



CAREER GUIDE for RESIDENTS



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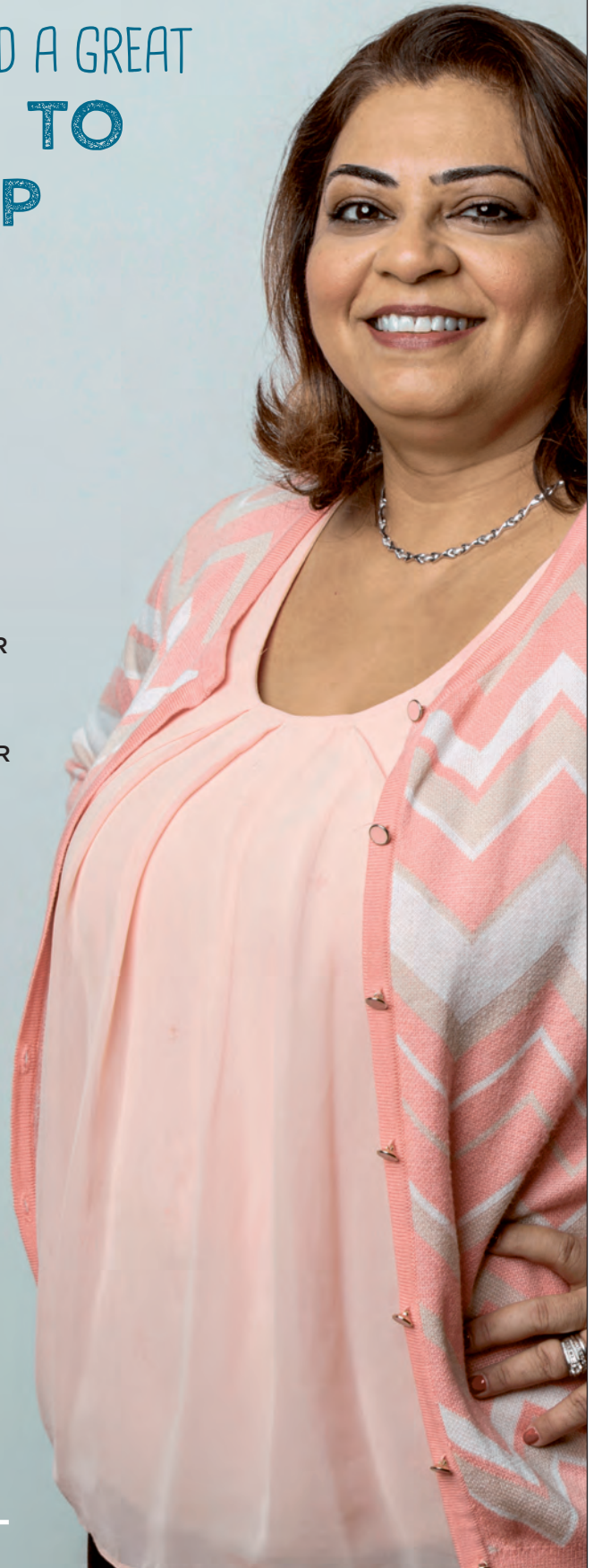
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2020 Winter Career Guide for Residents

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Authorization to treat and other quagmires

Authorization for medical decision making regarding end-of-life planning is something that patients need to consider both at the beginning of adulthood and in the later years of life.

By Margo Williams, MHA, CMPE

When a patient is unable to make sound decisions about her own care, what is the physician practice to do? It could be an elderly patient whose cognitive abilities are declining, or a college student who is over 18 but has never dealt with medical care on his own before, or a seriously ill patient who is planning for the future. It is important for the practice to have someone to communicate with about such patients without fear of violating HIPAA or state laws.

Authorization for medical decision making is something that patients need to consider both at the beginning of adulthood and in the later years of life. Although young adult patients may not need the same level of thought regarding end-of-life planning, it is important to educate them about HIPAA privacy and security rules. Young adults often incorrectly assume that their parents or significant others will have automatic access to their information and can and will make decisions on their behalf in case of emergencies, so it is important to ask them specifically and proactively about who is allowed to communicate with members of the care team if and when needed. This can easily be accomplished by including one or more forms along with new-patient paperwork.

For older patients, or patients with serious or terminal conditions, it is even more important to address what they want and who is authorized to make decisions on their behalf. Clinicians may conduct (and bill Medicare for) advance care planning as needed (typically at the time of a health status change or other significant life change, such as marriage, divorce, or event that might affect whom a patient may wish to educate or designate).

Practices can be prepared for these scenarios with a little planning. Clinicians and staff should know about several documents. The living will or advance directive provides general guidance about what treatment a patient would or would not want, but it is not a medical order, so clinicians cannot use it to guide treatment decisions. The power of attorney (sometimes called a medical power of attorney, medical proxy, or health care agent, depending on the state) designates a specific individual to make decisions for a person when and if he is unable to make his own decisions. The physician orders for life-sustaining treatment (or physician orders for scope of treatment) form is generally used to detail treatment wishes of patients who are nearing the end of life. This last document would



be used together with the other documents when a patient cannot make treatment decisions. For older patients, advance care planning is an important discussion to have at least once and to likely revisit as things change.

The practice should establish a policy that staff and clinicians can follow regarding when and how to discuss advance care planning. You can start by contacting your malpractice carrier to see if they have any examples you can use. Because rules can vary by state, your state or local medical society may have policies that provide state-specific information. ACP's Advance Care Planning Toolkit provides resources to explain and bill for advance care planning and to access forms that you might need to provide your patients. The HIPAA Privacy Manual includes authorization forms that patients can use to authorize specific individuals to have access to their information. The Patient Education and Caring: End of Life (PEACE) Series also provides guidance. ■

Margo Williams, MHA, CMPE, is Manager of Practice Support for ACP's Department of Medical Practice, which provides members with resources related to practice management, regulatory compliance, and health information technology.

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How to be successful at early discharges

A hospitalist offers tips on planning and working ahead.

By Kashif J. Piracha, MBBS, FACP

Somebody once said that more than half the battle is won with good preparation. This certainly applies to early discharges, which are very important to most hospitals and many patients. Hospitalists are at the forefront of all early-discharge efforts. Since I am a hospitalist myself, this is something that I deal with daily. I have come up with some strategies to make myself more efficient in my practice, and I think other hospitalists might benefit from these strategies too.

Things to do at admission

The foundation of any discharge can be laid as early as the day of admission. Many times, even then, the hospitalist has a rough idea about some aspects of a successful discharge. One of the most common examples of this is the discharge destination. Depending upon the physical abilities of the patient and the circumstances of the case, one can estimate whether the patient will be able to go back home or will require placement in a facility for rehabilitation or continued medical care. If the latter is the case, case management consultation should be sought immediately. Also, physical and occupational therapy consultations should be obtained right up front because often these recommendations form the basis for insurance approval. This allows the hospitalist the time to focus on the patient's medical issues while case management is simultaneously approaching the patient's insurance.

Things to do the day before discharge

As much attention as possible should be paid to the day before anticipated discharge. This is where most successful early discharges are planned and executed. The hospitalist should review all of the patient's pertinent labs and imaging results. A lot of times, this alone is enough to plan for discharge the next day. However, in certain cases, the morning labs on the day of discharge need to be satisfactory for the patient to be successfully sent home. In these circumstances, the hospitalist must make sure to order those labs the night before, so they are done and results are available the next morning. Also, the hospitalist must communicate with any consultants on the case the night before to make sure that they clear the patient to be discharged from their perspective. Often, consultants are tied up on the morning of discharge, so this conversation *must* happen the night before.

I cannot tell you how many early discharges fail because of

a lack of transportation on the day of discharge. Most times, patients depend on a relative or a loved one to come pick them up from the hospital. If the hospitalist waits to inform the patient about his discharge until the actual day it's happening, his ride may not be available until after 5 p.m., when most people get off work. Transportation issues must be worked out with the patient the day before discharge if an early discharge is to be successful.

Things to do the day of discharge

The first thing to do on the day of discharge is to look over all the morning labs and imaging results to make sure they are satisfactory. Next, the hospitalist must talk to the patient's nurse to inquire about any important overnight events that

could have a bearing on discharge, such as a rapid response or deterioration in the patient's condition. Next, if a placement is planned, the hospitalist should communicate with the case manager to make sure insurance approval has been obtained. By this time, the hospitalist should have already obtained clearance from the consultants on the case and the patient's transportation should have been adequately arranged. Often, hospitalists have 15 to 20 patients on their list to see every day, so they must take the time to see their possible discharges first. The hospitalist must sit down with each patient to carefully give them a brief synopsis of their hospitalization and go over discharge instructions, discharge prescriptions, and follow-up

appointments. Most electronic medical records allow the hospitalist to electronically prescribe medications, but the hospitalist must make sure that any prescriptions are transmitted to the patient's preferred pharmacy.

