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Peers offer welcome, ongoing support

In recent years, hospitals and other medical groups have begun to embrace peer support programs as more informal pathways for physicians to get help with burnout and related issues.

By Charlotte Huff

Even before the pandemic, medical societies including ACP have been increasingly aware of the risk physicians face from related mental health strain, potentially complicated by a reluctance to get help. Image by RyanKing999

One physician got in touch with Liz Lawrence, MD, FACP, after several patients died of COVID-19 on a single hospital shift. In another circumstance, a physician reached out and wanted to talk about feeling overwhelmed with professional commitments, working shifts, and handling Zoom calls while juggling child care.

"Just being asked to do the impossible," said Dr. Lawrence, chief wellness officer at the University of New Mexico (UNM) School of Medicine in Albuquerque, who participates in the peer support program there. "I don't have the answers. But I can listen, and I can acknowledge, 'Yes, that's an impossible situation. That's normal that you feel overwhelmed.' Often having that opportunity to be heard is healing."

The training and practice of medicine have always demanded a significant degree of stamina and resilience, considering the long hours and potentially life-and-death stakes involved. Even before the pandemic, medical groups including the American College of Physicians have been increasingly aware of the risk that physicians face from related mental health strain, potentially complicated by a reluctance to get help.

Along with worries that any mental health treatment may have to be disclosed on future licensing and other applications, physicians can be prone to skimping on self-care because of time, or at least a perceived lack of time, said Louis Snitkoff, MD, MACP, a retired general internist in Upstate New York and one of ACP's Well-being Champions, a program created in 2015 to foster wellness and professional satisfaction. (More information about ACP's well-being initiatives is available online.) The stigma against getting mental health care may be even greater among physicians than among the general public, Dr. Snitkoff said. "Just because we're not supposed to be sick—it's this culture of invincibility."

In recent years, hospitals and other medical groups have begun to embrace peer support programs as more informal pathways for physicians to get help. While the specific design may vary, the underlying goal is to pair trained physicians with colleagues, preferably those with similar training and background, who have requested or agreed to the support.

Since COVID-19 emerged, physicians have been coping with the daily challenges of social distancing and the loss of a prepandemic lifestyle faced by all Americans, Dr. Snitkoff said.

"Now on top of that, they're working in an environment where there is a surge of serious and critically ill patients. They're being called upon to provide professional services that may be outside of their comfort zone just because the needs are so extreme," he said. "And they're dealing with patient death at unprecedented levels."

The need to ramp up peer support efforts became apparent following the April death by suicide of Lorna Breen, MD, a New York City emergency physician who had been treating COVID-19 patients, said Caroline Gomez-Di Cesare, MD, PhD, FACP, the Bassett Healthcare network director of well-being. The hospital system, based in Cooperstown, N.Y., has received funding from the New York State Health Foundation to build a peer support network for clinicians at Bassett and four other health systems in central New York State.*

"It really helped bring to the forefront the incredible stresses that clinicians, particularly physicians, were experiencing," Dr. Gomez-Di Cesare said.

Culture of silence

Peer support programs will ideally counteract the sometimes engrained mindsets and work dynamics that can discourage physicians from seeking care, Dr. Gomez-Di Cesare said. As leaders of clinical teams, physicians have been trained to fix things and don't tend to admit vulnerability in any regard, she said.

"We have a culture of endurance and a culture of silence," Dr. Gomez-Di Cesare said. "It's really an ethical imperative that we provide as supportive of communities as we can. And that we change this culture of endurance to one where we care for ourselves and we care for each other in order to best care for our patients."

While the administrative burden for all physicians is extensive, it can be particularly so for primary care doctors given the documentation and insurer authorizations required for patient care coordination and specialist referrals, Dr. Snitkoff said. "So much of what physicians are experiencing in terms of work-related stress and moral injury is a product of the health care system," he said.

The stakes of untreated mental symptoms are high, including burnout and far worse. One analysis, done before the pandemic and published Oct. 14, 2020, in *JAMA Network Open*, found that 52% of 1,305 internists and internal medicine trainees participating in an ACP Well-being Champion program reported symptoms of burnout. (See the related Q&A in this issue.) These symptoms were most frequently associated with lack of work control and documentation time pressures. Even more worrisome, the rate of suicide among physicians was found to be 44% higher than among the general population in a meta-analysis of studies worldwide published Dec. 12, 2019, in PLOS One.

But frequently, physicians who may need help don't get it, a pattern that begins in training. A meta-analysis published Dec. 6, 2016, in *JAMA* found that 27.2% of medical students screened positive for depression or depression symptoms. Among those who screened positive for depression, 15.7% sought psychiatric treatment.

In recent years, some medical groups have pushed to limit the scope of mental health or addiction treatment questions in applications for a medical license, with the Federation of State Medical Boards adopting a policy in 2018 that state medical boards should scrutinize whether such questions are necessary at all. If they are incorporated, the federation recommends that they be limited to current impairment and not diagnosis or prior treatment.

Still, states don't consistently follow this guidance, Dr. Lawrence said. "I've had students say things to me like, 'I can't take Prozac. I'll never be allowed to practice.' That really isn't true in most states and most places. But I can never really reassure them that it's not true at all."

Thus, medical institutions have begun to launch peer support programs, most notably in the last several years, said Dr. Lawrence, who credits them with some inherent advantages. Since some states may consider these programs to fall under quality improvement or peer review initiatives, and the conversations are typically not documented, they may not be discoverable during litigation, she said.

Fellow physicians are also more likely to be available during weekend or evening hours to talk when more traditional services aren't typically open, Dr. Lawrence said. Plus, there's built-in trust, she said. "Who has a better understanding of what you're going through than a peer?"

Making connections

Dr. Gomez-Di Cesare said that she had planned a limited peer support network prior to the emergence of COVID-19, but its scope was expanded with a second grant from the New York State Health Foundation after the pandemic began. As of November 2020, about 50 volunteers—nurses and other clinicians along with physicians—have been trained across the five participating health systems, she said.

Her program, which is adapted from one that Jo Shapiro, MD, developed at Boston's Brigham and Women's Hospital, involves building a network of trained peer supporters across a variety of clinical backgrounds. Then, when physicians reach out, or are referred to the network, they are matched up with a peer supporter who has similar clinical training, she said.

UNM School of Medicine, which launched a pilot peer support project in a few departments shortly before the pandemic started, has since revamped and broadened its approach to make it more proactive, with the hope of better reaching physicians, Dr. Lawrence said. In early November 2020, 38 faculty members, residents, and medical students participated in training, she said.

Kerri Palamara, MD, MACP, a Boston general internist and physician lead for ACP's coaching services, said that in mid-2020 she started gathering nearly 70 ACP Well-being

Champions for monthly coaching calls to help them process and discuss ways to better assist physicians during the pandemic. Massachusetts General Hospital, where Dr. Palamara practices and directs the Center for Physician Well-being, is also developing a multifaceted support program for clinicians there, with access to everything from a buddy system to peer support to more formal group support and therapy, she said.

