17; doi:10.1097/ ACM.0000000000003133). When Dr. Nasca and colleagues went to investigate the situation at Hahnemann firsthand, “the team found that residents, fellows, and program directors alike considered their voices to have been ignored in decision making and deemed themselves ‘out of the loop’ of important information that would affect their career transitions.”

While the hospital closed in September 2019, the effects are still being felt to this day. In Pennsylvania, the Medical Care Availability and Reduction of Error Act requires that hospitals and providers have malpractice insurance, including tail insurance for when a doctor’s insurance policy expires. American Academic announced it would not be paying tail insurance for claims made while physicians were at Hahnemann. This meant residents, fellows, and physicians who worked at Hahnemann during the closure would be on the hook for paying their own malpractice insurance.

“On one hand, the risk is very low for the house staff. Lawsuits that come up later for house staff are generally dropped at some point,” said William W. Pinsky, MD, FAAP, FACC, president and CEO of the Educational Commission for Foreign Medical Graduates. “But who wants to take that risk going forward? It’s an issue that’s still not resolved.”

The American Medical Association, Association of American Medical Colleges, the Philadelphia County Medical Society, and other medical societies have collectively put pressure on Hahnemann’s owners to pay for tail coverage. Beyond a Feb. 10, 2020, deadline, former Hahnemann physicians were still expected to cover their own tail insurance.

To further complicate matters, American Academic attempted to auction more than 570 residency slots at Hahnemann. The slots were sold to a consortium of six health systems in the area – Thomas Jefferson University Hospitals, Einstein Healthcare Network, Temple University Health System, Main Line Health, Cooper University Health Care, and Christiana Care Health System – for $55 million. The Centers for Medicare & Medicaid Services opposed the sale, arguing that the slots are a contract that hospitals enter into with CMS, rather than an asset to be sold. An appeal is currently pending.

The case is being watched by former physicians at Hahnemann. ‘American Academic said, ‘If we don’t get this $55 million, we’re not going to be

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able to cover this tail insurance. ‘They’re kind of linking the two things,’ said Dr. D’Mello. “To me, it’s almost like putting pressure to allow the sale to happen.”

**Urban hospital closures disrupt health system balance**

When an urban hospital like Hahnemann University Hospital closes, there is a major disruption to patient care. Patients need to relocate to other nearby centers, and they may not always be able to follow their physician to the next health center.

If patients have comorbidities, are being tracked across multiple care points, or change physicians during a hospital closure, details can be missed and care can become more complicated for physicians who end up seeing the patient at a new center. For example, a patient receiving obstetrics care at a hospital that closes will have to reschedule their delivery at another health center, noted Dr. Pinsky.

“Where patients get lost is when there’s not a physician or an individual can keep track of all that, coordinate, and help to be sure that the patient follows through,” he said.

Patients at a closing hospital need to go somewhere else for care, and patient volume naturally increases at other nearby centers, potentially causing problems for systems without the resources to handle the spike in traffic.

“I’m a service director of quality improvement and patient safety for Drexel internal medicine. I know that those sorts of jumps and volumes are what increases medical errors and potentially could create some adverse outcomes,” said Dr. D’Mello. “That’s something I’m particularly worried about.”

Physicians are also reconciling their own personal situations during a hospital closure, attempting to figure out their next step while at the same time helping patients figure out theirs. In the case of international medical graduates on J-1 or H1-B visas, who are dependent on hospital positions and training programs to remain in the United States, the situation can be even more dire.

During Hahnemann’s closure, Dr. Pinsky said that the ECFMG, which represents 11,000 individuals with J-1 visas across the country, reached out to the 55 individuals on J-1 visas at the hospital and offered them assistance, including working with the Department of State to ensure they aren’t in jeopardy of deportation before they secure another training program position.

The ECFMG, AMA, AAMC, and ACGME also offered funding to help J-1 visa holders who needed to relocate outside Philadelphia. “Many of them spent a lot of their money or all their money just coming over here,” said Dr. Pinsky. “This was a way to help defray some immediate costs that they might have.”

Education and research, of which hospitalists and residents play a large role, are likewise affected during a hospital closure, Dr. Pinsky said. “Education and research in the hospital is an important contributor to the community, health care, and medical education nationally overall. When it’s not considered, there can be a significant asset that is lost in the process, which is hard to ever regain.”

“The hospitalists have an integral role in medical education. In most hospitals where there is graduate medical education, particularly in internal medicine or pediatrics, and where there is a hospitalist program, it’s the hospitalists that do the majority of the in-hospital or inpatient-care.”

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**Amit Vashist, MD, SFHM**

Amit Vashist, MD, SFHM, is the senior vice president and chief clinical officer at Ballad Health, an integrated 21-hospital health system serving 29 counties of northeast Tennessee, southwest Virginia, northwest North Carolina, and southeast Kentucky.

Dr. Vashist, who is a member of The Hospitalist’s editorial advisory board, focuses on clinical quality and safety, value-based initiatives to improve quality while reducing cost of care, performance improvement, and oversight of the enterprise-wide clinical delivery of care. He also provides administrative oversight of the Ballad Health Clinical Council – a model of physician partnership for clinical transformation and outcomes improvement.

Dr. Vashist is a dual board-certified internist and psychiatrist and an avid proponent of initiatives aimed at promoting quality, improving safety, reducing cost, and minimizing variation in the delivery of patient care across diverse settings. His work has been instrumental in improving outcomes and reducing mortality in patients with sepsis, earning him several local, regional, and national awards, and his work in promoting a zero-harm culture at Ballad Health has been instrumental in significantly reducing hospital-acquired infections systemwide.

Before he transitioned into the role of the chief clinical officer, Dr. Vashist served as the chair of theBallad Health Clinical Council and the system chair for Ballad Health’s hospitalist division running a group of over 130 hospitalists.

**Why did you choose a career in medicine?**

The ability to have a positive impact and help others. In addition to that, I love learning new information and skills, and medicine affords one the opportunity to be a lifelong learner.

**What do you like most about working as a hospitalist?**

The relatively fast-paced nature of the work and the ability to tie seemingly fragmented episodes of patient care together. I believe that no other specialty offers that 30,000-foot vantage view of things in clinical medicine.

**What do you like the least?**

The shift-worker mindset emanating from the traditional and rigid 7-on, 7-off model. A sense of team can be lost in this model and, contrary to conventional thinking, this model can accelerate hospitalist burnout.

**What’s the best advice you ever received?**

“You’ve gotta learn to listen!”

**What’s the worst advice you ever received?**

“Don’t rock the boat.” I strongly believe that frequent disruption is required to change the established status quo.

**What aspect of patient care is most challenging?**

A perceived disruption in the continuity of care by virtue of a new hospitalist seeing those patients, and the challenge to build the same level of trust and comfort as the outgoing hospitalist. Superior models of care have developed over the years promoting a better continuity of care but this domain continues to pose a challenge to proponents of hospital medicine.

**What’s the biggest change you’ve seen in hospital medicine in your career?**

Hospitalists being increasingly perceived as the “quarterbacks” and gatekeepers of quality, costs of care, and clinical outcomes in our hospitals and health care systems.