These are just some of the general tactics that I have used in my practice to successfully achieve the goal of early discharges. Of course, every patient is unique and one size does not fit all. But if hospitalists focus on some of the key points I have mentioned, in most cases they should come out ahead. ■

Dr. Piracha is the internal medicine clerkship director and an adjunct assistant professor at Texas A&M College of Medicine and a hospitalist at Houston Methodist Willowbrook Hospital in Houston.

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Photo courtesy of Dr. Piracha

Document to defeat malpractice suits

An experienced expert witness offers 10 tips for hospitalists.

By Stacey Butterfield

When thinking about malpractice risk and documentation, the key thing to remember is context, G. Randy Smith Jr., MD, MS, told attendees at the 2019 Midwest Hospital Medicine Conference, held in Chicago in October.

As the care for a hospitalized patient is initially being documented, “everybody’s living in real time with us—the nurses, our consultants, the patient—and everybody involved kind of understands the context of the moment,” said Dr. Smith, an assistant professor of medicine and a hospitalist at Northwestern University in Chicago who has served as an expert witness in lawsuits.

But years later, at the point when a malpractice claim would typically be judged, the context has changed significantly.

“When your documentation gets into a lawsuit, the relationship is flipped, right? Everybody’s trying to read your documentation to recreate the context,” he said. “Craft your documentation in such a way that many years down the road, somebody can read it and understand what the context was; that’s a little different than just writing during a busy day to try to communicate whatever you need for billing or for communication about care.”

If that sounds difficult to do, don’t worry. Dr. Smith broke down his big-picture documentation advice into 10 actionable tips.

1. Minimize cut and paste.

Overuse of cut and paste carries multiple risks. First, if you move your own words from one day to another without careful editing, the information may be inaccurate. “You render a note which becomes invalid and indefensible. You might have seen a note like this, where someone says in error that [a patient was] intubated and extubated and intubated and extubated all in the same day,” said Dr. Smith.

There are also risks to reusing others’ words. “If you cut and paste somebody else’s words like a radiology report, those words become your own. You have to justify those findings yourself as if they’re your own, and then you also have to justify why you chose to cut and paste that aspect of information, as opposed to something else in the vast expanse of [a patient’s] medical chart,” he said.

2. Use abbreviations with caution.

“This is where the issue of context becomes very important,” he said. Suppose a patient has a rare disease and

you use an abbreviation for it. “Everybody knows what the abbreviation means at the time, but three years down the road, you can actually spend time in a deposition or with opposing counsel arguing over what that abbreviation meant,” said Dr. Smith.

In court, abbreviations can even be misinterpreted as something offensive. “There has been at least one case I know of where SOB was successfully argued by a plaintiff to be an insult put into the chart,” he said.

Such a misunderstanding may seem deliberate, but other abbreviations can be reasonably understood in different ways. “‘Dw Dr. So and So.’ This one is actually very

dangerous. Does it mean discuss with or discussed—past tense—with?” said Dr. Smith. This uncertainty leaves room for a physician involved in a lawsuit to argue he was never consulted, he explained.

This doesn’t mean you have to avoid abbreviations entirely, though. “If you take the approach you see in the medical literature where every time an abbreviation is used you actually define it for the first time and then you use the abbreviation in the rest of the note, then you can copy that approach and save yourself some time,” he said.

3. Shorten notes.

“When you write a progress note for the day, it should reflect what your thoughts are at the moment. If your thoughts change four hours later, that’s

OK. But one thing that you need to avoid ... is this concept of using the daily note as a running continual gross summary of everything that’s happened during the hospital course,” said Dr. Smith. Don’t bring information forward from an old note to a new one if it’s no longer relevant, he advised.

This strategy offers multiple benefits. “It actually makes your note a little bit more likely to be read and understood ... not only by the expert witness or lawyers, but by people who are helping you take care of the patient at the time,” he said.

4. When in doubt, quantify.

Don’t document something as simply “abnormal” when it’s possible to be more specific. “‘Patient complains of weakness.’ ... Was it a little bit? Enough to where you thought that there was a spinal cord compression—really, really, really severe?” said Dr. Smith. “If you don’t quantify, your finding is up for debate.”



Dr. Smith

5. Consultation doesn't necessarily protect you.

The effect of requesting a consult on a hospitalist's malpractice liability depends on how much the consultant's procedural skills and expertise on the subject differ from what a hospitalist is expected to possess. For example, asking an ophthalmologist to use a skill hospitalists don't have to diagnose retinal detachment is much different from asking a hematologist to consult on anticoagulation for pulmonary embolism, Dr. Smith explained.

If in the latter case "you get the wrong guidance, and you follow it, and you just say, 'Well, that's what hematology told me to do,' it doesn't protect you at all," he said, "because most expert witnesses will be able to make a case that the standard of care is such that there are hospitalists throughout the country who can take care of pulmonary embolism without hematologists and that you should be able to do this on your own."

The documentation solution to this issue is to include your own perspective and expertise when describing the consultation. "Instead of saying 'Starting enoxaparin as recommended by hematology,' say something like, 'Have consulted with hematology, and I agree that we should start enoxaparin despite the risks,'" said Dr. Smith.

6. Chart a differential diagnosis.

For both good patient care and malpractice mitigation, hospitalists should make it a habit to consider, and document, possible other causes of patients' illnesses, Dr. Smith advised. "It's OK in your documentation to show doubt. You're actually better off if the patient's chart actually shows that you were engaged and thinking and you weren't entirely certain, but you were weighing possibilities," he said.

7. It's OK to reference the literature.

This recommendation applies to treatments that differ from normal day-to-day care. "If you feel like you're doing something which is maybe new at your institution ... or if you feel like there's a high-risk situation, you want to share evidence which is buttressing what you've decided to do ... that can do a lot to defend you," said Dr. Smith. "It shows to everybody involved that you're thinking about things and you actually have some sort of evidence to back up what you were doing."

To do this, simply cite the relevant study or guideline in the note documenting the related treatment choice.

8. Chart your doubts.

"The classic example is anticoagulation in the setting of bleeding risk," Dr. Smith said. "If you can quantify the risk by using some sort of a risk score calculator and writing that down, that will help you a lot." If you are concerned that a treatment carries significant risks, it's also good to document a plan to monitor and mitigate them, he added.

Of course, those doubts and risks should also be disclosed to the patient, and that disclosure should also be documented, Dr. Smith noted. In particularly risky or uncertain situations, consider pulling a witness—ideally an uninvolved clinician—into the conversation to verify in the record that the disclosure occurred.



Detailed documentation during patient care can reduce a physician's risk of ending up in a courtroom later. Photo by Getty Images

9. Consider deferring some decisions to the patient.

Even better than explaining and documenting tough decisions is letting the patient and/or family make them, when they are capable and sufficiently informed. "For a plaintiff's attorney to look at a chart and see that the decision to proceed, after a full explanation of risk and benefits ... was actually made by the patient ... it puts you in a very good stead," said Dr. Smith.

10. Do not alter the chart after the fact.

This final tip is actually "nondocumentation guidance," Dr. Smith noted, and it applies when you've been notified of a malpractice claim.

In such situations, many physicians feel the urge to go review the chart, he explained. "And if that urge slips too far, you might actually get the urge to go back and alter notes. Altering notes will not help you. In fact, altering notes after the fact is probably the quickest way to ruin your credibility as a witness."

All of the widely used electronic health records track and timestamp documentation changes, and a physician having made changes after being sued can be used to dramatic effect by a plaintiff's attorney at trial, according to Dr. Smith. "It's absolutely indefensible, and there's nothing that an expert witness can do to help you." After notice of a lawsuit, "seek whatever support you need. Talk to risk [management], talk to your local legal representation, but don't touch the chart," he said.

The 10 tips are designed to reduce malpractice liability, but applying them in daily practice can offer other benefits as well, Dr. Smith concluded. "It helps to foster professional growth. It'll also help to clarify communication with peers in real time, which can head off a lot of the communication factors that lead to lawsuits," he said. ■

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Helping hands come from the community

Community health workers can help physicians and patients as part of a broader recognition that many factors that don't involve direct treatment can still drive medical outcomes.

By Charlotte Huff



Image by Ja_inter

Doctors treating patients at Henry Ford Hospital's general internal medicine clinic knew that they were sometimes in the dark about the financial, transportation, and other challenges that sabotaged their patients' ability to manage chronic conditions.

"What we often find here is that our patients will tell our medical assistants who are checking them in more than they might tell the physician," said David Willens, MD, FACP, division head for general internal medicine at the Detroit hospital.

Valuable skills for community health workers include innate traits, such as empathy and a nonjudgmental nature, that are needed to connect with vulnerable patients.

So several years ago, the clinic decided to hire a community health worker to assist with a phone-based insulin titration program. The program allowed patients to call in their blood glucose readings but also potentially share other frustrations, Dr. Willens said.

"We felt that the right person to ask those questions would be someone who hopefully would be most comfortable for those patients," he said.