The buddy system will pair up clinicians so they can check in on each other on an ongoing basis, she said. The peer support program will be more formally structured with trained volunteers that will be available if the need arises, such as if a physician wanted to discuss a difficult or upsetting clinical experience.

"Then you could reach out and be connected with a peer supporter who will be with you during that and help you to process that," Dr. Palamara said. "And then if you need additional resources, they can help connect you."

Peer support efforts don't have to be highly structured to help strained physicians, said Diana McNeill, MD, MACP, who directs Duke AHEAD (Academy for Health Professions Education and Academic Development) at Duke University School of Medicine in Durham, N.C. As part of that program, she launched a series of video happy hours during the early months of the pandemic with various themes, including navigating Zoom calls and coping with virtual school at home. Icebreaker discussions led to more complex ones, from professional dilemmas to personal anxieties about contracting the virus, Dr. McNeill said: "The impact that COVID care has had on physicians may mandate the need for more peer support and more organized peer support."

Will they come?

The UNM School of Medicine program had barely launched before the surge of COVID-19 patients arrived in spring 2020, Dr. Lawrence said. The program was thus unfamiliar and physicians coping with patient fatalities and draining shifts along with home logistics didn't reach out much for support, she said.

Dr. Lawrence and her colleagues decided to change up the program, starting at the end of 2020. Groups of physicians, such as those who have just wrapped up a stretch of COVID-19 care at the hospital, will now be contacted with offers of support at the same time. "Part of doing that blanket approach is that no one feels stigmatized," she said.

When physicians respond that they are doing well, the peer supporter will still offer to send along some resources in case they're helpful later, Dr. Lawrence said. "It's a way of establishing a contact and a bridge that will hopefully lower barriers as we move forward."

Dr. Gomez-Di Cesare is also working on ways to open the path for reluctant clinicians. A lot of time will be devoted to educating departmental leaders, as well as risk managers and employee assistance programs, about the support network to make it a proactive resource, she said. A continuing medical education series will focus on the impact of stress on clinicians and patients, along with the importance of self-care in the care of patients.

Health systems ignore the fallout from poor mental health at their financial peril, Dr. Snitkoff said: "There's a very strong business case for institutions to be attentive to this issue." The cost to replace a physician who leaves or retires early can run a health system between $500,000 to $1 million in lost revenue, as well as recruiting and training costs, according to data published March 28, 2017, on the *Health Affairs* blog.

Peer support has limits, said Dr. Lawrence, stressing that volunteers are not there to provide counseling. "They are there to listen, to validate, to maybe refer to other resources," she said. "It can be a starting point to enter into more formal resources." The UNM program, she noted, has a psychiatrist for backup if there's a concern about a pressing need, such as a physician with suicidal ideation.

Dr. Lawrence also noted that physicians who volunteer may learn that supporting others provides an emotional payoff for them as well.

"I think one great strength about a peer-to-peer program is that in terms of burnout we find meaning and purpose in helping others," said Dr. Lawrence, who has experienced that feeling herself. "It feels like a tremendous honor that a colleague would trust me enough to call." ■

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

**This paragraph was modified on Jan. 5, 2021, to note the funder of Bassett Healthcare's peer support efforts and to update Dr. Di Cesare's title. Return to the corrected sentence.*

When the Dust Settles: Preventing a Mental Health Crisis in COVID-19 Clinicians

By Stephanie B. Kiser, MD, MPH, and Rachelle E. Bernacki, MD, MS

On 26 April, after spending weeks caring for patients with coronavirus disease 2019 (COVID-19) in New York City, emergency room physician Lorna Breen took her own life. Her grieving family recounts days of helplessness leading up to this as Dr. Breen described how COVID-19 upended her emergency department and left her feeling inadequate despite years of training and expertise.

The clinical experience of Dr. Breen during this pandemic has not been unique. During the past 5 months, COVID-19 has caused an upheaval of medical systems around the world, with more than 4 million cases and 300 000 deaths worldwide so far (1). Unfortunately, we've also seen that the experience in caring for patients with the virus may have profound effects on clinicians' mental health (2). A recent study conducted at the center of the outbreak in China reported that more than 70% of frontline health workers had psychological distress after caring for patients with COVID-19 (3).

Understanding and addressing these effects starts with naming the problem. Watching patients die alone, constant worry about inadequate resources, and paranoia about our own health are all deeply distressing and unprecedented experiences that cannot be described as anything other than trauma. Much of what we are facing daily is uncharted territory, but history tells us that this trauma, like other types, may have profound implications for the mental health of clinicians. In a study of health care workers involved in the 2003 SARS (severe acute respiratory syndrome) outbreak in Toronto, one third of those surveyed reported posttraumatic stress symptoms at levels similar to those of victims of a large-scale natural disaster (4). Furthermore, the risk for this secondary trauma comes for clinicians who already have a higher burden of mental health disease than the average population (5).

Many institutions have established resources, such as employee assistance programs, offering counseling and debriefing groups. These institution-wide approaches are crucial, but from our work in palliative care, where death is experienced daily, we know they will not be enough. We have learned the value of finding meaning in times of intense grief and sorrow—a new skill for many clinicians outside palliative care. As we have struggled to adapt our own coping mechanisms during this time, we have also observed our colleagues throughout the health care system in despair, often without the support, structure, and skills to process these events. With that in mind, we share a foundational set of principles to use as guidance for building internal support for the trauma caused by the pandemic: looking past the illness, fostering community, promoting vulnerability, and establishing boundaries and limitations.

Look Past the Illness

The practice of health care often dehumanizes our patients, reducing them to a list of symptoms and diagnoses. As we grieve over the restrictions currently limiting family members' presence at the bedside in our hospitals, we lose our most valuable connection to remembering who the patient is outside of their illness. During these times, we seek out ways to grasp small pieces of what that family presence often provides us. We spend a few extra minutes on the phone listening to a patient's wife tell us about the time they first met. We ask about an intubated patient's favorite song and play it at their bedside. These humanizing moments are desperately needed now. They sustain us and allow us to process our experiences as part of the complex narrative of illness.

Foster Community

For many persons, the first response to trauma is self-isolation (4). Although personal processing and reflection are certainly needed, healing requires community. Topics that are challenging to discuss often are not talked about transparently in our work culture. In palliative care, these challenges bring us together and we make time to talk about them in groups; 1 example is weekly Bereavement Rounds to share grief about the death of our patients. These groups promote and honor each other's strengths to further build resiliency and help us process the grief and ensure that we protect ourselves.