**What’s the biggest change you would like to see in hospital medicine?**

Inpatient volumes across the country continue to shrink, and this trend will not change for the foreseeable future. Hospitalists have got to embrace newer models of care faster, like hospitals at home, post-acute care, transitional care clinics, etc. Remember what they say: ‘If you are not at the table, you are on the menu.” Now is our time to be at the table, and be the champions of change and move to true value (quality plus experience/cost), or else, we could end up and vanish like Blockbuster.

**Outside of patient care, tell us about your career interests.**

I’m interested in implementing value-driven initiatives, pursuing endeavors aimed at cutting out waste and redundancy in health care, and developing a new generation of physician leaders with these skill sets.

**Where do you see yourself in 10 years?**

Leveraging my experience, training, and expertise in hospital medicine to design better systems of health care that transcend above and beyond the four walls of the hospital, and facilitate true consumerism and ‘patient centeredness.”

**What has been your most meaningful experience with SHM?**

Attending the annual SHM meetings for the past several years, which have helped me to not only reap rewards from the numerous educational sessions but has also helped me develop a rich network of friends, colleagues, and mentors whose advice I solicit from time to time.
Rural hospital closures affect access to care
Since 2005, 163 rural hospitals have closed in the United States. When rural hospitals close, the situation for hospitalists and other physicians is different. In communities where a larger health system owns a hospital, such as when Vidant Health closed Pungo District Hospital in Belhaven, N.C., in 2014 before reopening a nonemergency clinic in the area in 2016, health care services for the community may have limited interruption.

However, if there isn’t a nearby system to join, many doctors will end up leaving the area. More than half of rural hospitals that close end up not providing any kind of supplementary health care service, according to the NC Rural Health Research Program.

“A lot of the hospitals that have closed have not been owned by a system,” said George H. Pink, PhD, deputy director of the NC Rural Health Research Program at the University of North Carolina at Chapel Hill. “They’ve been independent, freestanding, and that perhaps is one of the reasons why they’re closing, is because they haven’t been able to find a system that would buy them out and inject capital into the community.”

This can also have an effect on the number of health care providers in the area, Dr. Pink said. “Their ability to refer patients and treat patients locally may be affected. That’s why, in many towns where hospitals have closed, we see a drop in the number of providers, particularly primary care doctors who actually live in the community.”

Politicians and federal entities have proposed a number of solutions to help protect rural hospitals from closure. Sen. Charles Grassley (R-Iowa), Sen. Amy Klobuchar (D-Minn.), and Sen. Cory Gardner (R-Colo.) have sponsored bills in the Senate, while Rep. Sam Graves (R-Mo.) has introduced legislation in the House. The Medicare Payment Advisory Commission has proposed two models of rural hospital care, and there are additional models proposed by the Kansas Hospital Association. A pilot program in Pennsylvania, the Pennsylvania Rural Health Model, is testing how a global budget by CMS for all inpatient and hospital-based outcomes might help rural hospitals.

“What we haven’t had a lot of action on is actually testing these models out and seeing whether they will work, and in what kinds of communities they will work,” Dr. Pink said.

Hospitalists provide community advocacy
Dr. D’Mello, who wrote an article for the Journal of Hospital Medicine on Hahnemann’s ownership by a private equity firm (doi: 10.12788/jhm.3378), said that the inherent nature of a for-profit entity trying to make a hospital profitable is a bad sign for a hospital and not necessarily what is in the best interest for an academic institution or for doctors who train there.

“I don’t know if I could blame the private equity firm completely, but in retrospect, the private equity firms stepping in was like the death knell of the hospital,” he said of Hahnemann’s closure.

“I think what the community needs to know – what the health care community, patient community, the hospitalist community need to know – is that there’s got to be more attention paid to these types of issues during mergers and acquisitions to prevent this from happening,” Dr. Pinsky said.

One larger issue was Hahnemann’s position as a safety-net hospital, which partly played into American Academic’s lack of success in making the hospital as profitable as they wanted it to be, Dr. D’Mello noted. Hahnemann’s patient population consisted mostly of minority patients on Medicare, Medicaid, and charity care insurance, while recent studies have shown that hospitals are more likely to succeed when they have a larger proportion of patients with private insurance.

“Studies show that, to [make more] money from private insurance, you really have to have this huge footprint, because then you’ve got a better ability to negotiate with these private insurance companies,” Dr. D’Mello said. “Whether that’s actually good for health care is a different issue.”

Despite their own situations, it is not unusual for hospitalists and hospital physicians to step up during a hospital closure and advocate for their patients on behalf of the community, Dr. Pink said.

“When hospitals are in financial difficulty and there’s the risk of closure, typically, the medical staff are among the first to step up and warn the community: ‘We’re at risk of losing our service. We need some help,'” he said. “Generally speaking, the local physicians have been at the forefront of helping to keep access to hospital care available in some of these small communities – unfortunately, not always successfully.'”

Dr. D’Mello, Dr. Pinsky, and Dr. Pink report no relevant conflicts of interest.
ABIM and the future of maintaining certification

By Nagendra Gupta, MD, FACP, CPE

Given the unpredictability and wide range of patients and conditions physicians see in a hospital setting, keeping current with the latest trends and methods is essential. Until now, options for maintaining certification in Hospital Medicine were limited to American Board of Internal Medicine’s 10-year, traditional Maintenance of Certification (MOC) exam taken at a testing center. Beginning this year hospitalists will have a choice for how they maintain their certification with the introduction of the Knowledge Check-In (KCI) in Focused Practice in Hospital Medicine (FPHM). Physicians who are currently certified in internal medicine can also use the KCI to earn their FPHM certificate once they have been admitted into the FPHM program.

What is KCI for hospitalists? The KCI is a shorter, lower-stakes assessment option that takes about 3 hours to complete. Similar to the traditional 10-year MOC exam, it includes access to UpToDate® without the need for a personal subscription. Physicians can choose to take the KCI at a test center or online, such as from their home or workplace. The test center experience resembles that of the traditional 10-year MOC exam, with the main difference being the shorter testing format.

Since this is the first year the KCI is offered in FPHM, it is considered to be “no consequences,” meaning that if a physician is unsuccessful they will continue to be publicly reported as certified as long as they are meeting all other MOC requirements, and their next assessment will be due 2 years later. However, the “no consequences” feature does not apply to physicians who are already in a grace period. Please refer to ABIM’s policy on Traditional 10-Year MOC Exam Grace Period.

What is the longitudinal assessment option? Responding to feedback from the community for an MOC program that is lower-stakes and more closely aligned with how physicians practice, in August 2019 ABIM announced it would develop a longitudinal assessment pathway for physicians to acquire and demonstrate current knowledge. Longitudinal assessment is a process that involves the administration of shorter assessments of specific content, such as medical knowledge, repeatedly over a period of time. A critical component of longitudinal is that it integrates education into the assessment experience.

What should you do now? All current ABIM MOC program requirements and policies remain in effect while the new longitudinal assessment is being developed and ABIM will communicate any program changes as well as more details on the program in advance of implementation. If you have an assessment due in 2020 or 2021, you can choose from the assessment options currently available in your discipline.

HM20 canceled: SHM explains why

COVID-19 made holding meeting impossible

In mid-March, the Society of Hospital Medicine board of directors concluded that it was impossible for SHM to move forward with Hospital Medicine 2020 because of the continued spread of virus that causes Coronavirus Disease 2019 (COVID-19). Given the most recent information available from the Centers for Disease Control and Prevention and the World Health Organization about the evolving global pandemic and the number of institutions that had travel bans in place, SHM leadership concluded that canceling the Annual Conference was the only path forward.