Community health workers, also sometimes described as lay health workers or, in Spanish, *promotores*, have enjoyed a bit of a renaissance in recent years. Their implementation has been rooted in part in the emergence of value-based reimbursement models along with a broader recognition that many factors that don't involve direct treatment can still drive medical outcomes.

In the U.S., there are slightly more than 56,000 community health workers, earning a median of \$39,540 annually, according to 2018 data from the Bureau of Labor Statistics. The picture for return on investment is still mixed and evolving, although a recent *JAMA Internal Medicine* analysis of a Philadelphia-based model published in December 2018 tracked a reduction in hospital days and 30-day readmissions.

"It's exciting to see that this workforce that has been around for hundreds of years finally is gaining some awareness and acceptance in mainstream health care, period," said Shreya Kangovi, MD, FACP, founding executive director of the Penn Center for Community Health Workers, which developed the model studied in *JAMA Internal Medicine*. But, she added, "I think the concern and the goal is to make sure that as the numbers grow, so does the effectiveness of these programs."

Dr. Kangovi and others who are knowledgeable about community health workers, sometimes dubbed CHWs, said that adding their skill set to clinical teams is easier to propose than to accomplish. Along with making savvy hiring decisions and providing optimal training, program directors must ensure that CHWs' practice role is well defined and then—perhaps most difficult of all—provide them the opportunity to wield their intuitive skills.

At the heart of these decisions, as Dr. Kangovi wrote in a piece she coauthored in a recent *Health Affairs* blog post, is a fundamental question: How best to "integrate a grassroots workforce into health care without totally coopting it?"

A broadening role

The Affordable Care Act has led to a number of federally driven changes and initiatives relevant to community health workers. Since 2014, a rule change made by CMS officials has opened the door to reimbursing state Medicaid programs for services provided by nonlicensed practitioners, including CHWs. Some demonstration projects funded by the Center for Medicare and Medicaid Innovation have incorporated community health workers. Earlier this year, the National Association of Community Health Workers formally launched as a nonprofit organization.

Even so, the profession is still evolving, and how CHWs are defined and what roles they play can vary from state to state, sometimes overlapping with other positions, such as patient navigator, said Sydne Enlund, a policy specialist at the National Conference of State Legislatures who focuses on health workforce issues.

"I think one of the biggest challenges generally is really that there's no uniformity around the profession," she said. "It's kind of like a patchwork among the states in terms of how they are using community health workers or whether they have mandatory certification or voluntary certification."

While training is vital, Dr. Kangovi said, a required certification process can create barriers, discouraging talented individuals who might otherwise be great candidates.

As the Penn Center developed its CHW model, called IMPaCT (Individualized Management for Patient-Centered Targets), Dr. Kangovi said they learned a lot about the sort of traits needed to connect with vulnerable patients while interviewing numerous individuals from lower-income communities. Clinical credentials are not on that list, she said, and in some cases might be counterproductive "because it increases the social distance that they have with their patients."

Moreover, some traits are largely innate and can't be taught, Dr. Kangovi said, such as "empathy or listening skills or a nonjudgmental nature." To locate those natural helpers, Dr. Kangovi recommended moving beyond job boards and traditional human resources recruiting channels. Consider posting in soup kitchens, churches, YMCAs, and other community service programs, said Dr. Kangovi, who also outlined in a recent *NEJM Catalyst* piece other elements of training and implementation to develop a successful CHW program, including assessing effectiveness.

"It's really easy to believe in the narrative around community health workers and just take on faith that these programs are inherently going to work, but that has not been the case," Dr. Kangovi said. "These are complex programs to get right."

To date, the research jury is still out. One systematic review of 53 studies, published in 2009 by the Agency for Healthcare Research and Quality, found mixed evidence regarding the potential for CHW interventions to improve participants' behavior or health outcomes. The six studies that looked at economic and cost impact "yielded insufficient data" to evaluate cost-effectiveness relative to other community health interventions.

Another more recent 2017 systematic review, which focused on social determinant interventions more broadly, including CHWs, was similarly critical. Studies involving health outcomes showed mixed results, and higher-quality research

is needed, the authors wrote in the *American Journal of Preventive Medicine*.

Yet other analyses have planted seeds for optimism. A 2018 report, which analyzed the impact of the federally funded Health Care Innovation Awards, found that out of six types of intervention components evaluated, ranging from health IT to telemedicine to workforce redesign, only community health workers lowered total health costs (by \$138 per beneficiary).

In the *JAMA Internal Medicine* study, which randomized nearly 600 patients with multiple chronic conditions to usual primary care or CHW support, the impact on hospitalizations was notable. After six months, the usual care group had spent a total of 345 days in the hospital compared with a total of 155 days for the group supported by an IMPaCT community health worker. The 30-day readmission rate was 25.7% for the usual care group versus 7.9% in the intervention group.

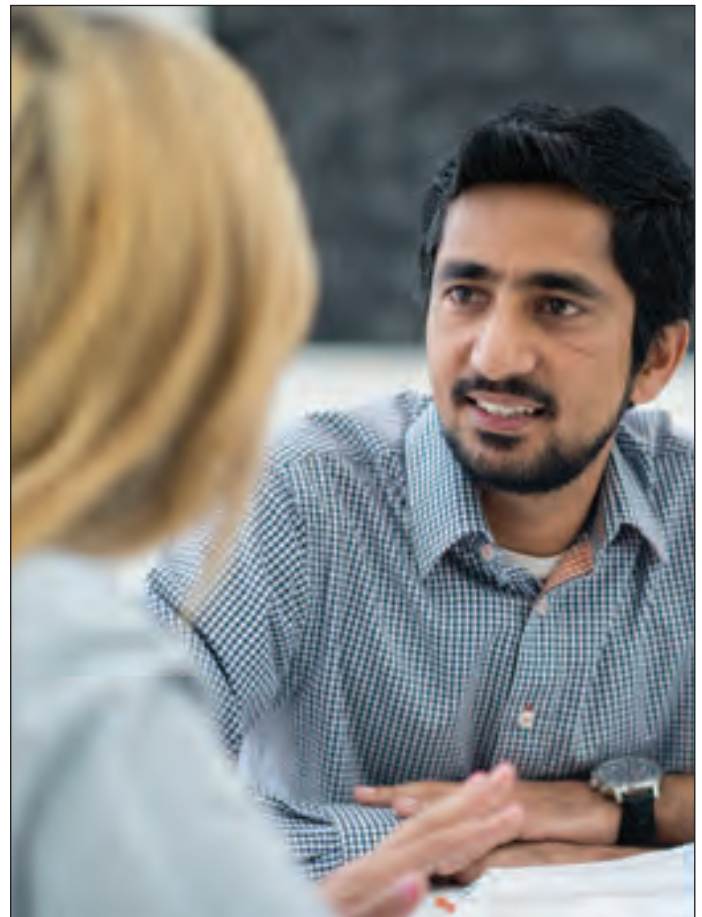


Image by FatCamera

Bridging the physician-patient gap

Community health workers can play a mix of roles, working with patients diagnosed with chronic conditions and those who are frequently hospitalized or, more broadly, working to reduce not just language but also cultural and other obstacles that can inhibit patients from speaking up, said Sergio Matos, a long-time community health worker who founded the National Association of Community Health Workers.

"There's an inequity between providers and recipients of health care," said Mr. Matos, who also heads up a Brooklyn, N.Y., firm that works to advance the CHW workforce, as well

as consults with hospitals or practices nationally. "Recipients don't always feel entitled to their voice in those encounters."

There's also some entrenched cultural mistrust that CHWs can help ease, he said. "There are a lot of experiential and cultural beliefs that the medical system is really in it for themselves and that they're in cahoots with the pharmaceutical industry."

If patients don't feel free to speak up, physicians may not realize that a patient is struggling to see the syringe because she can't afford glasses, Mr. Matos said. Another patient might not be taking his blood pressure pills but is loath to admit to his doctor that it's because they're impacting his sexual performance.

"The medical system tends to label those folks as noncompliant," Mr. Matos said. "It's not that men don't want to control their blood pressure. It's just that the consequences of what they are being prescribed are not acceptable."

At Henry Ford Hospital, Linda Hopkins-Johnson works with patients prescribed basal insulin, checking with them by phone on their latest readings as well as any other difficulties they might have encountered. As a community health worker who got her core competency training through the Michigan Community Health Worker Alliance, along with taking diabetes educator classes, she works under the oversight of a nurse. That way the nurse can focus on adjusting insulin dosages as needed and Ms. Hopkins-Johnson can delve into lack of adequate refrigeration and other daily challenges that undercut health, Dr. Willens said.

But that only works if the community health worker is accepted as part of the multidisciplinary team, Dr. Willens stressed.

"Accept their eyes and ears as important information just like you would history from a patient or from testing," he said. "It's incredibly valuable, especially if they're bringing a different perspective than what you can elicit from a patient."