Promote Vulnerability

Throughout the pandemic, the community has praised health care workers. From posters of support to donated meals, these gestures are a warm embrace. In much of this, health care workers are cast as "superheroes." Although the sentiment is honored, the disconnect it creates cannot be ignored. Many health care workers may not feel they are "flying" but instead barely keeping their heads above water. Clinicians are not superheroes. We make mistakes, and we have limits. Leaders of our departments and institutions must broadcast this message. Senior clinicians can acknowledge the reality of the situation and encourage questioning of ourselves and our systems during this period of uncertainty. In palliative care, these thoughts are often shared during structured weekly Reflection Rounds. Although some may worry that this approach promotes weakness, we have seen the strength and support it provides.

Establish Boundaries and Limitations

The calling to the medical profession may feel even stronger during these times of intense need. This comes at the risk of throwing ourselves into the work without considering our own needs and protection. Leaders must protect their clinicians by carefully considering appropriate time off in scheduling and ensuring that colleagues, superiors, and trainees use this time. A need will always exist to do more, but this need cannot be met without ensuring that clinicians are well.

For our palliative care department, incorporating all these supports means making dedicated time with intentional activities and, more importantly, fostering a cohesive community of constant reflection. The strength of our program in honoring these principles comes from our leaders, who have made them a priority and have led by example. We do this together and have learned the power of community and how diversity within community can provide perspective.

As we offer these thoughts, we remain hopeful. The time for us to do more is now. If we take timely and targeted action, we will provide the support our fellow clinicians desperately need. We challenge leaders to act and make this a priority in the culture of their institutions. Today, we honor Dr. Breen and we grieve with her family. As we continue to mourn the catastrophic mortality from this pandemic, we must recognize that some outcomes can be prevented. ■

From Harvard Medical School, Boston, Massachusetts (S.B.K.); and Dana-Farber Cancer Institute, Boston, Massachusetts (R.E.B.).

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Corresponding Author: Stephanie Kiser, MD, MPH, 450 Brookline Avenue, Jimmy Fund 8, Boston, MA 02215; e-mail stephanie_kiser@dfci.harvard.edu.

Current author addresses and author contributions are available at Annals.org.

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References

1. Johns Hopkins University of Medicine. COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU). Accessed at https://coronavirus.jhu.edu/map.html on 15 May 2020.
2. Chou R, Dana T, Buckley DI, et al. Epidemiology of and risk factors for coronavirus infection in health care workers. Ann Intern Med. 2020;173:120-36. [PMID: 32369541] doi:10.7326/M20-1632
3. Lai J, Ma S, Wang Y, et al. Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. JAMA Netw Open. 2020;3:e203976. [PMID: 32202646] doi:10.1001/jamanetworkopen.2020.3976
4. Maunder R. The experience of the 2003 SARS outbreak as a traumatic stress among frontline healthcare workers in Toronto: lessons learned. Philos Trans R Soc Lond B Biol Sci. 2004;359:1117-25. [PMID: 15306398]
5. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). Am J Psychiatry. 2004;161:2295-302. [PMID: 15569903]

Lessons learned from telemedicine

Although many internists may have felt inexperienced with telemedicine before the pandemic, they could well have been doing it all along.

By Mollie Frost

A simple act such as asking patients to open the curtains during a telemedicine visit does more than make them more visible. Letting in sunlight might relieve symptoms of anxiety and isolation for those at home during the pandemic. Image by davidf

None. That's how Lauren Nelson, MD, FACP, described how much experience she had in telemedicine before March.

Zero. But when the COVID-19 pandemic hit, she had to learn the ropes—and fast. "Between March and June, almost all of my visits were telehealth," said Dr. Nelson, an internist in private practice in Omaha, Neb.

Zilch. And she is far from alone. In April, nearly half of Medicare primary care visits were provided via telehealth, compared with fewer than 1% of in February, according to a July HHS report. One reason for the lack of widespread use of telehealth services prior to the pandemic was the lack of reimbursement.

"Telemedicine, as far as we were aware, was not a reimbursable service, and it was difficult to sell patients on the fact that they could have a visit from the comfort of their own homes if insurance companies were not prepared to foot the bill for the visit," said William E. Fox, MD, FACP, Chair of ACP's Board of Governors.

Although many internists may have *felt* inexperienced with telemedicine before the pandemic, they could well have been doing it all along, just not getting paid for it. "While it was very common for us to talk to patients on the telephone, which we did all the time, no one ever had any expectation that that time we spent on the telephone would be reimbursable," said Dr. Fox.

Due in part to advocacy from ACP and other groups, CMS responded to the pandemic by reimbursing telemedicine visits, whether furnished by phone or video, to a level equivalent to in-person visits, as well as relaxing the rules on HIPAA compliance. These flexibilities currently extend to Oct. 23 and are set to be renewed based on the public health emergency.

"As miserable and devastating as the pandemic has been, one silver lining has been many regulatory groups, as well as CMS, being proactive in making it feasible for physicians and other clinicians to expand the use of telemedicine," said Tabassum Salam, MD, FACP, ACP's Vice President of Medical Education.

As ACP's physician lead for telemedicine, she led the development of the College's telemedicine module in response to a 2019 survey of ACP members that showed a very low usage of virtual visits. By coincidence, the module launched in March. "Thank goodness it was ready for launch because it was sorely needed by our membership, as well as those members who are educators," said Dr. Salam.

On the morning of Dr. Nelson's first telehealth visit, she visited ACP's website and completed the module. "That was my crash course in telehealth," she said. (See sidebar for more information on this and other ACP resources.)

While resources like this have helped many clinicians get up to speed on telemedicine, the shift has had its challenges. Internists shared the lessons they've learned and spoke about how they're planning to use telemedicine during this flu (and COVID-19) season and beyond.

Testing, testing …

Once the Trump administration declared a public health emergency on March 13, "Everything ground to a halt, and

nobody was coming into the office," said Dr. Fox, an internist in private practice in Charlottesville, Va.

The practice had to work fast to create an option for telemedicine visits. While one platform his partner found was easy to use and HIPAA compliant, it only worked with a Chrome browser on a PC. So to accommodate patients with Macs, the practice also offered the option of using FaceTime or another smartphone-based video conferencing app, Dr. Fox said.

"We quickly discovered all of these as we were going along and then quickly converted everybody to telemedicine visits. … I went from absolutely zero experience in telemedicine to this is all that I did in the span of just a couple of days," he said.

Even at Thomas Jefferson University in Philadelphia, which already had its own telemedicine platform, primary care clinicians had not fully embraced virtual visits, said Lawrence Ward, MD, MPH, FACP, executive vice chairman in the department of medicine.

"There was still resistance by a lot of patients, and there was a lot of this resistance by certain clinicians as well," he said. "The nice thing was, when we were all forced by the pandemic to do telehealth, a lot of those hesitancies fell by the wayside."

The clinicians had to learn fast, as demand for Jefferson's telemedicine services, which operate 24/7, spiked after the pandemic. "That expanded our work hours and made it harder to separate when you are at work and when you are not at work," said Dr. Ward, who is also professor of medicine at Jefferson. "It was a pretty exhausting first eight weeks of the pandemic."