“Canceling the conference during this unprecedented time is the right thing to do,” said Benji K. Mathews, MD, SFHM, CLHM, course director for HM20. “With the evolving circumstances out of our control, there were risks to our community as it would have gathered, communities we connect with on our travels, and our home communities and hospitals – canceling was the best way to mitigate these risks. Through it all, I couldn’t have asked for a better leadership team and the larger SHM community for their support.”

Because hospitalists are on the front lines of patient care at their institutions, they will be needed more than ever as the pandemic continues to grow in order to manage care of hospitalized patients with COVID-19 and other illnesses. As the only medical society dedicated to hospital medicine, SHM will continue to support hospitalists with resources and research specific to COVID-19 and its impact on the practice of hospital medicine. SHM is aware that this necessary cancellation impacts many from both a financial and logistical perspective. As such, SHM will refund all conference registration fees for HM20 in full. SHM is also providing the opportunity to defer your HM20 registration to HM21, taking place May 4-7, 2021, in Las Vegas, or Pediatric Hospital Medicine 2020, taking place July 23-26, 2020, in Lake Buena Vista, Fla. For accommodation or travel cancellations, SHM requests that individuals please refer to their respective hotel or carrier’s customer service team and related cancellation policies.

To provide the world-class education that conference attendees have come to expect from SHM, the SHM team is exploring virtual options to offer select content originally anticipated at HM20. SHM also offers online education via the SHM Learning Portal and the new SHM Education app.

Visit shmannualconference.org/faqs for a full list of FAQs. For additional questions, please contact meetings@hospitalmedicine.org.

SHM will continue to monitor the COVID-19 pandemic and provide hospitalists with useful resources in this time of need at hospitalmedicine.org/coronavirus. For news coverage of COVID-19, visit https://www.the-hospitalist.org/hospitalist/coronavirus-updates.
Charu Puri, MD, FHM

Charu Puri, MD, FHM, is a hospitalist and medical informaticist at Sutter East Bay Medical Group in Oakland, Calif. She also serves as medical director for onboarding, mentoring, and physician development.

Dr. Puri has been a member of the Society of Hospital Medicine since 2009, and attended the Society’s Leadership Academy, where she was inspired to create a mentorship program at her own institution. She is a member of the San Francisco Bay chapter of SHM and serves on the Performance Measurement and Reporting Committee.

At what point in your education/training did you decide to practice hospital medicine? What about hospital medicine appealed to you?

It was early on in my residency that it became clear to me that I wanted to pursue the hospitalist track. It was a natural fit, and I gravitated toward the hospitalist side of medicine. What appealed to me most was that we had the opportunity and privilege to provide care to patients in their most vulnerable state and experience the effects of that care in real time. I found that very gratifying.

There is also a sense of community and camaraderie that comes with working in a hospital setting. Everyone is working together, trying to help patients. The collegiality and the relationships that develop are very rewarding. I have been fortunate enough to have built strong friendships with the hospitalists in my group as well as colleagues from other disciplines in medicine that work in the hospital.

What is your current role at Sutter Health?

Alta Bates Summit Medical Center is part of the larger Sutter Health system. I have an administrative role with my medical group in addition to the clinical work I do at the medical center, although first and foremost I identify myself as a hospitalist. About 5 years ago I took on a role in clinical informatics, when our hospital implemented an EHR. Since then I have been working as an inpatient physician informaticist. Most recently I took on a new role as medical director for onboarding, mentoring, and physician development in my medical group.

How do you balance the different duties of your various roles?

I am full time in my administration role, between my informatics role and my onboarding role. I technically don’t have to do clinical shifts if I don’t want to, but it’s important to me to continue clinical practice and maintain my skills and connection to the hospital and colleagues. I do about four clinical shifts a month, and plan to continue doing that. In our group you must do 14 shifts a month to be considered full time, so what I do could be considered about one-third of that.

What are your favorite areas of practice and/or research?

I haven’t had a lot of research experience. My residency program was a community-based program, and my current setting is a community hospital. I haven’t been involved much in the academic side of hospital medicine. As far as clinical practice goes, I think it’s the diversity of hospital medicine that appeals to me. You really get to be a jack of all trades, and experience all the different disciplines of medicine.

Both my informatics and onboarding roles came out of a need that I identified, and just began doing the work before there was an official role. When we implemented our EHR, it was essential to get our doctors organized to make sure they were ready to take care of patients that first day of go live. By the time our hospital went live on the EHR, I had a good understanding of how it worked, and so I was able to create a miniature curriculum for our physicians – templates, order sets, workflows, etc. – to help ensure everything went smoothly. A few months after we implemented the EHR, I was officially offered a physician informaticist role.

The onboarding role came about in an interesting way. I was participating in the leadership course offered by SHM and was lucky enough to be in the pilot for the Capstone course. That leadership course is focused around mentoring and sponsorship, and one of the faculty members was Nancy Spector, MD, the associate dean of faculty development at Drexel University, Philadelphia. She talked a lot about mentoring, and I was inspired to set up a mentoring program for our hospitalists. Dr. Spector graciously agreed to mentor me as I worked on my Capstone project, which was to create a mentoring program in a community-based hospitalist group. As I continued to work on the project, coincidentally our medical group decided to redesign our new physician onboarding process. Because I was already involved in the onboarding and training related to our EHR, I became very involved with our medical group’s onboarding redesign.

My group’s CEO decided to create a new directorship role for onboarding and mentoring, which I recently interviewed for and was offered about 2 months ago.

I think setting up systems to support our doctors is the common thread between the informatics and the onboarding roles. I want to implement systems that support our doctors, help them succeed, and hopefully make their jobs easier.

What are the most challenging aspects of practicing hospital medicine? What are the most rewarding?

We practice in a very urban environment, with many low-income patients who have limited resources and access to health care. That can be very challenging. You always wonder if these patients have all the support they need after leaving the hospital. Sometimes I feel that I am just putting a band-aid on the medical problem, so to speak, but not solving the underlying issue. But it can be very rewarding when the hospital and the broader community can bring our resources together to create interventions to help at-risk patients. It doesn’t happen as frequently as we would like, but when it does happen it feels good.

Another challenging aspect is related to perception. There are a lot of consultants in the hospital who view hospitalists as “house staff.” That can be very frustrating, and it’s important to steer the conversations away from that perspective, and really try to establish ourselves as colleagues and peers.

How will hospital medicine change in the next decade?

It’s a relatively young field, and we’re still figuring it out. I don’t know how hospital medicine is going to change, but I do know that the field will continue to evolve, given the way health care is changing.

Do you have any advice for students and residents interested in hospital medicine?

It’s a fun way to practice medicine and I would encourage students to go into hospital medicine. It’s great for work/life balance. It is very important to get involved early in your career. Get involved in medical groups or hospital committees. Stay away from the “shift mentality” – that can lead to early burnout, which is a real concern in our field now. Early engagement is essential, so you can help lead these conversations at your hospital.
COMMENTARY

Continuity rules

Simple operational adjustments your team can make

By John Krisa, MD

Although there are many benefits to the hospital medicine model of inpatient care, there is perhaps no greater Achilles heel than the discontinuity inherent to the care model. The trust and familiarity garnered from longitudinal patient-provider relationships is sacrificed for the benefits of focused practice, efficiency, and enhanced availability.