Ms. Hopkins-Johnson is typically introduced to patients at one of their appointments, so they know who is on the other end of the line when she calls for their latest glucose readings.

"I try to build up that friendship or relationship with the patient as we talk," she said. "Once they find out that I'm not a nurse or a doctor, then they'll tell me different things," such as not being able to afford much food at all, never mind a special diet.

She brainstorms with them about how to achieve bite-sized goals. She encouraged one patient who couldn't walk all of the way around a track to walk halfway or even a quarter of the way and slowly increase from there. For some patients, kicking the sugar habit is the hardest, said Ms. Hopkins-Johnson, describing how some might consume four or five candy bars daily. She advises them to cut back over time and "to eat them earlier in the day while you're still moving around."

An analysis of a year's worth of data involving 144 Henry Ford patients with diabetes who worked with Ms. Hopkins-Johnson found that 56.9% had lowered their HbA1c by at least 1% compared with 36.2% in a control group.

Pitfalls to consider

Dr. Kangovi cautioned that tying a CHW's responsibilities to a single condition or medical challenge, such as improving diabetes control or mammography screening, can make it harder to scale up the program. IMPaCT has developed a patient-centered approach in which the community health worker conducts a semistructured interview, soliciting where patients most want to improve their health.

For instance, one patient might need a reason to get out of bed in the morning, and the community health worker might help him sign up for an art class at the local rec center, Dr. Kangovi said. Another might be fretting most about affording glucose test strips, so they work on that first, she said.

"I think clinicians have a lot of reluctance or skepticism with letting patients drive the agenda," she said. "But what we've found through three clinical trials is that the very patient-centered empowerment approach, rather than the targeted approach, actually I think is what lets us move these hard clinical outcomes in the end, that patients are the experts at what they need."

In IMPaCT, the community health workers are embedded in clinical teams, so they build relationships with both a roster of patients and their clinicians, Dr. Kangovi said. She discourages clinics and practices who are considering adding CHWs to try to shoulder the logistics of hiring, training, and supervising them. A more efficient approach, she said, is to contract with an outside resource or center that can provide training and other services and then deploy the CHWs back to the practice.

Regardless of their precise roles and program designs, the work prospects for CHWs look bullish. Other 2018 data from the Bureau of Labor Statistics, which combines CHWs and health educators into a single category, predicts job growth of 11% through 2028.

All of these additional workers will need training in core competencies, such as communication, behavior change, and goal setting, Mr. Matos said, plus additional specialized training for those who will focus on pregnancy, diabetes, or another medical condition. The National Association of Community Health Workers is planning to compile a list of training resources, he said.

Like others, Mr. Matos emphasized that doctors and other clinicians should be ready to provide some latitude to maximize their investment in this growing CHW workforce. "They can't make life miserable for them and try to alter their character to be mini-doctors or mini-nurses," he said. "You have to give them the freedom to do what they know how to do." ■

Charlotte Huff is a freelance writer in Fort Worth, Texas.

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Increasing nutrition education in medicine

Diet-related diseases, including hypertension, diabetes, and obesity, comprise a large portion of primary care visits in the U.S.

By Mollie Frost

Diet-related diseases, including hypertension, diabetes, and obesity, comprise a large portion of primary care visits in the U.S. But nutrition can be an overlooked component of care in a 15-minute visit.

"Dietary interventions, despite being first-line therapies for a lot of these conditions, are very seldom prescribed by physicians," said Megan McLeod, a fourth-year medical student at the University of Michigan in Ann Arbor. A lack of focus on nutrition during medical training, time and compensation constraints, and a potential perceived inefficacy of nutritional interventions all factor in, she said.

To get a better understanding of primary care physicians' baseline knowledge of and attitudes about dietary interventions, Ms. McLeod conducted a study of about 350 internal medicine physicians, family medicine physicians, and pediatricians across the state of Michigan. She presented the results at the American Public Health Association's 2019 annual meeting, held last November in Philadelphia.

Through a 50-item online survey, physicians rated their self-perceived knowledge and tested their objective knowledge base about dietary interventions. Interventions included the Dietary Approaches to Stop Hypertension (DASH) diet, the Mediterranean diet, the ketogenic diet, carbohydrate counting for patients with diabetes, and fermentable oligosaccharides, disaccharides, monosaccharides, and polyols (FODMAPs) and elimination diets for irritable bowel syndrome.

The respondents' overall objective knowledge score was 70.3% and was positively associated with number of years in

practice. Self-rated knowledge score and self-rated efficacy in counseling patients were also positively associated with their objective knowledge score, Ms. McLeod reported. "So physicians are doing a reasonable job of guessing their overall knowledge base pertaining to these topics, and it's not great," she said. Nonetheless, overall agreement with the importance of dietary interventions was 3.95 on a scale of 1 (strongly disagree) to 5 (strongly agree).

Despite being able to accurately predict their overall knowledge base, physicians were less apt at accurately rating their knowledge about specific nutrition topics, such as the DASH diet and portion control, Ms. McLeod said.

"I think [the study] speaks to the breadth of misunderstanding within the topic of nutrition that physicians are facing ... and it does help inform future efforts to improve nutrition education, which we have seen and will continue to see," she concluded.

Two other presentations at the session focused on efforts to increase nutrition education and awareness, both among practicing clinicians and among medical students.

Medical nutrition for the busy clinician

Increasing nutrition knowledge and performance among primary care physicians is included in the U.S. Department of Health and Human Services' Healthy People 2020 objectives.

Within nutrition and weight status objectives, there are two broad workforce training objectives: increasing the proportion of primary care physicians who regularly measure body mass index, and increasing the proportion of physician office visits that include counseling or education related to nutrition and weight.

To help support these objectives, the Institute of Human Nutrition at Columbia University in New York City launched a medical nutrition certification program for health professionals in 2013.

The program enrolled students from a variety of health professions, including dental professionals, nurse practitioners, physicians, physician assistants, and registered dietitians, said Kim Hekimian, PhD, an assistant professor of nutrition in pediatrics at the Institute of Human Nutrition at Columbia. Classes were held one full weekend a month for a year, with some online modules.

In one of their first assignments, the students were asked to review their own professional society's guidelines on



Efforts are under way to increase nutrition education and awareness among practicing clinicians and medical students. Image by kitcorner

nutrition, she said. "Most had never seen their own nutrition guidelines before and certainly felt that they were not trained in those guidelines," Dr. Hekimian said. "So this lack of awareness confirms the literature and confirms the need for further workforce training."

The overall aim of the program was to improve clinicians' understanding of the etiology, prevention, and treatment of nutrition-related diseases, she said. "We really hoped to develop content that we could give on the weekends that the practicing health professionals could apply to their clinical practice on Monday morning," said Dr. Hekimian.

The program aimed to emphasize educational components that were relevant to clinical practice and also covered the biochemical basics of nutrition and metabolic disease, she said. While some clinicians were initially apprehensive about taking biochem again, "We felt that it was very important for clinicians to be able to assess future nutrition claims by understanding the fundamental science behind them," Dr. Hekimian said, adding that there was also much emphasis on evidence-based nutritional counseling, particularly motivational interviewing.

Another core component was teaching cooking skills, which students were also a bit hesitant about initially, she said. But the cooking sessions were soon a very popular component of the program.

"So not only were they learning quick, easy recipes that they could share with their patients, but ... if we talked about a particular nutrient or metabolic pathway that day, we could show them with food what the relation was," Dr. Hekimian said.

The program led to changes in three components of students' clinical practice, according to focus-group data and in-depth interviews.

First, all participants who were interviewed reported more frequently offering nutritional counseling, and many gave examples of using their clinic appointments to focus specifically on nutrition, Dr. Hekimian said. She quoted a primary care cardiologist, who said, "I do more intense counseling, more frequent follow-up visits, [and] I've learned that motivational interviewing is a valuable technique in getting patients to acknowledge their problematic food choices."

Second, some participants reported changing their professional focus or seeking out professional opportunities where nutrition was their focus. "As a component of that practice, some are now developing training modules for other residents [at] Columbia about nutrition, and some are developing surveys on nutrition within their practice," Dr. Hekimian said.

Third, an unexpected area of change was that participants reported shifts in their own habits. "Many students ... utilized the recipes and the cooking skills that they had [learned] to change their own eating habits, and they felt that they could then utilize those changes to express more confidently to their patients that their patients could do this too," she said.

Overall, the impact on clinical practice was significant, but the program was labor-intensive and unsustainable in its current format, Dr. Hekimian said. The next step for Columbia is to develop similar workforce training modules in nutrition that are online only.

Cooking up a new rotation

At West Virginia University in Morgantown, nutrition education is starting even earlier.

From mid-February through March 2019, fourth-year medical students were recruited to join a two-week culinary medicine elective rotation. Culinary medicine, which combines the art of food and cooking with the science of medicine, often uses a hands-on curriculum to strengthen nutrition and culinary skills (see "Setting a Course for Food as Medicine," *ACP Internist*, June 2018).