But demand for telemedicine has not been high everywhere. For Jason M. Goldman, MD, FACP, an ACP Regent who has for several years offered telemedicine visits at his solo practice in Coral Springs, Fla., even a pandemic has not led to wide implementation. He estimated that at the height of the pandemic, the proportion of his visits that were virtual was still fewer than 20%.

"Telehealth in my area has not necessarily really taken off too well, at least for my population, for many reasons," Dr. Goldman said. For example, he said his elderly population does not necessarily embrace telemedicine technology.

To address the technology barrier, Jefferson created a way to send a direct link to those who are having trouble accessing visits through the patient portal, Dr. Ward said. "People really found we needed a way to reach out to patients if they can't get on the portal," he said. "I think that has helped many patients who are not tech savvy to be able to link into telehealth more easily."

Sarah Candler, MD, MPH, FACP, an internist and care team medical director at Iora Primary Care in Houston, recalled one patient who told her she missed her and wanted to see her, but didn't know how without coming into the office. Although the patient had video capability through her phone, she didn't know how to use the technology she already had, she said. "I feel fortunate to have a team that I work with … and one of my team members helped walk the patient through that."

Even still, some patients lack the technology necessary for video visits altogether. For Ankita Sagar, MD, MPH, FACP, a general internist at Northwell Health in Great Neck, N.Y., visits with older patients tended to be via telephone since most of them didn't have smartphones.

"There is a limitation in that," she said. "But over time, I think we were able to ask particular questions, listen to how they were breathing on the phone, understand that they were struggling to breathe, and to quickly triage and see what we can offer to them."

Dr. Candler estimated that about 10% of her patients have a technology barrier, such as not owning a tablet or phone or having insufficient internet bandwidth. In May, her health system began experimenting with delivering patients tablets with the capability to do video visits.

"In some of our markets, they have started delivering the tablets right before the visit so … that we can provide safe, socially distant visits to our patients in a way that feels more comprehensive than just a telephone call," she said. "Our current program loans the tablets just for the duration of the visit."

Looking ahead

Telemedicine appears to be here for the long term. As Seema Verma, administrator of CMS, told the *Wall Street Journal* in April, "I think the genie's out of the bottle on this one."

But as of August, many internists were seeing their telemedicine visits dwindle as their in-person visits increased. For Dr. Sagar, there are two reasons behind the transition away from telemedicine.

First, she said many of her patients have very complex illnesses and require in-person visits. "They really do need to come in to be evaluated, whether that's diagnostic testing, lab work, or just a physical exam," said Dr. Sagar. "So we are trying to focus on that right now while our COVID cases in New York are pretty controlled."

Second, she said her practice is putting an emphasis on in-person visits as a one-time check-in ahead of the fall flu and COVID-19 season. "We have our older folks who usually come in for their annual physicals in the springtime that really did not get a chance to come in due to COVID, so we're trying to catch up with them as well, just to make sure that we are getting all of our preventive services appropriately completed ahead of the winter season," Dr. Sagar said.

At Jefferson, the proportion of telemedicine visits was about 100% at the height of the pandemic but has settled in the 20% to 30% range, said Dr. Ward, who is also Governor for the ACP Pennsylvania Southeastern Chapter. Telehealth will likely continue to comprise a substantial portion of visits for as long as the pandemic lasts and even beyond, since patients and clinicians feel more comfortable with it, he said.

"I'm interested to see if during the cold and flu season actually the proportion of telehealth visits bounces back up again because we're going to be using it as a major way to manage patients that are calling in with colds and flu symptoms, rather than bringing them into the office," said Dr. Ward.

Telemedicine will also continue to be a large part of practice at Iora Primary Care, a national company that has grown as a result of the opportunities of telemedicine, said Dr. Candler. "Our goal is to be conducting at least 30% of our visits by telemedicine even after a vaccine. Even when things look better, we think that this is the future," she said.

Part of the reason for the health system's success is that it works in a value-based payment model as opposed to a traditional fee-for-service model, said Dr. Candler. "Because

Medicare has said that video visits count for some of those high-risk adjustment scores, the hierarchical condition category scores, we were able to still capture our value while providing a safe way to interact with our patients and our staff," she said.

For Dr. Candler, the best part about telemedicine has been that it encourages patients to reach out more frequently than they might have otherwise. "Sometimes that means people who have a rash know that, even if it's after hours and I'm on call, they can send me pictures of it or we can video chat and see what it looks like," she said. "It's not that I wasn't available to do those things before, but something about the instant gratification … is really reassuring for people."

In addition to evaluating rashes, telemedicine is particularly useful for visits related to behavioral health issues like anxiety and depression, said Dr. Nelson. "I would say the majority of my telehealth visits not related to COVID [at the height of the pandemic] were actually anxiety and depression related, and I'm really glad patients had that access," she said. "Especially during COVID, I'm not sure some of the people who did the telehealth visits would have come in to get an appointment."

Dr. Nelson recalled one patient who was feeling depressed and isolated during the pandemic, but telemedicine offered a clue that an in-person visit would not have. "I could see that she was in her house with all of her curtains closed," she said. "It wasn't going to be a cure, but part of my approach was just saying, 'Hey, let's open the curtains. Maybe you can't go outside and socialize, but it's bright and it's daylight.'" (See sidebar for 10 tips on conducting telemedicine visits.)

Telemedicine is also useful for follow-up visits and drug refills, but there are gaps in certain clinical areas, particularly cardiology, said Dr. Ward. "Our cardiologists are doing minimal telehealth calls," he said. "They really feel that they need to see people in person and obviously need to see them in person to get their [echocardiogram] and that sort of stuff."

While patients may be able to provide data for certain vital signs, like temperature, blood pressure, and weight, listening to a patient's heart murmur just isn't feasible during most telehealth visits, Dr. Goldman added. "You have to know the limits of telehealth and how to utilize it, and that comes with experience," he said. "When is telehealth appropriate and when should you do an in-person visit? That's just, in some ways, common sense, and then, in other ways, it's medical judgment."

An in-person visit is warranted whenever a physical examination or a procedure is paramount to the care of that patient's condition, said Dr. Salam. "Even though we have some remote devices that can fill in some of those gaps, when a physical examination and/or a procedure are central to the care of the patient in that visit, that's the time when it's absolutely the best for the patient to come in," she said.

Some larger health systems are investing in remote monitoring devices, although they have not quite become mainstream. "We really leveraged remote patient monitoring in the setting of COVID to keep patients outside of facilities who either were suspected of having COVID or were confirmed positive," said Todd Czartoski, MD, chief medical technology officer of CE Telehealth at Providence St. Joseph Health in Seattle.