Any system involves competing priorities, and some degree of discontinuity is inevitable. Would it make sense for a hospitalist to stay on service until every panel patient is discharged? For obvious economic, lifestyle, and other reasons, of course not. Our charge then is not to make the perfect the enemy of the good, but to ensure thoughtful and consistent continuity for the good of the patient, the provider, and the hospital. The following tips should help your team achieve the best possible balance.

Avoid orphan rounding shifts

An ‘orphan’ rounding shift refers to a single shift untethered to a stretch. For admitting or administrative duties, this generally poses no problem, but for a rounding shift it is undesirable. No matter how talented or industrious the provider, it is very difficult for them to effectively provide seamless care for a single day; such care is often disconcerting for patients, families, case managers, and consultants. In situations such as significant census spikes, this may be a necessary evil, but avoid this if you can.

Assign orphan shift duties

If you can’t avoid an orphan rounding shift, be creative regarding which patients get assigned. Can that provider cover observation or simple short stay patients who may be discharged, or consult follow-ups that may be signed off? Can they see stable long-stay patients where the plan isn’t changing and the patient isn’t going anywhere? (Think guardianships, chronic ventilated patients awaiting a facility, stable patients with a history of intravenous drug abuse who may not be safely discharged with a line, etc.) Can they do lab, culture, or path report follow-up calls? Getting creative in responsibilities for an orphan shift can benefit all involved.

Alternate rounding shifts and admitting shifts

Dedicated admitting and rounding shifts are the norm these days. But rather than a pure stretch of one or the other, consider a few days admitting followed by the rest of the stretch rounding. Particularly in a small- to mid-sized hospital, multiple admits done over a few days (and especially if also cross-covering floor calls) will mean many familiar cases when rounding thereafter.

Use standard sign-out that travels with patients

The hospital is a dynamic environment. Patients, providers, and staff move around a lot. Given this reality, the importance of a complete standardized and accessible sign-out is paramount.

Imagine a rounder starting their last day with 15 patients. By the end of the shift, some have been discharged, transferred to telemetry or the ICU, or left against medical advice, leaving seven patients to sign out. By the next day, there are eight new faces, including fresh admits or consults from the prior day, swing, and night providers as well as existing patients transferred from telemetry/ICU to the general medical ward. A practical solution incorporates an asynchronous sign-out that travels with the patient regardless of geographic location or which provider(s) are following them. Billing software or census reports can typically achieve this. Allow for additional verbal communication as necessary and appropriate.

Bend for geographic rounds

Geographic rounds make sense most of the time. Less transit time and phone tag and more frequent interactions with the care team make for a more efficient day. But sometimes it’s best to bend this rule.

A patient that you’ve seen for 5 days and was transferred off your telemetry floor to go home tomorrow might best be served by you trekking up a flight of stairs to do the discharge. Similarly, complicated medical, psychosocial, or other circumstances may argue for keeping the patient on your list despite a change in location.

Wind up, wind down

It’s difficult to walk into a full panel of patients especially when many have been in house for a while. Consider overlapping providers coming onto and going off a shared service.

In a buddy arrangement the oncoming provider starting would take new patients from the outgoing provider finishing. The provider finishing discharges patients with length of stays and continues to round on more-complicated patients with whom they are familiar. Opportunities for face-to-face verbal handover, and even bedside introduction to the provider starting, can improve care coordination and safety and enhance the patient experience.

Split rounding and admitting

Most physicians would attest that the second time seeing a patient is much easier than the first, the third easier than the second, and so on. This holds true even more so when the first encounter is the history and physical, and the provider subsequently rounds on the patient for the duration of the hospitalization. You know what the plan is because you made it; you are confident that the patient’s leg with cellulitis looks better or the patient with congested lungs sounds clearer because the baseline against which you’re comparing is your own. It can be a challenge to interrupt a busy day of clinical rounds, discharges, and interdisciplinary meetings to admit a patient. But the upstream investment pays rich downstream dividends.

Hospital medicine outcomes as measured by cost, quality, and patient and provider experience are often hampered by suboptimal continuity of care. With recognition of the problem and some simple operational adjustments as outlined above, your team can minimize negative impacts.

Hospitalist profile: Ilaria Gadalla, DMSc, PA-C

Ilaria Gadalla, DMSc, PA-C, is a hospitalist at Treasure Coast Hospitalists in Port St. Lucie, Fla., and serves as the physician assistant department chair/program director at South University, West Palm Beach, Fla., where she supervises more than 40 PAs, medical directors, and administrative staff across the South University campuses.

Dr. Gadalla is the chair of SHM’s NP/PA Special Interest Group, which was integral in drafting the society’s recent white paper on NP/PA integration and optimization.

She continuously drives innovative projects for NPs and PAs to demonstrate excellence in collaboration by working closely with C-suite administration to expand quality improvement and education efforts. A prime example is the optimal communication system that she developed within her first week as a hospitalist in the Port St. Lucie area.

At what point in your life did you realize you wanted to be a physician assistant? I worked as a respiratory therapist and had a desire to expand my knowledge to manage critical care patients. I applied to Albany (NY) Medical College.

Continued on page 18

Dr. Krisa is a former regional medical director for a national hospitalist group and currently serves as a physician adviser for St. Peter’s Health Partners, a large integrated health system in Albany, N.Y. You can contact him at johnkrisa@hotmail.com.

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ERIC TAKAHASHI, DO
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How did you decide to become a PA hospitalist?
From day one at my first job, I knew that I loved inpatient medicine. I had a unique position as a cardiology hospitalist in Baltimore. As a team of PAs, we worked closely with hospitalists in addition to the cardiologists. I enjoyed the acuity of hospital medicine, and the brilliant hospitalist colleagues I worked with. They fueled my clinical knowledge daily, and that drew me further into hospital medicine.

What is your current position?
I have a unique position. I work primarily in an academic role, as a program director and department chair of the physician assistant program at South University in West Palm Beach. I provide oversight for four PA program campuses located in Florida, Georgia, and Virginia. I also work clinically as a hospitalist at Treasure Coast Hospitalists in the Port St. Lucie area.

What are your favorite parts of HM work?
My favorite aspect within the academic environment is what I call the “lightbulb moment” – that instant when you see your students comprehending and applying critical thinking regarding patient care. In clinical practice, I really enjoy educating and navigating a patient through their diagnosis and management. It’s like teaching, in that a patient can also have a lightbulb moment.

What are the most challenging aspects of practicing hospital medicine, from a PA’s perspective?
Medicine is an art, and each patient’s body is different. It’s a challenge to create individualized care in a system where metrics and templates exist. An additional challenge is simply navigating the culture of medicine and its receptiveness to physician assistants.

How does a hospitalist PA work differently than a PA in other health care settings?
PAs in hospital medicine must excel in communication skills. We are frequently the primary liaison between families, patients, specialists, consultants, and various departments daily. PAs in other care settings also communicate with a broad variety of people, but in hospital medicine that communication is required to be much more rapid. Your skills must really rise to the next level. There is also the opportunity for PAs to integrate within hospital committees and the C-suite.