As part of the rotation, students participated in lectures, hands-on learning, and cooking activities that were held in the lifestyle intervention research lab, which has a teaching kitchen, said Rachel Wattick, a nutritional and food science master's student and graduate research assistant at West Virginia University. The research team measured changes in the students' nutritional knowledge and attitudes with a pre- and post-survey.

A total of 15 students were included, four on the first two rotations and seven on the third, she said. "Because of space limitations, as well as the need for that one-on-one interaction, we did have relatively small groups," Ms. Wattick said.

The curriculum included lecture topics such as behavior change theories, basic food groups, food safety, culinary techniques, macronutrients, biochemistry, nutrition counseling, and fad versus evidence-based diets, she said. Students also had to create cost-conscious meals, going to the grocery store with a specific budget for ingredients and returning to the lab to cook them. For example, an assignment to feed a family of four where the parents were watching their blood pressure yielded a healthy, plant-based meal of chickpeas, quinoa, and four different types of vegetables for less than \$10.

"We are in West Virginia, which is a very health-disparate, low-socioeconomic-status state," Ms. Wattick said. "So we thought it was really important to talk about cooking healthy on a budget so they could have the knowledge to recommend low-cost, healthy options to their patients."

Before and after the rotations, students took surveys that measured nutrition knowledge, attitudes, and self-efficacy. Overall, there were statistically significant increases in nutrition knowledge and self-efficacy. However, the increase in attitude scores trended toward but did not reach significance. "We do think it's because attitudes are already rather high coming in," Ms. Wattick said. Students also completed an elective evaluation to provide feedback on the course. Overall, they rated the course highly and rated the hands-on cooking sessions and presentations as most helpful, she said.

Based on student feedback, the school will continue to refine and test the curriculum with a new cohort of students this coming spring, Ms. Wattick said. As for the students who took the elective and have since moved into residency, "It'd be interesting to see how it has impacted what they've been exposed to so far in practice," she said. ■

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How doctors can be social media 'influencers'

Meet a chief medical social media officer.

By Mollie Frost

Austin Chiang, MD, MPH, gets away with using social media at work. In fact, it's part of his job description.

In 2018, Dr. Chiang became chief medical social media officer at Jefferson Health in Philadelphia. While some physicians were early adopters of social media, medical and educational uses of these networks are only just becoming widespread, he said. "I think now is really when it's starting to take off. . . . We might even see it take off even more, especially with the rising generations of trainees," said Dr. Chiang. "In some programs, it's become almost a requirement to get on Twitter and participate in the discussions there."

Even those who use social media within medicine may not engage much with nonclinicians, however. "Part of the beauty of social media is how it indirectly impacts our lives and influences our decisions. That's the whole concept behind 'influencers' out there," said Dr. Chiang. "If we can go back to having that sort of impact on patients and the public, that would be really great."

Dr. Chiang, who also directs Jefferson's endoscopic bariatric therapy program and is president of the new Association for Healthcare Social Media, recently spoke with *ACP Hospitalist* about why he wants to get more doctors on social media.

Q: How did you become chief medical social media officer?

A: Professionally, I started using social media, namely Twitter, a couple of years ago after spending some time with ABC News as part of their medical unit. At the time, they were hosting weekly Twitter chats, and that's when I realized that a lot of public figures and important representatives of organizations out there were jumping on these Twitter chats and having a productive discussion about certain health topics each week. . . . I started doing social media research by using social media data and also was live tweeting at conferences and participating in Twitter chats. From there, I was able to get on different committees within my field of gastroenterology, serving in this role of [public relations], social media, and member engagement. That's ultimately what led to this role, which came out of a discussion with our CEO, Stephen Klasko, MD.

Q: What do you do in this position?

A: The main role is reaching out to other health professionals in our system to get them on social media, so I have been speaking to various divisions and giving talks. The other thing is amplifying whatever messages our institution wants to amplify, so I help with rallying up all the social media heavy-hitters within our institution, and also helping to better define the internal social media policy.

My role there is still evolving. Initially, the charge was pretty straightforward: to get more health professionals on social media. But I think that's a challenging task because it requires

an understanding of what the do's and don'ts are and how to use it effectively. Part of the reason why this society can be helpful in the future is that we'd like to define our best practices. . . . A lot of us don't have a marketing background or a communications background. Many of us have just learned by trial and error and asking each other and teaching each other.



Photo courtesy of Dr. Chiang

Q: Can you share some of the social media lessons you've learned?

A: The first thing that most people come to me with are questions about patient interaction and patient privacy. That's not anything new, in that we have to be very careful about how we're interacting with patients, but I also feel that the way we communicate with patients is changing now. In the past, I think there was a hard stop, saying just don't have any sort of online interaction with patients, and you want to keep your social media presence separate in terms of personal versus professional. I think those lines, for me at least, are blurred because I want to make sure that what I'm putting out there professionally isn't just something that's so robotic and so professional that it seems like I'm marketing to someone. I genuinely want to share aspects of my life and humanize what I'm doing because, as we all know, trust has eroded in medicine and in health care. We can restore that trust by showing that we have the same struggles as our patients and we are trying to take care of our own health. Patient privacy [on social media] is also something that has yet to be fully defined, which is again where our society hopes to come in and provide some form of consensus.

Q: How did the Association for Healthcare Social Media get started?

A: After the [chief medical social media officer] role was created last year, I then had a hashtag campaign on Instagram called #VerifyHealthcare, and that was really highlighting misrepresentation [of health care credentials] on Instagram. One example I keep putting out there is the Medical Medium. . . . The guy has over 2 million followers at this point. He's backed by a lot of celebrities, and a lot of his claims are not really based on evidence. In fact, his bio on his website says that he gets his medical information from communicating with spirits. . . . Things that really have no scientific basis or mechanism behind it can be not only concerning to read coming from him, but in the comments, people try to explain away how that works. From [the #VerifyHealthcare campaign], that's what led

to the creation of the Association for Healthcare Social Media, which we launched recently.

Q: What do you say to doctors who are reluctant to get involved in social media?

A: It's not right for everyone, [but] I think the more, the better. I think that being nervous is a normal sentiment. For me, even though I've been on several social media platforms, even adopting a new social media platform is nerve-wracking. I recently started on YouTube. I had been thinking about it for years, but to actually take that leap was challenging because it's a whole different time commitment, and being on video is very different than putting photos out there. That leap to Instagram was also a challenge because it was a step more than just putting text posts on Twitter. With every step of the way, I've had to just trust my instincts and go for it and give it a trial at the very least. For a lot of people, [the problem] is not just accidentally posting something they shouldn't be, but also the time commitment. Especially in academia, it's not entirely rewarded or encouraged to be spending time on social media or even contributing to lay health journalism, and I think that needs to change. What I've adopted as one of my charges is to see how we can incentivize what we're doing here.

Q: Do you think other hospitals should have positions like yours?

A: Yes, absolutely. In terms of a C-suite title, I'm probably the only one, and there have been some similar positions that

have come up since. I've had folks who've reached out to me to try to develop similar roles at their institutions. For the most part, I think there are a lot of institutions out there that don't quite understand why this is necessary, and I'm very grateful that at Jefferson, they're forward-thinking and are open to having me come in and be a part of the media relations team because when it comes to the posts and the content that they're putting out there, I think things have to be vetted. . . . I think that some institutions rely so heavily on their media relations and communications teams, and sometimes the medical information out there may not be entirely accurate or presented in the right frame. So I think the more positions like mine, the better.

Q: What would you like to see from hospitalists on social media?

A: The general public might not even know what the role of a hospitalist is. There are several hospitalists who are active on social media who can lend a perspective to what a hospitalist does. I think it might clear up some confusion patients might have if they are hospitalized, like who exactly is dictating their care and what the difference is between their outpatient physician versus the hospitalist taking care of them. I think that's something patients should be better informed about. ■

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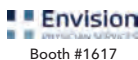
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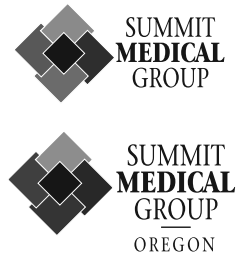
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Internal Medicine Physician Opportunities Available in 20 States

Urgent Needs

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NORTH CAROLINA	Cypress
Asheville	San Antonio
Marion	

Please contact:
Kathy.Haley@HCAHealthcare.com

HCA



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Internal Medicine and Primary Care

Nebraska

WELL-ESTABLISHED INTERNAL MEDICINE PRACTICE - Physician needed to join team of 6 MDs and 1 PA. Practice is outpatient only with patient base established by retiring partners. Position provides base salary plus incentives; health, dental, vision, life insurance and retirement plan; liability insurance; CME allowance; relocation assistance. Hastings, Nebraska, is a city of 25,000 with a 100-bed hospital, two colleges, good schools, walking trails and microbreweries. Please email resume to: jshuck@hastingsinternalmed.com W-39446