In March, the health system ordered 5,000 non-Bluetooth-enabled pulse oximeters and 5,000 digital thermometers at a cost of $30 for each combined kit, he explained at the Virtual Summit for Health System Recovery from COVID-19, held in June. Patients with suspected or confirmed COVID-19 were sent home from the clinic, ED, or hospital with a kit.

"Then we used a secure texting platform to text them three times a day and have them answer a few questions about their breathing, how they were feeling, their respiratory rate, their pulse ox," said Dr. Czartoski. "And then we put that on a dashboard, and the dashboard had green, yellow, red in terms of risk stratifying them, and that allowed [us] to monitor up to 100 patients per nurse and only focus on the ones that were of concern."

While ACP's telemedicine module does not discuss remote monitoring, this technology may well appear in the College's future modules and educational products, said Dr. Salam. "It's an ever-growing field, and I think now that so many physicians and patients have become more comfortable with video visits, for example, remote patient monitoring is the next step where comfort is going to creep in," she said.

Perhaps the biggest uncertainty surrounding the future of telehealth is reimbursement. ACP is urging CMS to consider continuing pay parity for audio-only and telehealth visits even after the public health emergency is over. As Dr. Salam put it, "We are advocating for a sensible balance" of virtual and in-person visits going forward.

"There are several types of care you can offer through the telephone or video visits, and there are several that you cannot. And there's a place and time for all of them," she said. "We really think it should be a shared decision between the physician and her patients, and there's a lot of potential for improving continuity of care by making the safety and convenience of telemedicine readily available when it's the right modality for care." ■

Telemedicine resources from ACP

Finding telemedicine to be virtually impossible? Wondering whether it's financially feasible? Still wrapping your head around changes to billing and reimbursement? The College has you covered.

ACP's online module, "Telemedicine: A Practical Guide for Incorporation into your Practice," is free and available to the public. The module provides crucial information to physicians who want to begin or expand their use of telemedicine during the COVID-19 outbreak. Free CME/MOC is available to ACP members.

In addition, ACP's other practice management resources on telehealth coding and billing during COVID-19, technology options, telehealth coverage, and a cost/benefit analysis are available.

Talk more online

Discuss this topic in our Member Forum on emerging technology.

Top 10 telemedicine tips and tricks

1. **Be open.** Try to have an open mind with regard to telemedicine, because the change appears to be here to stay, said Sarah Candler, MD, MPH, FACP, an internist and care team medical director at Iora Primary Care in Houston. "It's not perfect, obviously, but part of not being perfect means that there's an opportunity to make it better," she said.

   Increasingly, physicians will need to meet patients where they are, added Lawrence Ward, MD, MPH, FACP, executive vice chairman in the department of medicine at Thomas Jefferson University in Philadelphia. "A lot of our patients are going to want telehealth. I think it would be to our detriment to fight that," he said. "I know it's not what a lot of people got into medicine to do, but I don't think we should be afraid of the medium."
2. **Be patient with patients (and yourself).** Throughout the difficult process of changing your practice and workflow, it's important to be patient with yourself and others, Dr. Candler recommended. "I think that it takes a certain amount of kindness to oneself and a few deep breaths," she said. "We have to have patience because it's going to take a minute to walk people through how to click on something."
3. **Try to schedule appointments during the daytime.** Poor lighting can cause myriad issues during a telemedicine encounter, especially when using the camera to examine the skin for rashes or bruising, so take advantage of daylight when possible, said Ankita Sagar, MD, MPH, FACP, a general internist at Northwell Health in Great Neck, N.Y.

   Daytime appointments also provide an opportunity to see if an older patient's space is too dark. "It's really important for the patient because if it's very dark, then they may have a higher risk for sundowning and delirium in the nighttime," she said. "So I try to tell them, 'Open your shades from 9 a.m. to 7 p.m.; let the sun come in.'"
4. **Mind your bandwidth.** Make sure that both you and your patient have enough internet bandwidth for a video visit, said Lauren Nelson, MD, FACP, an internist in private practice in Omaha, Neb. "I did have to make sure I had enough internet bandwidth for telehealth to work while my kids were all doing streaming work," she said. "I would also have to tell patients to make sure that their kids weren't doing all kinds of streaming, games, or things like that."
5. **Get camera ready.** For the best visuals, have patients sit by a window and encourage them to use a cellphone versus a computer when possible, since cellphone video capabilities are typically more up to date, said Dr. Nelson. "We always have people use a cellphone if they've got a smartphone," she said. "And then they can move around too, and you've got a little bit more flexibility."
6. **Keep hearing loss in mind.** Before each telemedicine visit, clinicians must assume that older patients have at least mild hearing loss and should take steps to optimize the encounter, such as illuminating their faces and speaking slowly and clearly, according to a communication checklist published online in August by *Annals of Internal Medicine*.

   "Usually, my script when I speak with patients is, 'Hi, how are you doing? Can you hear me OK?'" said Dr. Sagar. "And I think that that part usually takes the longest because for my older folks, many of them might have hearing aids or they might not have their volume high enough."
7. **Be prepared to ask for help.** Examining a patient through telemedicine often requires asking for some assistance. For example, try having patients hold the camera near their ankles and having them press on their lower shins to assess for lower-extremity edema, said William E. Fox, MD, FACP, Chair of ACP's Board of Governors and an internist in private practice in Charlottesville, Va.

   Patients can also press on their own abdomen or joints to help evaluate for pain and tenderness, said Dr. Nelson. "You can have people press on their ankle or their joints and say, 'Does it hurt here?' or 'Does it hurt your belly when you press it?'" she said. "But if there was anything that I was acutely worried about, we would try to steer that away from telehealth."
8. **Get the family involved.** If family members are willing to help, don't be afraid to get them involved, especially when seeing older patients, said Dr. Sagar. "I don't think we can reliably connect via video with a lot of patients who are older, but sometimes their family members are willing to go over to their houses or neighbors are willing to hold up their iPhone to do the video visit," she said.

   Family members in the home can also help with the physical exam. To help examine the abdomen, the patient could move to a couch or a bed, one family member could hold the tablet, and another could push on the patient's belly while the clinician walks them through the process, said Judd Hollander, MD, senior vice president of healthcare delivery innovation at Thomas Jefferson University in Philadelphia, speaking at the Virtual Summit for Health System Recovery from COVID-19, held in June. "We've learned to do all those things," he said.
9. **Keep your hands busy.** One problem Dr. Nelson discovered is that she talks with her hands. While this isn't an issue during in-person visits, "I'm trying to demonstrate something to a patient, and you can't see it on the video," she said. "So I decided that if I actually sat there and I took notes or was writing down what I was telling the patient, I wouldn't talk with my hands as much."
10. **Take a peek inside the patient's home.** During telemedicine visits on video, Dr. Sagar said she loves to ask two unusual questions. First, she asks patients to open their refrigerators. "That's so telling of what's happening in the home. I can screen for food insecurity, health literacy issues, dietary issues," said Dr. Sagar.