How can PAs and nurse practitioners fit best into hospital medicine groups?
Initially, a hospital medicine group needs to identify their specific needs when deciding to integrate PAs and NPs. There must be a culture of receptiveness, with proper onboarding. That is a vital necessity, because without a proper onboarding process and a welcoming culture, a group is set up to fail.

What kind of resources do hospitalist PAs require to succeed?
There is a big need for education that targets the hospital C-suite and our physician colleagues about the scope of practice and autonomy that a PA can have. There are significant misconceptions about the capabilities of hospitalist PAs, and the additional value we bring to a team. PAs do not want to replace our MD/DO colleagues.

What do you see on the horizon for PAs and NPs in hospital medicine?
As the chair of SHM’s NP/PA Special Interest Group, we see a significant need for onboarding resources, because there is a hospitalist staffing shortage in the United States, and that gap can be filled with NPs and PAs. There is a lack of understanding about how to onboard and integrate advanced practice providers, so we are working intently on providing a toolkit that will assist groups with this process.

Do you have any advice for students who are interested in becoming hospitalist PAs?
I would encourage students to seek mentoring from a hospitalist PA. This can help prepare you for the inpatient world, as it’s very different from outpatient medicine with a higher acuity of patient care.

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Save the date for next year: March 4, 2021.

[hospitalmedicine.org/hospitalistday](http://hospitalmedicine.org/hospitalistday)

#HowWeHospitalist
By Danielle Scheurer, MD, MSCR, SFHM

As I transition out of the role of medical editor for The Hospitalist, and into the role of president of the Society of Hospital Medicine, it is a bittersweet but exciting transition. In the relatively short time I have served as editor, so much has changed in our hospitalist community! In the last 4 years alone, we have increased:

- Membership from 14,000 to 20,000
- Chapters from 46 to 68
- Special Interest Groups from 8 to 22
- Subscribers to The Hospitalist from 15,000 to 30,000

This is all a testimony to the engagement of our membership. SHM is clearly no ordinary specialty society; it is full of incredibly intelligent, invested, and talented members, who actively participate in the society for the betterment of their local teams and patients. It is such a privilege to lead this amazing team.

As for The Hospitalist, I would like to warmly welcome Weijen Chang, MD, FACP, SFHM, as the incoming editor. Weijen served as the pediatrics editor for many years and has been extensively involved on the editorial advisory board for even longer. He also has a broad track record of experience as a hospitalist in many settings; that combined with an inquisitive mind and curious spirit makes him the ideal editor for The Hospitalist. He brings energy and enthusiasm and will serve us very well.

While I will miss being intimately involved with The Hospitalist, I am very much looking forward to serving in the role of SHM president starting this month. During this pivotal year, SHM will transition from our one-and-only CEO, Larry Wellikson, MD, MHM, to our newly minted CEO Eric Howell, MD, MHM, who will officially transition in July 2020. This is a very exciting time in the history of SHM, as we refocus on our mission, vision, values, and core activities. As a membership organization, our primary focus has been, and will always be, serving our member’s needs! As a “Big Tent” organization, we have always supported a broad and diverse set of members, ranging far beyond physician hospitalists, to trainees, medical students, nurse practitioners, physician assistants, practice administrators, and other hospital-based specialists. Being in such a dynamic industry, our diverse members needs are constantly and rapidly changing along with the dramatic transformations in the landscape, including profound shifts in care and reimbursement models that could change the very definition of a hospitalist.

While we continuously scour the landscape and anticipate our members’ needs, we will never lose sight of our core mission, which is to promote exceptional care for hospitalized patients. We will continue to do this by supporting all of our members with tools and materials to help them be the very best they can, for all of our patients. As a humble and servant leader, I am prepared to meet the demands and challenges of the year ahead, with energy and focus, and fulfill the needs of our members, so that together, we can make health care better for those we serve.

Thank you in advance for allowing me the great pleasure of serving you as president-elect of SHM.

Sha вш
 helpers me bring realistic solutions to the front lines since I have a good understanding of what needs to be done, but also what is likely to actually happen.

As president of SHM over the next year, what are your primary goals?

My primary goal is to deeply connect with the SHM membership and understand what their needs are. There is enormous change happening in the medical industry and SHM should be a conduit for information sharing, resources, and most importantly, answers to all our difficult problems. Hospitalists are critical to success for our hospitals and our communities during the COVID-19 pandemic. We must be able to give and receive information quickly and seamlessly to effectively help each other across the country and the world. SHM must be seen as a critical convener, especially in times of crisis.

You mention COVID-19. What resources will SHM offer to help?

We have opened up the SHM Learning Portal to help members and non-members address upcoming challenges, such as expanding ICU coverage or cross-training providers for hospital medicine. Several modules in SHM’s “Critical Care for the Hospitalist” series may be especially relevant during the COVID-19 crisis:

- Fluid Resuscitation in the Critically Ill
- Mechanical Ventilation Part I – The Basics
- Mechanical Ventilation Part II – Beyond the Basics
- Mechanical Ventilation Part III – ARDS

Finally, in this time when so many hospitalists are busy dealing with COVID-19, SHM is committed to offering valuable resources and is in the process of offering new material, including Twitter chats, webinars, blogs, and podcasts to help hospitalists share best practices. Please bookmark SHM’s compilation of COVID-19 resources at hospitalmedicine.org/coronavirus.

We also continue to forge ahead with our publications, The Hospitalist and the Journal of Hospital Medicine, by adding online content as it becomes available. Visit the COVID-19 news feed on the Hospitalist website at www.the-hospitalist.org/hospitalist/coronavirus-updates.

In this trying time, we can still connect as a community and continue to learn from each other. We encourage you to use SHM’s online community, HMX, to share resources and crowd-source solutions. Ideas for SHM resources can be submitted via email at ideas@hospitalmedicine.org.

How will hospital medicine change in the next decade?

I believe one of the biggest changes we will see is the shift to ambulatory settings and the use of telehealth, and we all need to gain significant comfort with both to be effective.

Do you have any advice for students and residents interested in hospital medicine?

It is an incredibly dynamic and invigorating career; I can’t imagine doing anything else.
IN THIS ISSUE

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By Joséphine Cool, MD; Brittne Halford, MD, MPH; Jennifer Hu, MD; Monica Midha, MD, MBS; Brian Persaud, MD; Joshua Allen-Dicker, MD, MPH, SFHM

Beth Israel Deaconess Medical Center, Harvard Medical School, Boston

1 Hospital admissions of nursing home patients declined after ACA quality initiatives

CLINICAL QUESTION: Following the Patient Protection and Affordable Care Act (ACA), how have hospital transfer rates from nursing homes for patients with advanced medical conditions changed?

BACKGROUND: Following the ACA’s implementation, several measures were introduced to reduce unnecessary admissions of long-term nursing home residents to hospitals. These measures included an initiative to enhance a nursing home’s on-site capability to handle target populations; the accountable care organization payment model; and the Hospital Readmissions Reduction Program.

STUDY DESIGN: Cross-sectional study using the claims-based nationwide Minimum Data Set during 2011-2016.

SETTING: Federally licensed nursing homes in the United States.