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New York

An excellent Internist opportunity exists with the Westmed Medical Group - a large, progressive, and financially thriving, physician-owned, multi-specialty practice. Within commuting distance from NYC, CT, and NJ, we offer an excellent, competitive compensation and benefits package. We are actively seeking Internal Medicine Physicians to join our existing teams in Westchester County, New York. New Graduates welcome! Physician works collaboratively with all providers as a multi-disciplinary team to provide comprehensive, compassionate health care to all patients. Candidates should send their CV to: hrphysician@westmedgroup.com W-39490

Pennsylvania

Internal Medicine Practice for Sale - located in the desirable Western suburbs of Philadelphia. Stable busy practice for over 30 years. Owner plans retirement. Excellent payor mix. Inquires to Markl753@outlook.com W-39499

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Hospitalist

National

Apogee Physicians Nationwide Hospitalist Opportunities. Apogee Physicians is the nation's largest, entirely physician-owned and operated, Hospitalist group. Founded in 2002, Apogee has grown to 750 physicians and nurse practitioners in 25 states. We are committed to creating the best opportunity for the best Hospitalists. Apogee has established programs in; Alabama, Arizona, Delaware, Georgia, Iowa, Illinois, Indiana, Kentucky, Louisiana, Michigan, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia and Wisconsin. Please send your CV to Mica Sylvain at mica@apogeephysicians.com or call 208-292-4088. Visit www.apogeephysicians.com. W-39489

Residencies and Fellowships



Massachusetts

Tufts Clinical and Translational Science Institute is now accepting applications for its TL1 Fellowship Program. The TL1 Program offers research training for postdoctoral scholars and clinicians with an interest in clinical and translational research. These prestigious, NIH-funded fellowships provide stipends and full tuition for the Clinical and Translational Science (CTS) MS/PhD Program at Tufts University. Fellows can choose from five tracks: Comparative Effectiveness Research; One Health; Drug and Device Development; Health Policy; and general CTS, and fellows will be matched with world-class research mentors across the translational spectrum. All fellowship recipients must be US citizens or permanent residents. Applications are due May 1, 2020. Contact: ewilstrout@tuftsmedicalcenter.org W-39514

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ICU Hospitalist/Nocturnist – Everett Hospital Cambridge Health Alliance (CHA)

Cambridge Health Alliance is a well-respected, nationally recognized and award-winning public healthcare system, which receives recognition for clinical and academic innovations. CHA is comprised of three hospital campuses with additional outpatient clinic locations throughout Boston's Metro North Region. CHA is an academic affiliate of both Harvard Medical School and Tufts University School of Medicine. We are a clinical affiliate of Beth Israel Deaconess Medical Center.

- Position requires PM (7p-7a) and weekend day shifts
- Work collaboratively with intensivist MDs to round on inpatients within the ICU
- Cross coverage of med/surg inpatient unit included in clinical responsibility (10% of FTE)
- Applicants comfortable with central lines, vent management, intubation, etc.
- Internal training/maintenance program exists to assist in certification of skills
- Academic appointment is available commensurate with medical school criteria

Applicants should be Board Certified in Internal Medicine or Family Medicine, possess clinical and communication skills, and show commitment to CHA's unique patient population.

We have a supportive and collegial clinical environment with strong leadership. CHA has a fully integrated electronic medical record system (Epic) throughout. We offer a competitive, guaranteed base salary and comprehensive benefits package.

Please visit www.CHAproviders.org to learn more and apply through our secure candidate portal. CV and cover letter may be also be submitted confidentially to Kasie Marchini at ProviderRecruitment@challiance.org. CHA's Department of Provider Recruitment may be reached at (617) 665-3555.

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.


DAY HOSPITALISTS AND NOCTURNISTS

White Plains Hospital, a leading Magnet designated hospital in Westchester, 25 miles from Manhattan, NY, is seeking full time and per diem Day Hospitalists and Nocturnists for our expanding Adult Hospitalist Program.

Hospitalists/Nocturnists will have a 7on/7off or 5on/5off schedule, closed ICU, with full sub specialty back up. Procedures are optional.

We offer an exceptional comp/benefits package and phenomenal work environment.

Please submit your CV for consideration to Sharon O. Alfonso
Email: salfonso@wphospital.org
Phone: 914-681-2768





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East Meadow, LI, NY. With a strong commitment to raising the bar for healthcare in our community, **Nassau University Medical Center** is a Level I Trauma Center and a 530-bed teaching hospital affiliated with Northwell Health and Stony Brook University. We are a full-service community hospital located just 30 miles from New York City.

NUMC is looking for an Internal Medicine Hospitalist to join our team. Board certification in Internal Medicine required.

We offer exceptional benefits including medical, dental, pension and much more!

For immediate consideration please forward CV and a letter of interest to:
Careers@numc.edu

WWW.NUMC.EDU AN EOE M/F/D/V



PennState Health
Milton S. Hershey Medical Center

DIVISION CHIEF, HOSPITAL MEDICINE DEPARTMENT OF MEDICINE Hershey, PA

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

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

Inquiries, nominations and expressions of interest, including a curriculum vitae and cover letter, should be submitted confidentially via email to Heather Peffley, PHR FASPR: hpeffley@pennstatehealth.psu.edu

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

Nocturnist-Internist

Penn State Health Milton S. Hershey Medical Center
Penn State Cancer Institute • Hershey, PA

The Division of Hematology/Oncology and Penn State Cancer Institute, Penn State Health Milton S. Hershey Medical Center, located in Hershey, Pennsylvania, seeks to recruit internists/nocturnists for our inpatient hematology/oncology service. This team of providers will have as their primary responsibility overnight care of our inpatients with opportunities for clinical research, and medical student and house staff education at the assistant professor level. The expected schedule for this position will be 17 weeks on duty annually for patient care.

Appropriate candidates must possess an MD, DO, or foreign equivalent and be board certified/eligible in internal medicine from an accredited institution. Candidates must have or be able to acquire a license to practice in the Commonwealth of Pennsylvania.

Individuals who are interested in joining this team of providers should forward their CV to:

Erica Geist - Physician Recruiter
Human Resources | Penn State Health
egeist@pennstatehealth.psu.edu



PennState Health
Milton S. Hershey
Medical Center

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

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Hospitalist Opportunity in Coastal Southern Delaware

Hospitalist BE/BC

7 shifts/2 week pay period • Employed within multi-specialty hospital network • Competitive salary with incentives and generous benefits package • Long established Hospitalist program with solid team

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- Profiles accepted January 2-April 25, 2020.

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- Bob Hoerr

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Come join us at the University of Kentucky in Lexington, KY.

We are a practice of more than 90 hospitalists and are well-integrated in college of medicine and medical center leadership. We are looking for hospitalist who want to build a career in hospital medicine. We offer opportunities for professional development in teaching skills, quality improvement, research, business and leadership. We have multiple service lines like procedure, oncology, malignant hematology, peri-operative, triage and nocturnist.

The division was founded by Mark Williams, a Past-President of the Society of Hospital Medicine and Founding Editor of the Journal of Hospital Medicine. Led by Romil Chadha, the division members participate in and direct numerous quality improvement, educational and operational efforts for the College of Medicine and UK Healthcare.

Full-time, non-tenure eligible faculty positions are available at a rank commensurate with experience. We offer a highly competitive salary and outstanding full benefits.

Lexington, KY is listed as the Top 25 Places to Live per US News and is consistently ranked nationally in the top 10 to Live in America (Money, 2018), Start a Business (HeroPay, 2017), Work-Life Balance (SmartAsset, 2018), Safety (SafeWise, 2019), and Raise a Family (Zumper, 2018).



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Please email cover letter and CV to:

Romil Chadha, MD, MPH, FACP, SFHM
Chief, Division of Hospital Medicine
University of Kentucky Healthcare
MN604, 800 Rose St
Lexington KY, 40536
Phone: 859-218-2658
Email: ukhm@uky.edu

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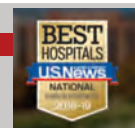
The Ohio State University Wexner Medical Center

Join a Leader in Hospital Medicine

As one of the nation's largest academic hospitalist programs, we lead a variety of teaching and non-teaching inpatient and consultative services. OSUWMC Division of Hospital Medicine is dedicated to the health and well-being of our patients, team members, and our OSUWMC community. Our mission is to improve the lives of our patients and faculty by providing personalized, patient-centered, evidence-based medical care of the highest quality. Our clinical practice meets rigorous standards of scholarship, and we are devoted to serving as expert educators and mentors to the next generation of physicians.

Preferred candidates are BC/BE in Internal Medicine or Internal Medicine-Pediatrics, have work experience or residency training at an academic medical center, and possess excellent inpatient, teamwork, and clinical skills.

OSUWMC is an equal opportunity/affirmative action employer and encourages applications from women and minorities. This is not a J-1 opportunity.