    She also asks patients to line up all of their medication bottles in the medicine cabinet. "There's so many things I find in there where I'm like, 'You can't take that, let's toss it and not come back to this,' or, 'You're running low on this medication, let me send it to your pharmacy for you,'" she said. "Those are probably my two favorite things that in no way an in-person visit can fulfill."

Don't put clinician burnout on the back burner

Patient- and non-patient-related administrative tasks can create burnout at any point during a clinician's career.

By Disha Patel

What is your practice doing to address clinician burnout? Recent studies have found that 50% of clinicians experience burnout over the course of their careers. Why, and what can be done? There are many contributing factors that if not addressed appropriately can lead to consequences like low job satisfaction, insomnia, anxiety, depression, or suicide.

Burnout can happen at any point during a clinician's tenure, especially while working through a pandemic. COVID-19 has stretched our health care system in every way possible. Not only are clinicians emotionally and physically drained from working around the clock to care for their patients, they are also facing financial burdens, with staff layoffs due to the decrease of in-person patient appointments.

So what causes burnout? It's patient- and non-patient-related administrative tasks such as charting, documentation, and billing and insurance, as well as other factors such as work-life balance, inadequate staffing, and the like.

Technology eases every aspect of our lives in ways we never imagined. However, with every new technology comes difficulties. Electronic health records (EHRs), for example, safely share patient data between patients and clinicians to ease documentation, streamline billing, manage prescriptions, and improve efficiency. However, clinicians complain that spending time looking at a screen during a patient visit takes away from face-to-face interaction. Clinicians also have to keep patient records up-to-date in real time, since EHRs allow for 24-hour patient access.

Although there is no single solution to easing electronic documentation, integrating a medical scribe into your practice may help reduce clinician documentation time. Medical scribes are in the room with the clinician and patient and complete all the documentation, prescriptions, and coding as needed, allowing the clinician to have face-to-face interactions instead of looking at a screen during patients' visits.

EHRs are not the only factor contributing to clinician burnout. Clinicians often do not have enough time to spend with each patient and just need to get through their patient appointments each day. Practices often do not have enough staff, causing the higher-paid clinicians to complete more tasks than their job description implies. Do you expect your clinicians to document patient visits, send prescriptions to the pharmacy, and code to submit for billing? Tasks that can be done by staff members cause clinicians to work overtime, which results in burnout.

If staffing cuts are necessary due to the pandemic, they should be handled strategically, ensuring that physicians do not need to manage all of the administrative tasks such as scheduling patient appointments, assisting with telehealth appointments, and handling billing and reimbursement. All clinicians and staff members alike need work-life balance. They need to be able to leave work without the burden of leaving work behind, working when they get home, or coming into the office early to finish work. Maintaining a broader clinical team and adequate staff for these jobs can alleviate this burden.

What can you do at an organizational level to alleviate the feeling of burnout? First, assess the situation and identify what you want to accomplish. Next, create a safe and positive space so your team feels comfortable addressing their concerns and finding common ground. This will encourage everyone to step in to identify problems and work together to solve them, creating a manageable agenda. Ask questions, identify next steps, and follow up. Ask, "Are the problems and solutions we identified working? If not, why, and what can you, and we, do differently?" Keep these important steps in mind even during COVID-19, when it is more crucial than ever to work as a team.

ACP Practice Advisor's MOC- and CME-approved online practice improvement module, "Making the Case to Address Clinician Burnout," offers additional tips and resources. ■

Disha Patel is an Analyst in the Department of Medical Practice in ACP's Washington, D.C., office.

Resident Response During Pandemic: This Is Our Time

By Jesse E. Ross, MD

In June 1981, the first report of a new "potentially transmissible immune deficiency" was published. In 1983, a virus attacking and killing T cells was isolated, and in 1986 received its final name: "human immunodeficiency virus" (HIV) (1). What followed would be a global pandemic infecting over 75 million people that resulted in over 32 million deaths and continues, presently infecting approximately 38 million people worldwide (2). Physician response at that time was a combination of eagerness, a sense of duty, commitment, and humanism. Several of my mentors have shared that as medical students and housestaff, they intentionally chose to train in hospitals and institutions where they would have the greatest opportunity to work with this patient population. A new field of medicine would emerge from this era, and national leaders and experts would be born from it. However, despite the heroic measures and actions by so many health care workers, there was also a response of fear, stigmatization, exhaustion, and despair.

In December 2019, we received the first reports of patients from Wuhan, China, with pneumonia of unknown cause. Through unbiased sequencing, we would discover a previously unknown coronavirus (3). This novel coronavirus would soon be named "severe acute respiratory syndrome coronavirus 2" (SARS-CoV-2) and causes the illness we now know as "coronavirus 2019" (COVID-19). On 11 March 2020, with more than 118 000 cases in 114 countries and more than 4000 deaths, the World Health Organization characterized COVID-19 as a pandemic (4). At the time of this writing, there are approximately 218 723 cases worldwide with 8943 deaths. More than 7800 cases are reported in the United States (5).

We have heard the harrowing reports from Lombardy, Italy, of physicians forced to choose which patients should be allocated resources and which patients were too sick to recover and should be sent home to die (6). I recently read of concerns that other European countries may soon find themselves in this troubling position, and indeed, by the time you are reading this article, this will probably already be the case in the United States. We are gravely unprepared, and if our future resembles, by any nature, that of our colleagues around the world, we will also soon find ourselves in a health care system that is profoundly underresourced, understaffed, and overwhelmed and reaching a maximum of an already minimally existent excess capacity. I am hearing from colleagues at other institutions that this strain is already beginning to reveal itself.

I am encouraged by the overwhelming response from many of my colleagues to this health care crisis. Similar to the 1980s, duty, commitment, humanism, and eagerness are all traits that ring through. Yet, understandably, there have also been responses amongst my housestaff colleagues of fear, despair, and anxiety about their own health, as well as the health of their loved ones. I have seen discontent, even anger, toward programs and our current health care system for our lack of preparedness. Perhaps most disheartening, there have even been a few who have expressed concern and questioned whether we, as residents, should be taking care of patients with COVID-19. As health care providers, I believe we have the right to be nervous, even fearful, about what is to come.

Dissimilar to the 1980s HIV pandemic, which involved a bloodborne pathogen, SARS-CoV-2 is a respiratory pathogen. It is spread by both air droplets and direct contact, making it much more transmissible. We also now know that health care workers are at increased risk and that asymptomatic transmission can occur (7).