SYNOPSIS: The authors examined the number of transfers between federally funded nursing homes and the hospital settings (EDs, observation, or inpatient hospitalizations) for greater than 460,000 long-term–stay patients with advanced dementia, advanced heart failure, and/or advanced chronic obstructive pulmonary disease (COPD). A risk-adjusted model showed that, during 2011-2016, there were significant decreases in transfers rates for potentially avoidable conditions, measured as the mean number of transfers per person-year alive, for patients with advanced dementia (2.4 vs. 1.6), heart failure (0.8 vs. 0.6), and COPD (2.7 vs. 1.5). Most of this decrease was linked to reductions in acute hospitalizations. Notably, hospice enrollment remained low throughout this time period, despite a high 1-year mortality. BOTTOM LINE: During the 2011-2016 period, transfer rates for patients with advanced dementia, heart failure, and/or COPD from nursing homes to the hospital setting decreased.


2 Significant reduction of alcohol intake reduced AFib burden and recurrence

CLINICAL QUESTION: In patients with symptomatic paroxysmal or persistent AFib who report alcohol consumption of 10 or more standard drinks per week, how does reducing alcohol intake affect AFib outcomes?

BACKGROUND: Prior observational studies have suggested that a dose-dependent effect may exist between alcohol intake and incident AFib, recurrence after ablation, and cardiac structural changes.

STUDY DESIGN: Prospective, open-label, multicenter, randomized clinical trial, with an intention-to-treat analysis.

SETTING: Six tertiary care hospitals in Australia.

SYNOPSIS: Study authors enrolled 140 patients with symptomatic paroxysmal or persistent AFib and regular alcohol consumption of 10 or more standard drinks per week. Participants were randomized to alcohol abstinence or usual alcohol intake. They underwent comprehensive rhythm monitoring and alcohol intake assessment for 6 months with in-person visits and oral/electronic communication. Over the 6-month period, patients in the abstinence group reduced their mean drinks per week from approximately 17 to 2, with 61% achieving complete abstinence. Patients in the abstinence group had a significantly longer period before recurrence of AFib when compared with the control group. Furthermore, the AFib burden over 6 months was significantly lower in the abstinence group, compared with the control group (0.5% vs. 12%).

BOTTOM LINE: For patients with symptomatic paroxysmal or persistent atrial fibrillation and regular alcohol consumption, reducing alcohol intake may significantly lower AFib burden and increase the time-to-recurrence of AFib at 6 months.


Dr. Cool is a hospitalist at Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, both in Boston.

By Brittne Halford, MD, MPH

3 High-flow nasal cannula improves dyspnea in palliative care patients with respiratory failure

CLINICAL QUESTION: Does a high-flow nasal cannula improve acute dyspnea in palliative care patients?

BACKGROUND: For patients receiving palliative care who develop respiratory distress, conventional oxygen therapy may not adequately relieve symptoms of dyspnea, and noninvasive ventilation may not promote comfort.

Few randomized controlled trials have investigated the use of high-flow nasal cannula (HFNC) for treatment of palliative care patients who present to the hospital with respiratory distress.

STUDY DESIGN: Randomized crossover study.

SETTING: Emergency department of a single institution.

SYNOPSIS: Forty-eight palliative care patients who presented to the ED with acute dyspnea were enrolled and randomized to receive HFNC for 1 hour, followed by conventional oxygen therapy for 1 hour, or vice versa. The authors found that patients using HFNC reported significantly less dyspnea on a breathlessness severity scale, compared with patients using conventional oxygen therapy. Additionally, patients using HFNC had significantly lower respiratory rates, and HFNC use was associated with significantly lower need formorphine in a 1-hour period. The study was limited because of its single institution and small sample size, and therefore the results may not be generalizable to other patient populations.

BOTTOM LINE: Treatment with a high-flow nasal cannula may improve symptoms of acute dyspnea in palliative patients when compared with conventional oxygen therapy.


Dr. Halford
Postop palliative care may improve outcomes for those undergoing high-risk surgery

**CLINICAL QUESTION:** Does postoperative palliative care consultation improve perception of care for high-risk surgery patients?

**BACKGROUND:** In the final year before death, surgery is common for many patients. Prior studies have shown that fewer than 38% of surgical patients receive palliative care services before death. Palliative care involvement has been shown to improve quality of life and coordination of care in surgical patients.

**STUDY DESIGN:** Retrospective cross-sectional analysis of administrative data.

**SYNOPSIS:** The authors identified a 90-day mortality analysis of bereaved family survey scores of patients who died within 90 days of surgery showed that families of patients who received a palliative care consultation improve perception of care for high-risk surgery patients. Prior studies have shown that fewer than 38% of surgical patients receive palliative care services before death. Palliative care involvement has been shown to improve quality of life and coordination of care in surgical patients.

**STUDY DESIGN:** Retrospective cross-sectional analysis of administrative data.

**BOTTOM LINE:** Palliative care consultation for patients undergoing high-risk surgery remains underutilized but may be beneficial for patients.

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[phmmeeting.org](http://phmmeeting.org)
By Monica Midha, MD, MBS

7 Hospital acquisition had no significant change in the rate of readmission or mortality

CLINICAL QUESTION: How do hospital acquisitions or consolidations affect patient satisfaction, the rate of readmission, and the mortality rate?

BACKGROUND: Prior studies have examined the impact of hospital system mergers on health care costs, but few studies have previously examined impact on quality and patient experience.

STUDY DESIGN: Retrospective, difference-in-difference analysis.


SYNOPSIS: The authors identified 2,232 hospitals, including 246 hospitals that were acquired between 2009 and 2013 and 1,986 control hospitals that were not acquired during this period. They used a difference-in-difference analysis to compare hospital performance on quality and patient experience measures from before and after an acquisition to concurrent changes in control hospitals.

Hospital acquisition was associated with a significant decline in measured patient experience. There was no significant differential change in 30-day readmission or mortality. Although there was an association between acquisition and significant improvement in clinical process metrics, the authors found that this improvement occurred almost entirely prior to acquisition.

BOTTOM LINE: Hospital acquisition was associated with worse experience for patients and had no significant impact on readmission or mortality rates.


8 For patients with advanced CKD, low risk of nephrogenic systemic fibrosis with group II GBCAs

CLINICAL QUESTION: What is the risk of nephrogenic systemic fibrosis (NSF) with use of group II gadolinium-based contrast agents (GBCAs) in patients with chronic kidney disease (CKD) stages IV and V?

BACKGROUND: With more than 500 cases of NSF reported during 1997-2007, a black box warning advises against use of all GBCAs in at-risk CKD patients. However, newer literature has shown that group II GBCAs may have lower risks of causing NSF. The risk to patients with CKD IV and V is not clear.

STUDY DESIGN: Systematic review and meta-analysis.

SETTING: 2,700 citations were screened for eligibility, of which 16 studies were selected.

SYNOPSIS: The authors evaluated 4,931 administrations of group II GBCAs in patients with CKD stages IV and V to determine the pooled incidence of NSF in this population. The pooled incidence of NSF was 0% (0 out of 4,931) with a 95% confidence interval of 0.07%. The analysis did not examine sequential group II GBCA exposures or the use of group II GBCAs in the setting of acute kidney injury. The authors advocate that the harms of withholding group II GBCAs in patients with advanced CKD (eg, underdiagnosis or delay in diagnosis) may outweigh the risk of group II GBCA administration in this population.