Our Faculty Enjoy:

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- Robust onboarding and mentoring program
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- Relocation allowance
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- University Hospital
- University Hospital East
- James Cancer Hospital & Solove Research Institute
- Richard M. Ross Heart Hospital
- Dodd Rehabilitation Hospital
- OSU Harding Hospital
- Nationwide Children's Hospital (Med-Peds)



Washington University School of Medicine is seeking full-time hospitalists, nocturnists and oncology hospitalists for our expanding program at Barnes-Jewish Hospital and Barnes-Jewish West County Hospital. MD/DO, internal medicine board certification or eligibility, and eligibility for licensure in the state of Missouri required.

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- Comprehensive liability insurance (no tail required)
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- Competitive base salary
- Health, dental, vision
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Barnes-Jewish Hospital is a 1,300-bed Level-I trauma center serving the St. Louis metropolitan and outlying areas. It is ranked as one of the nation's top 12 hospitals by *US News & World Report*.

All qualified applicants will receive consideration for employment without regard to sex, race, ethnicity, protected veteran, or disability status.

Interested candidates should apply: facultyopportunities.wustl.edu
Select "Internal Medicine" and see "Hospitalist".



Opportunities in California

NORTHERN CALIFORNIA

HOSPITALISTS

- SMG is hiring Hospitalists in Auburn, Davis, Roseville, & Sacramento, CA. Ideal candidates must be willing to work a minimum of 2-3 swing and 2-3 night shifts per month.
- Nocturnist Opportunities are also available.
- Flexible scheduling (17-18 shifts per month).

JOIN US AND ENJOY:

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- Great benefits, including medical, dental, vision, and 401(k).

Send CV to: develops@sutterhealth.org | sutterhealth.org

Sunrise Medical Associates is looking for full time /part time Hospitalists to join our ambitious team in the Los Angeles and Inland Empire areas. Successful candidates will demonstrate skills in inpatient medicine and teamwork and be an MD or DO BE/BC in IM/FP. Great Incentives available. Please send CV to smamedoffice@gmail.com or fax to 951-339-8461 for consideration. (Multiple positions available)

CALIFORNIA

Hospitalist and Intensivist opportunities available in the Los Angeles area. The City of Angels provides countless entertainment and cultural experiences and is host to professional sports teams. **Northern & Central California opportunities also available.**

For additional details contact:

Jennifer Winkler
jwinkler@vephealthcare.com
 925-482-8235

The UCLA Hospitalist Service has openings for full-time hospitalists and nocturnists in our new Santa Barbara cohort.

Positions include traditional inpatient internal medicine coverage with consultation on perioperative issues. The successful applicant will enjoy a full-time faculty appointment at the David Geffen School of Medicine at UCLA as well as an attractive benefit and retirement plan. California medical license required. The University of California is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, age or protected veteran status. For the complete University of California nondiscrimination and affirmative action policy see: UC Nondiscrimination and Affirmative Action Policy.

Please apply at:
<https://recruit.apo.ucla.edu/JPF04841>

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- California State Prison, Solano – Vacaville
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- Central California Women's Facility – Chowchilla
- Correctional Training Facility – Soledad
- Pelican Bay State Prison – Crescent City
- Salinas Valley State Prison – Soledad*
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or CentralizedHiringUnit@cdcr.ca.gov • www.cchcs.ca.gov



EOE

INTERNAL MEDICINE PHYSICIAN

Internal Medicine Physician needed in Greensboro, NC at Eagle Physicians, a multi-specialty, physician-owned group practice. The position is open at Eagle Internal Medicine at Tannenbaum due to a physician retirement - candidate will join 6 other internists. Hospital rounding is handled by the Triad Hospitalists and call is 1 in 7. Hospital admissions are at Cone Health, Wesley Long or (rarely) Women's Hospitals in Greensboro, all of which are part of the Moses Cone Health System (MCHS). At the 3 MCHS hospitals in Greensboro, there is a comprehensive range of secondary and tertiary level diagnostic and treatment services and 800+ beds. Eagle's other specialties are available with consultation from board-certified physicians in gastroenterology, endocrinology, sleep medicine, ob-gyn and pediatrics.

Eagle offers a competitive financial guarantee and a comprehensive fringe benefit package during the first year with the group.

A new residency graduate is eligible for shareholding consideration after 2 years with Eagle. Greensboro is a city of 260,000 people, with a regional population of approximately 1 million. Greensboro is located in the central "Piedmont" area of North Carolina, within easy driving distance of both the mountains and the beach via Interstate 40 and several other major highways.

For more information please go to
www.eaglemds.com
Send your CV via email to:
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ACADEMIC PRIMARY CARE DIVISION OF GENERAL MEDICINE

The University of Michigan, Division of General Medicine, seeks BC/BE internists to join our expanding Academic Primary Care faculty. Duties for Primary Care faculty include providing direct patient care in an outpatient setting with teaching opportunities. There are also opportunities to engage in population management and quality/safety activities. Prior training or clinical experience in an academic teaching environment is preferred.

Excellent benefits:

- Compensation package with guaranteed salary plus incentive bonuses
- Relocation support
- Generous signing bonus

Interested individuals should forward their curriculum vitae via email to:

Laurence McMahon, MD, MPH, Chief, Division of General Medicine
GenMedFacultyRecruit@umich.edu

Application review will continue until the positions are filled.

PRIMARY CARE SITES

- Briarwood Medical Group
- East Ann Arbor Health Center
- West Ann Arbor Health Center
- Brighton Health Center
- Canton Health Center
- Northville Health Center
- Saline Health Center
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WWW.MEDICINE.UMICH.EDU/GENERAL-MEDICINE

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- Sacramento - Primary Care, GI, Dermatology/Mohs, Compensation & Pension, Hospitalist, Hepatology*, Cardiology*
- Martinez - Primary Care, Compensation & Pension
- Fairfield - Hematology/Oncology, Anesthesia, Primary Care
- Redding - Primary Care (Staff & Supervisory)
- Chico - Primary Care

Several locations throughout Northern California

The VA Northern California HealthCare System is seeking BC/BE physicians. Benefits: 26 days vacation, 13 days sick leave, 10 Federal Holidays, Competitive salary, Malpractice coverage, Annual Physician Performance Pay, a variety of health plans (FSA, LTC, Dental, etc.) Retirement options.

Northern California has a lot to offer to those seeking good weather and an abundance of outdoor activities whether you prefer beach, mountains, snow, etc. Whether you are interested in academics, research, or a better work/life balance, you'll find the VA has a lot to offer, including the unmatched satisfaction you'll get from caring for those who have served our country. Must: 1) have a U.S. medical license, any state, 2) be a U.S. citizen, 3) be board-prepared in specialty

Recruitment & Education Incentives Available

Interested candidates may send a current CV or questions to VANCHCS Physician Recruiter:
Crystal.keeler@va.gov • (916)843-9256



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The **National Rural Recruitment and Retention Network (3RNet)** members are non-profit organizations helping medical professionals find jobs in rural and underserved areas throughout the country. Some of the medical professions we serve and the kinds of jobs posted may include:

Residency and Fellowship	• Cardiology
Family Practice	• Infectious Disease
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Internal Medicine	• Gastroenterology
Psychiatry	• Geriatrics
General Surgery	• Rheumatology
Emergency Medicine	• Neurology
Hospitalist	• Hematology/Oncology
Physician Assistants	• Nephrology
Nurse Practitioners	• Pulmonary / Critical Care

Please visit our web site for more information on positions in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming as well as the Cherokee Nation, Veterans Affairs, Indian Health Service and Saipan.

www.3rnet.org

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Williamstown Medical Associates of Berkshire Health Systems Is Seeking Primary Care Physicians To Join Their Established Team

Live, Work and Play – you can do it all here. One of the most beautiful settings in the northeast makes it easy to balance work with a healthy personal lifestyle. The Northern Berkshires seamlessly blends the warmth and connectedness of a small community with the endless cultural opportunities of a big city.

- Located in an idyllic New England college town, Williamstown is home to the top ranked Williams College
- Rich cultural environment including the legendary Williamstown Theater Festival, world famous Clark Art Institute and MassMoCA with the summer home of the Boston Symphony a short drive away at Tanglewood
- Recreational opportunities including skiing, hiking, fishing, nature preserves, kayaking and national forests

This is an exceptional outpatient opportunity for new and experienced providers:

- Skilled and dedicated physicians and advanced practice providers
- Cohesive and collaborative practice environment
- Affiliation with University of Massachusetts Medical School and University of New England College of Osteopathic Medicine
- Hospital employment
- Specialty support including a hospitalist team and NP coverage of long term care facilities
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We are proud of our commitment to the community. Join an outstanding medical team at a long-established practice in a unique New England setting.

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Liz Mahan, Physician Recruitment Specialist

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(413) 395-7866

emahan@bhs1.org

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The Portland Clinic - Outpatient IM

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Visit our website at
www.ThePortlandClinic.com/about-us

Please contact:

Jan Reid, Director of Provider Relations

(503) 221-0161 x4600

JReid@tpcllp.com

*The Portland Clinic is an
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PRIMARY CARE PHYSICIANS- Up to \$50,000K Sign on Bonus!!