This article is a call to action to all of my resident colleagues around the United States that we will find ourselves remaining on the front lines in the days, weeks, and months to come. That despite our fears, we must continue to remember, and believe in, the duty of our profession and our oath to care for the sick. Furthermore, this article is a call to action for all program leadership and administration. We are well trained; we are eager to get involved; and most, if not all, of us are willing to remain on the front lines in the battle that is to come. Please ensure that we are prepared; have adequate resources at our disposal, including personal protective equipment; and receive training on best practices. Please ensure that we stay informed of advancements in the science, the current state of affairs, and updates in protocols in our respective institutions, as information is rapidly changing. Please ensure that we have direct access to leadership, mental health support, and debriefing when difficult decisions are made or we experience the worst of outcomes. Please protect those of us who are pregnant, immunocompromised, or at higher risk owing to ongoing comorbid conditions.

Also, like you, we have families, young children, elderly parents, and grandparents. We have friends outside of the medical field, and we are part of communities, schools, churches, mosques, and synagogues. Many of us have made the decision to isolate ourselves from these support systems to protect them, and so that we can continue to work when we are needed the most. We will, like you, continue to make sacrifices like these along the way. In the 1980s, as the story goes in my home institution, the unusual pattern of previously

young healthy patients contracting opportunistic infections was first noticed by a resident in internal medicine. I hope this will serve as a reminder of our value to the profession.

Many of us are already experiencing the first signs of what is to come. For those who are, I hope you are finding the support and resources you need to face these challenges. I will leave you with a portion of the Hippocratic oath recited at my medical school on graduation: "As I labor in places of healing, my first thoughts will be the life, happiness, and health of my patients." I wish anyone who reads this all of the best in the days, weeks, and months to come. May we rise to the occasion, upholding the oath and honor of our profession. This is our time. ■

From UCLA David Geffen School of Medicine, Los Angeles, California (J.E.R.).

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Corresponding Author: Jesse E. Ross, UCLA David Geffen School of Medicine, RR UCLA Medical Center, 757 Westwood Plaza, Suite 7501, Los Angeles, CA 90095; e-mail, jeross@mednet.ucla.edu.

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References

1. HIV.gov. A timeline of HIV and AIDS. Accessed at www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline on 18 March 2020.
2. Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Preliminary). Vol. 30. November 2019. Accessed at www.cdc.gov/hiv/library/reports/hiv-surveillance.html on 18 March 2020.
3. Zhu N, Zhang D, Wang W, et al; China Novel Coronavirus Investigating and Research Team. A novel coronavirus from patients with pneumonia in China, 2019. N Engl J Med. 2020;382:727-733. [PMID: 31978945] doi:10.1056/NEJMoa2001017
4. World Health Organization. Rolling updates on coronavirus disease (COVID-19). March 2020. Accessed at www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen on 18 March 2020.
5. Dong E, Du H, Gardner L. An interactive web-based dashboard to track COVID-19 in real time [Letter]. Lancet Infect Dis. 2020. [PMID: 32087114] doi:10.1016/S1473-3099(20)30120-1
6. Rosenbaum L. Facing COVID-19 in Italy– ethics, logistics, and therapeutics on the epidemic's front line. N Engl J Med. 2020. [PMID: 32187459] doi:10.1056/NEJMp2005492
7. Wu Z, McGoogan JM. Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China: summary of a report of 72 314 cases from the Chinese Center for Disease Control and Prevention. JAMA. 2020. [PMID: 32091533] doi: 10.1001/jama.2020.2648

Drive-in visits can fill the cracks of telemedicine's reach

Practices in rural areas are tackling the logistics of providing telemedicine to patients who are unable to access it on their own.

By Ryan DuBosar

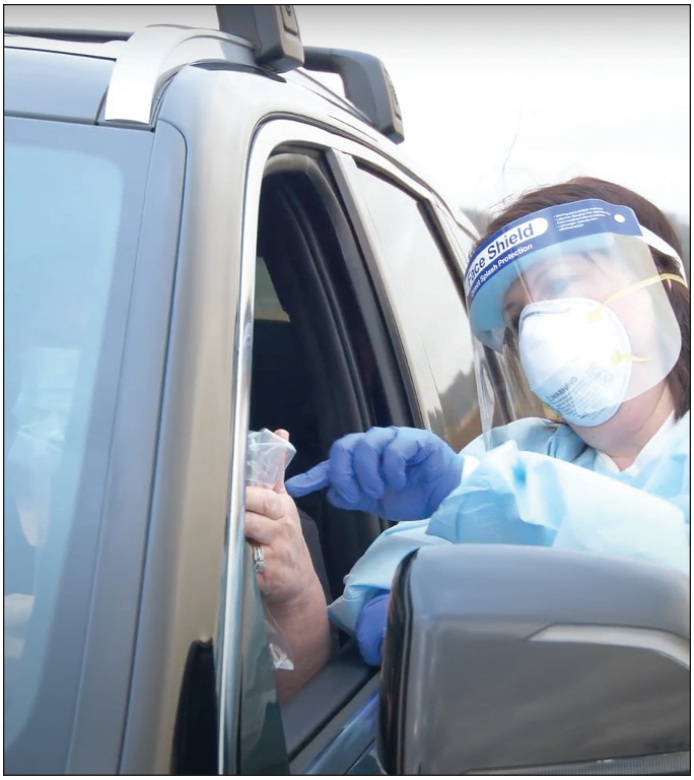
With the uptake in telemedicine as a response to the COVID-19 pandemic, it's important to remember that not every patient has access to the necessary technology, especially in rural areas, and not every patient is savvy enough to use what might be available. For Patrick Goggin, MD, FACP, of Medical Associates of Cambridge in rural Ohio, the solution was conducting drive-in visits in the office's parking lot.

Dr. Goggin's grandparents started the practice in the 1930s, complete with house calls, a progression that the COVID-19 pandemic has seemingly forced into reverse. Dr. Goggin's father led the practice from the 1960s into the 2000s. Now Dr. Goggin—along with his brother, ACP Member Mark Goggin, MD; ACP Member Doug Rush, MD, a friend from medical school; Kayode Ojedele, MBBS, FACP; Sandra Schubert, MD; and Rebecca Brauch, MD—operates the practice of seven physicians, six physician assistants and nurse practitioners, and associated staff in a town of about 10,000 people in southeastern Ohio. Dr. Goggin, who is also vice president of Physicians Group of Southeastern Ohio, spoke with ACP Internist about the logistics of providing telemedicine to patients who are unable to access it on their own.

Q: What is it that you're doing in terms of "parking lot" visits?

A: As with many practices, we on-boarded virtual visits via a telehealth platform at the beginning of the pandemic. But being in rural Ohio, with a large census of senior patients, we're finding there's a significant technology gap. Many of our patients, especially older people in more rural settings with a higher burden of chronic disease, had a technology gap, either where they didn't have smartphones or didn't have internet access, and were unable to do virtual visits. Colleagues from Pittsburgh, who are among the 12 practices we collaborate with through a partnership with agilon health, let us know that they were doing some parking lot virtual visits. We adapted their plan and designated an office iPad with cellular access so the patients could come to our parking lot.