BOTTOM LINE: The risk of NSF with use of group II GBCAs in patients with advanced CKD is likely less than 0.7%.

SHORT TAKES

Brief smoking cessation intervention in ED patients awaiting care leads to higher quit rates

Patients in the ED who received brief “self-determination” smoking cessation interventions with four follow-up phone calls had significantly increased rates of biochemically validated abstinence at 6 months, compared with patients who received only a cessation pamphlet.


Health outcomes and utilization similar for emergent surgery and acute medical illness

A retrospective review of Medicare patients undergoing emergent general surgery showed similarly high rates of 1-year mortality, hospital days, and days away from home as seen in those patients hospitalized with pneumonia, heart failure, and acute MI.


USPSTF continues to recommend one-time AAA screening for older men who have ever smoked

In recently updated guidelines, the United States Preventative Services Task Force recommended that men aged 65-75 years who smoke or used to smoke would benefit from one-time abdominal aortic aneurysm (AAA) screening with ultrasonography; selective screening is also recommended for men aged 65-75 years who have never smoked.


Patients need rapid follow-up after admission for e-cigarette or vaping product use–associated lung injury

Patients with e-cigarette or vaping product use–associated lung injury have a high risk of rehospitalization and death within 2 days of discharge; optimal outpatient follow-up should be scheduled within 48 hours of discharge to reduce the risk of rehospitalization and death.


One in eight patients with atherosclerotic cardiovascular disease report medication cost as primary reason for nonadherence

A U.S. national survey of 14,279 adults with atherosclerotic cardiovascular disease found that 12.6% reported “cost-related nonadherence,” defined as skipping doses, taking less medication than prescribed, or delaying refills to save money.

By Brian Persaud, MD

Hospital-level care at home for acutely ill adults may be as safe as inpatient care

CLINICAL QUESTION: Does hospital-level care at home reduce health care cost, usage, and readmission rates?

BACKGROUND: Providing hospital-level care at home for select patients has proven to reduce health care cost, usage, and readmission rates, while maintaining quality and safety in other developed countries but few studies exist in the United States.

STUDY DESIGN: Randomized, controlled, unblinded, parallel-design trial.


SYNOPSIS: The study enrolled 91 adult patients from the emergency department who were deemed appropriate for non-ICU admission for treatment of prespecified diagnoses (i.e., COPD exacerbation, heart failure exacerbation, etc.). Participants were randomized to usual inpatient care or home hospital care. All home hospital patients received daily internist visits, twice-daily nursing visits, home access to additional services (physical/occupational therapy, social work, etc.), oxygen, IV medications, labs, radiology, and continuous monitoring. The authors found that home hospital care resulted in a lower total cost ($P < .001), lower use of imaging and labs, and lower 30-day readmission rate, without appreciable differences in quality or safety between the two groups. Given that the study was performed at only two academic hospitals, it is unclear if these findings can be generalized to other health systems.

BOTTOM LINE: For the care of select illnesses, hospital-level care at home may be cheaper, may be just as safe, and reduced readmission rates when compared with inpatient care.


Early high-dose vitamin D₃ did not reduce mortality in critically ill, vitamin D–deficient patients

CLINICAL QUESTION: Does early administration of high-dose vitamin D₃ in critically ill, vitamin D–deficient patients reduce 90-day all-cause mortality?

BACKGROUND: Critically ill patients are often vitamin D deficient, but no large randomized trials have investigated whether early vitamin D supplementation can affect clinical outcomes.

STUDY DESIGN: Multicenter, randomized, double-blind, placebo-controlled phase 3 trial.


SYNOPSIS: The study enrolled 1,078 patients with 25-hydroxyvitamin D levels < 20 ng/mL who were critically ill (defined as patients being admitted to the ICU with one or more risk factor for lung injury or death). Participants were randomized to early administration of a single dose of 540,000 IUs of enteral vitamin D₃ or placebo. The authors did not identify a statistically significant difference in the 90-day all-cause mortality between the two groups. Additionally, there were no significant differences in length of stay, ventilator-free days or serious adverse outcomes between the two groups.

BOTTOM LINE: Early administration of high-dose enteral vitamin D₃ did not decrease 90-day all-cause mortality in critically ill, vitamin D–deficient patients.


Dr. Persaud is a hospitalist, Beth Israel Deaconess Medical Center, and instructor in medicine, Harvard Medical School, both in Boston.
Acute kidney injury in children hospitalized with diarrheal illness in the U.S.

By Anika Kumar, MD, FAAP

CLINICAL QUESTION: What are the incidence and consequences of acute kidney injury among children hospitalized with diarrheal illness in the United States?

BACKGROUND: Diarrheal illness is the fourth-leading cause of death for children younger than 5 years and the fifth-leading cause of years of life lost globally. In the United States, diarrheal illness remains a leading cause of hospital admission among young children. Complications of severe diarrheal illness include hypovolemic acute kidney injury (AKI). Hospitalized children who develop AKI experience longer hospital stays and higher mortality. Additionally, children who experience AKI are at increased risk for chronic kidney disease (CKD), hypertension, and proteinuria.

STUDY DESIGN: Retrospective cohort study.

SETTING: Kids’ Inpatient Database (KID) from 2009 and 2012. The authors used secondary International Classification of Diseases, Ninth Revision (ICD-9) diagnoses of AKI to identify patients.

SYNOPSIS: The authors reviewed all patients with diarrhea and found that the incidence of AKI in children hospitalized was 0.8%. Those with infectious diarrhea had an incidence of 1% and with noninfectious diarrhea had an incidence of 0.6%.

There was a higher incidence of dialysis-requiring AKI in patients with infectious diarrhea. The odds of developing AKI increased with older age in both infectious and noninfectious diarrheal illnesses. As compared with noninfectious diarrheal illness, infectious diarrheal illness was associated with higher odds of AKI (odds ratio, 2.1; 95% confidence interval, 1.7-2.7). Irrespective of diarrhea type, hematologic and rheumatologic conditions, solid-organ transplant, CKD, and hypertension were associated with higher odds of developing AKI.

AKI in infectious diarrheal illness was also associated with other renal or genitourinary abnormalities, whereas AKI in noninfectious diarrheal illness was associated with diabetes and cardiovascular and neurologic conditions.

Hospitalizations for diarrheal illness complicated by AKI were associated with higher mortality, prolonged length of stay, and higher hospital cost with odds of death increased eightfold with AKI, mean hospital stay was prolonged by 3 days, and costs increased by greater than $9,000 per hospital stay. The development of AKI in hospitalized diarrheal illness was associated with an up to 11-fold increase in the odds of in-hospital mortality for infectious (OR, 10.8; 95% CI, 3.4-34.3) and noninfectious diarrheal illness (OR, 7.0; 95% CI, 3.1-15.7). The strengths of this study include broad representation of hospitals caring for children across the United States. The study was limited by its use of ICD-9 codes which may misidentify AKI. The authors were unable to determine if identifying AKI could improve outcomes for patients with diarrheal illness.

BOTTOM LINE: AKI in diarrheal illness is relatively rare. Close attention should be given to patients with certain serious comorbid illnesses.