Baystate Health is western Massachusetts's premier healthcare provider and home to the prestigious University of Massachusetts Medical School - Baystate.

At Baystate Health (BH), our extensive and experienced primary care network is the foundation on which our health system is built. Comprised of Baystate Primary Care Medical Practices (academic and community), Baystate Medical Center, a 716-bed tertiary care hospital and the region's only Level-1 trauma center, 3 community hospitals and Baystate Children's Hospital, we have practice settings that fit your career goals. Baystate Health is a well-established and growing organization which has the resources and support to start or advance your career.

Baystate Health is seeking a Primary Care Physician to join our network. Whether you want to work part-time, full-time, or per diem. BH wants to work with you to find the right fit and schedule that works for your life!

Position Highlights

- **SUPPORTIVE WORK ENVIRONMENT** - Excellent and experienced ancillary team. 1:1 Medical Assistant support. Direct access to a large multispecialty group including Behavioral Health network integration. Lab and practice specialty scheduler onsite. State of the art EMR system with technology support.

- **WORK LIFE BALANCE** - Flexible work schedules. Locations throughout western MA.

- **PATIENT CENTERED MEDICAL HOMES** - Community-based primary care offices recognized by NCOA as Patient Centered Medical Homes.

- **FACULTY APPOINTMENT** - UMASS School of Medicine (dependent on practice setting).

- **OUTSTANDING BENEFITS PACKAGE** - Up to \$50,000K sign on bonus (paid within first 30 days of EMPLOYMENT, specific dollar amount will be dependent on experience and site of employment) Generous compensation package, CME Allowance and time, high quality, low cost medical/dental, robust paid time off.

Qualifications: Candidates must be BC/BE. Role modeling of exceptional clinical, teaching and communication skills in a collaborative and multidisciplinary environment is expected.

The Pioneer Valley is a thriving area located in western Massachusetts and provides extensive access to urban, suburban and rural amenities. Anchored by the city of Springfield, our region boasts a myriad of opportunities for recreation, music, education and art enthusiasts. When you live and work in the Pioneer Valley, you will enjoy picturesque four-season living, excellent schools and year-round social and cultural events. In fact, Massachusetts was once again ranked #1 in Education nationally by U.S. News and World Report.

For more information please visit us online at:

ChooseBaystateHealth.org or interact with us socially at facebook.com/BaystateCareers or on Twitter @BaystateCareers.

All correspondence can be directed to:

Elizabeth Fox, DASPR, Physician and Advanced Practitioner Recruitment

Phone: 413-794-7726 Fax: 413-794-5059

Elizabeth.fox@baystatehealth.org

Reinventing healthcare takes courage. It takes collaboration. It takes you.

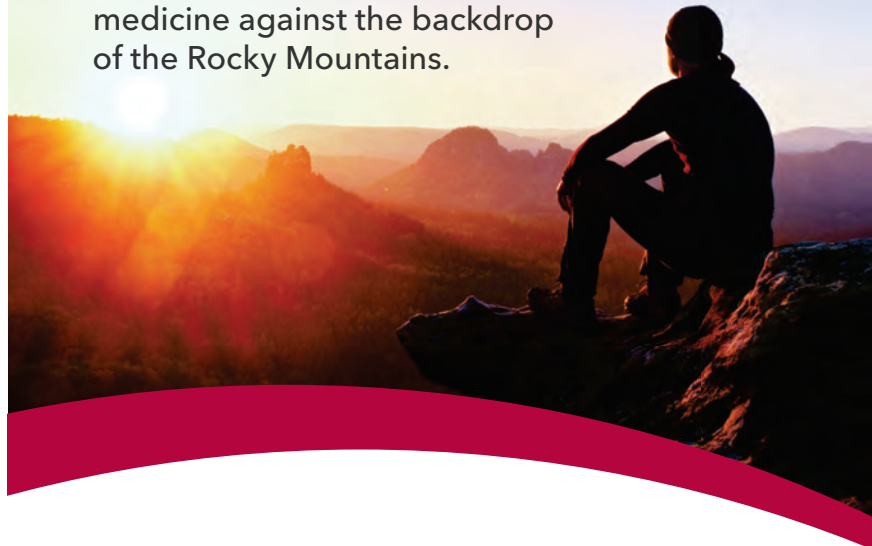
EOE Statement

Baystate Health is an Equal Opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, marital status, national origin, ancestry, age, genetic information, disability, or protected veteran status.



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MEDICAL DIRECTOR

LOOKING TO ESCAPE THE BUREAUCRACY OF LARGE HEALTHCARE SYSTEMS? Then this is the position for you! Nittany Valley Medical Associates is looking to bring on a physician with Medical Director responsibilities for a continuing care retirement community located in the heart of Pennsylvania close to Penn State University. You will have the opportunity to work with a team that values family and work life balance. Our group of 9 providers with specialties in Internal Medicine, Hospice, Palliative Care and Physical Medicine & Rehabilitation have been caring for the senior population in Central Pennsylvania for over 20 years. We are seeking a physician who desires flexibility and autonomy in their career.

Here is what we offer:

- Medical Directorship of a 160+ bed continuing care retirement community setting
- Shared weekend call by phone only
- Competitive salary
- Choose your hours and create your own schedule-Approximately 30 hours per week with option for full time.
- Great benefits that include 4 weeks of PTO, 2 weeks of CME, health insurance, malpractice insurance, 401k with company match
- Support staff that includes nursing, billing, administrative services and EMR.

The Community – According to the Central PA Convention & Visitors Bureau, our region enjoys national distinction and has been recognized as one of the safest places for families, a best city for entrepreneurs, a top-rated location for young professionals, and one of the fastest-growing areas in the state. Here is a bit of what you will find:

- Central PA is home to several well-known universities, including the Pennsylvania State University, Bucknell University, & Juniata College
- Year-round recreational activities including hiking, bike trails, mountain biking, downhill & cross-country skiing, the best fly fishing in Pennsylvania as well as access to many State Parks
- Exceptional public schools with private and charter school options
- Year-round farmers markets with locally sourced produce and products of all kinds. Abundant restaurants featuring local craft breweries, wineries, distilleries & cideries
- Countless opportunities to experience the performing and fine arts. Our area is home to the Central Pennsylvania Festival of the Arts, one of the country's largest summer arts festivals.

For more information contact Jen Gallagher at 814-235-1402.
You can send your CV to jgallagher@adventassociates.com

Check out ACP's collection
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PRIMARY CARE CLINICIAN EDUCATOR

Baystate Health is seeking a Primary Care physician to join our nationally recognized faculty. We welcome you to join our team and teach the next generation of Internal Medicine or Med Peds residents in Springfield, MA. Key components of the position:

- FACULTY APPOINTMENT TO UMASS SCHOOL OF MEDICINE and an opportunity to teach medical students from the UMMS-Baystate Regional Campus and residents from the Baystate Internal Medicine and Internal Medicine-Pediatrics Residency Programs.
- TEAM-BASED CARE MODEL IN A PATIENT CENTRIC ORGANIZATION THAT CARES FOR A CULTURALLY DIVERSE AND EQUALLY VALUED COMMUNITY. The physician experience includes being part of a team of healthcare professionals working together. The team includes nurse clinical coordinators, behavioral health partners, community health workers, pharmacy consultants, on-site specialists, advanced practice providers and residents.
- A UNIQUE SYSTEM EXPERIENCE aiming to work on population health, patient access, system efficiencies, service and quality of care as we evolve towards a value based system in the Medicaid and Medicare payers. The new ACO model provides coverage to the vast majority of the population we serve.
- AN OPPORTUNITY TO WORK IN A NCOA LEVEL III PATIENT CENTERED MEDICAL HOME that is nationally recognized for its work in Academic Innovation, Patient Access, Highly Reliable Systems and Top Tier Quality.
- OUTSTANDING BENEFITS PACKAGE AND WORK LIFE BALANCE. Sign on bonus (paid within first 30 days of EMPLOYMENT), Generous compensation package, CME Allowance and time, high quality, low cost medical/dental, robust paid time off. Flexible works schedules.

Candidates must be BC/BE by the American Board of Internal Medicine or Med Peds. Role modeling of exceptional clinical, teaching and communication skills in a collaborative and multidisciplinary environment is expected.

For more information, please visit:
www.ChooseBaystateHealth.org

Apply to: Ariana Caradiaz, MBA, DASPR
Physician and Advanced Practitioner Recruiter at Baystate Health
413-794-7726(P)
413-794-5059(F)
Ariana.Caradiaz@baystatehealth.org

EOE



Baystate Health System



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- On-site department assistant
- On-site care coordinator
- RN Triage

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- Flexible scheduling
- Hospital rounding opportunities
- Infrastructure to manage care quality
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- Outstanding benefits/annual compensation reviews
- Teaching opportunities
- Personal development & participation in patient care initiatives

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