Fight COVID-19 myths and misinformation

By Randy Dotinga

Misinformation about COVID-19 travels faster than the virus and complicates the job of doctors who are treating those infected and responding to concerns of their other patients.

An array of myths springing up around this disease can be found on the Internet. Widespread misinformation hampers public health efforts to control the disease outbreak, confuses the public, and requires medical professionals to spend time refuting myths and re-educating patients.

Know what physicians can do to counter misinformation

Pulmonologist and critical care physician Cedric ‘Jamie’ Rutland, MD, FCCP, who practices in Riverside, Calif., sees misinformation about the novel coronavirus every day. His patients worry that everyone who gets infected will die or end up in the ICU. His neighbors ask him to pifer surgical masks to protect them from the false notion that Chinese people in their community posed some kind of COVID-19 risk.

As he pondered how to counter myths with facts, Dr. Rutland turned to an unusual resource: his 7-year-old daughter. He explained to her how COVID-19 works and found that she could easily understand the basics. Now, Dr. Rutland draws upon the lessons from chats with his daughter as he explains COVID-19 to his patient audience on his YouTube channel “Medicine Deconstructed.” Simplicity, but not too much simplicity, is key, he said.

Make sure all staff get reliable information

Hospitals are scrambling to keep staff safe with up-to-date directives and debunk false narratives about the virus. Keeping all hospital staff informed with verified and authoritative facts about the coronavirus is a key objective of the Massachusetts General Hospital’s Center for Disaster Medicine. The Center’s coronavirus educational materials are distributed to all staffers from physicians to janitors.

Use patience with your patients

Boston cardiologist Haider Warrach, MD, of Brigham and Women’s Hospital, said it’s important to “put medical information into a greater human context.” For example, he has told patients that he’s still taking his daughter to school despite COVID-19 risks. “I take the information I provide and apply it to my own life,” he said.

The Washington State Department of Health offers this advice to physicians to counter false information and stigma: “Stay updated and informed on COVID-19 to avoid miscommunication or inaccurate information. Talk openly about the harm of stigma. View people directly impacted by stigma as people first. Be conscious of your language. Acknowledge access and language barriers.”

Use public health organizations to fight the ‘infodemic’

The World Health Organization identified early in the COVID-19 outbreak the global wave of misinformation about the virus and dubbed the problem the “infodemic.” The WHO “Q & A” page on COVID-19 is updated frequently and addresses myths and rumors currently circulating.

The CDC has followed with its own “frequently asked questions” page to address questions and rumors. State health agencies have put up COVID-19 pages to address public concerns and offer advice on prevention.
DIVISION CHIEF, HOSPITALIST MEDICINE
DEPARTMENT OF MEDICINE
Hershey, Pennsylvania

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

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Hospitalist Opportunities with Penn State Health

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

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- Community Setting Hospitalist opportunities (Lancaster and Berks County positions)
- We'll foster your passion for patient care and cultivate a collaborative environment rich with diversity
- Commitment to patient safety in a team approach model
- Experienced hospitalist colleagues and collaborative leadership
- Salary commensurate with qualifications
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**What We're Seeking:**
- Completion of an accredited training program
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The future of hospital medicine

Ensured? Or a definite maybe?

By Laurence Wellikson, MD, MHM

When I started at SHM in 2000, there were fewer than 1,000 hospitalists in the United States, and now there are more than 60,000. SHM (back then, we were the National Association of Inpatient Physicians) had about 300 members; now, we have more than 20,000.

Today, hospitalists are part of the medical staff at virtually every hospital in the country, and hospital medicine is recognized as a unique medical specialty with our own knowledge base, textbooks, competencies, meetings, and medical professional society. In a health care environment swirling with change, we are one of the few specialties forged with the ability to adapt and, at times, lead this change. Yet there is so much disruption and instability that there are still many twists and turns in the road that will affect hospitalists’ ability to carve out an even brighter future.

Consolidation has come to health care on a large scale. Hospitals are merging. Health insurers are combining, and even large hospital medicine companies like TeamHealth, Sound, Envision, and others are merging, growing, and acquiring.

At the same time, outside forces from industries not usually associated with health care or inpatient care are swirling into our world: CVS acquires Aetna and aims to reshape primary care; Amazon dominates health care supply chains and moves into pharmacy benefits, and even gets into health care delivery via their partnership with Berkshire Hathaway and JP Morgan; Walmart merges with Humana to create one of the biggest players in Medicare; and Apple expands their inroads into wearables and chronic disease management.

Employment of clinicians has grown logarithmically, especially with inpatient physicians, reshaping the medical staff compensation and accountability. At the same time, payers, both government and private, are evolving into population health with an emphasis not so much on transactions (visits and procedures), but more aligned with outcomes, effectiveness, and efficiency.

All of this leads to a new paradigm of what is important and a new set of values that seems

“...in a health care environment swirling with change, we are one of the few specialties forged with the ability to adapt and, at times, lead this change.”

at times more like corporate America where the loyalty of employees can be torn between their employer and the patient. This is especially troublesome in a field traditionally based on the primacy of the doctor-patient relationship. This can put the hospitalist right in the middle of the time when the patient can be most vulnerable.

This has led to new ways to deliver the care that hospitalists provide. First as a pilot and now moving more mainstream, patients with several diagnoses (e.g., heart failure, dehydration, or pneumonia) are now managed not in bricks and mortar hospitals, but in “hospitals at home.” The last few days of a typical hospitalization now take place outside the hospital in a skilled nursing facility (SNF). Fear of uncompensated and unnecessary readmissions leads hospitals to engage hospitalists to handle the first few postdischarge outpatient visits.

This is just a small part of the expanding scope for hospitalists. In addition to managing SNFs and the discharge clinic, hospitalists are now the major providers of perioperative care and play a growing role in palliative care, especially for inpatients. As other specialties that abut hospital medicine have increasing demands and yet fewer new specialists, hospitalists are taking on more critical care and geriatrics, providing procedures, and occupying an evolving role in the emergency room.

There is a lot of work coming toward hospital medicine, and to expand our workforce, hospital medicine groups have incorporated advanced practice providers, including nurse practitioners and physician assistants. But building a true team of health professionals is not seamless or easy with each constituency having a unique scope of practice, limits on their licensure, their own culture, and a distinct training background.

“In the end, this all comes back to how hospitalists add value, how we can create a career that is rewarding, and how we can help hospitalists be resilient and avoid burnout.”

But wait. There will be more new players on the hospital medicine team going forward – some we cannot even anticipate at the present time. In the future, the hospitalist may not even touch the electronic health record. Clinicians have never excelled at data entry or analysis, and it is time to use a combination of artificial intelligence (AI), voice-activated gathering of history into the electronic health record. Clinicians will need to adapt to changes in what is valued (i.e., how you can be the most effective and efficient) and to a new job description (i.e., overseeing more patients and managing a team that does more of the H&P, data collecting, and bedside work).

After 20 years of coming out of nowhere to being in the middle of everything in health care, I am confident that hospitalists, with the help of SHM, can continue to forge a path where we can be key difference makers and where we can create a rewarding and sustainable career. It won't “just happen.” It is not inevitable. But if the past 20 years is any example, we are well positioned to make the adaptation to succeed in the next 20 years. It is up to all of us to make it happen.
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Swati Mehta, MD
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