We created a dedicated front desk phone line so the patients can let us know when they arrive. A receptionist wearing personal protective equipment [PPE] would take the fully cleansed iPad out and initiate the visit. We hand the iPad to the patients in their car. Meanwhile, a doctor or advanced practitioner would then joins the visit via the portal, and conducts the virtual visit while the patient is just a few yards away out in their car, without the potential risk of exposure by coming into our office or being in our waiting room.



Jennifer Holbein, certified medical assistant, dons full personal protective equipment during a drive-in visit. Image by Elliott Cramer

Q: Do you have any patients in your offices at any point now, or is it all telehealth?

A: We are still doing face-to-face encounters every day. We have essentially eliminated patients from our waiting room or congregating in any sort of public areas of the office. So in addition to doing the parking lot virtual visits, we've also created a virtual waiting room in which we ask people to come for their face-to-face encounter, remain in their car, call the dedicated front office line, and our receptionist completes intake tasks over the phone, has them wait in the car until we have an exam room ready, and then we call them in when we can take them directly to an exam room, bypassing the waiting room.

Q: How do you determine who gets a face-to-face visit versus who gets a parking lot visit?

A: The doctors have been looking at their schedules and identify the highest-risk patients based on age, chronic conditions like COPD, heart failure, diabetes, or chronic kidney disease, or immunocompromised state and advising them to not come into the office. We strongly encourage those people either to have a telehealth visit or a drive-in virtual visit, or to simply defer their care for another month or two.

Q: How do you manage the staffing of a parking lot visit?

A: Our staff presence in the parking lot is limited to a receptionist who takes the iPad out and retrieves it at the end of the encounter, and we're also doing parking lot blood draws. We have a phlebotomist going out to the parking lot in full personal protective equipment and drawing blood in the parking lot. Occasionally a medical assistant might help with checking a blood pressure or checking an oxygen level. But really, it's just a handful of designated people. We're trying to keep traffic in and out of the building fairly low.

A patient uses a covered iPad to begin her drive-in telehealth visit at Medical Home Primary Care Center in Zanesville, Ohio. Image by Elliott Cramer

We just ask that when staff come back in, they take off any PPE that they have, and cleanse their hands and cleanse the iPad. Inside our office, we're taking precautions like most workplaces are, where everyone is at least six feet apart from each other and wearing masks all the time.

Q: How many of these parking lot visits might you do on a typical day? What's a broad rough average?

A: Our total virtual visits probably peak at around 35 per day. The virtual drive-in visits might be about five a day. So it's really not a large volume. But we know it helped fill in the cracks with some of our most vulnerable patients.

Q: What have the patient uptake and acceptance been like?

A: It's been well received by both the patients who are doing virtual visits at home, and the patients doing the drive-in virtual visits. There still can be some technology issues, especially when people are at home, depending on their internet service or devices. But this process has certainly helped allow us to provide care to our patients, many of whom are in the highest-risk categories and who need the care most and for whom it would not be safe for them to come into the office.

Q: What's the reimbursement for a parking lot visit?

A: It's the same as if as if it's a telehealth visit. CMS has stated that virtual visits will be reimbursed at the same rate as face-to-face encounters. And for the most part, we are getting reimbursed. Some have been denied and we're working those denials just like we would any others. I think it came on so quickly that the payers weren't ready.

It's not like we've got a line of cars down the street; we're not doing a high volume of these virtual drive-in visits. But we do feel like it's helped. There's not one answer to caring for patients in this pandemic. There's a lot of different answers, and you have weave them together, to try to reach as many of your patients as possible. This has been one of the tools we're using which is helping connect us to some of our most vulnerable patients. ■

Nocturnists and residents

Internal medicine residents were surveyed about overnight supervision.

By Mollie Frost

Nocturnists, or hospitalists who work in-house overnight, have become a fixture of many teaching hospitals. But how does their presence affect the internal medicine residents in the hospital at the same time?

Looking for an answer, researchers posed a new question on the survey given at the end of the 2017 ACP Internal Medicine In-Training Examination: "How often do you receive adequate supervision to ensure patient safety when you are working overnight?" They also asked residents whether their programs had an attending in the hospital overnight who was responsible for their supervision on general medicine wards.

Out of 21,000 residents, about 51% reported that their supervision at night was "always" adequate to ensure patient safety, according to results published online in April as a research letter in JAMA. About 32% responded "most of the time," 11% responded "sometimes," 4% responded "rarely," and 2% responded "never." Fifty-three percent of respondents reported having nocturnists.

ACP Hospitalist spoke about the findings with coauthors Jillian S. Catalanotti, MD, MPH, FACP, an associate professor of medicine and of health policy and management and internal medicine residency program director at The George Washington University School of Medicine and Health Sciences in Washington, D.C., and Davoren Chick, MD, FACP, ACP's Senior Vice President for Medical Education.

Dr. Catalanotti

Q: What led you to study this issue?

A: Dr. Catalanotti: The overall thing that led us to want to study it is just the experience that we've had. Three of the authors—myself, Alec B. O'Connor, MD, MPH, FACP, and Kathlyn E. Fletcher, MD, MA, FACP—are all residency program directors. So the experience that we have had is that traditionally, overnight is a time for residents to have more autonomy, but that also has been synonymous with less supervision.

And now, as we talk more and more about patient safety and about the clinical learning environment, it really made us start to think about, "What are we doing overnight for supervision?" Some folks have nocturnists, some don't. It was unclear to us how many programs use them, how many don't, and what their real impact is on supervision. Several years ago, the [Association of Program Directors in Internal Medicine] survey had asked this of program directors, and we knew they were planning to ask it again of program directors. But we thought maybe we should actually ask the residents this question, and we didn't know anyone who had asked the residents. So that was what led us to put the questions on the ACP In-Training Exam survey, which is how we met up with Dr. Chick.

Q: What were your most interesting findings?

A: Dr. Catalanotti: A useful finding was just knowing what percent of residents actually report having nocturnists . . . and what percent of residents say that their overnight supervision is adequate. I feared that the number of residents saying that overnight supervision was always adequate for patient safety would be low. When I saw that it was only 51%, that was definitely lower than I thought it was going to be. So I think that is interesting as a sort of red flag to us all. I think maybe the most interesting finding to me personally is that even among residents who have nocturnists present, actually only 61% of those residents reported always having adequate supervision [compared to 41% among those who reported not having a nocturnist].

Q: What are the take-home points for residency and hospital medicine leaders?

A: Dr. Catalanotti: I think it's really important for program directors and/or hospital leadership to really do some personal assessment of your nighttime supervision of residents. Because it sounds like whether or not we have nocturnists, we've got a lot of room for growth in terms of trying to meet that bar of always adequately supervising our residents overnight. I think the holes we'll find are different in different programs, but this, to me, is a message that we need to go looking for those holes. We should all be speaking with our

housestaff and actually thinking about, "What is our overnight supervision structure? Are we providing adequate supervision? Should we have nocturnists if we do not? If we do, what exactly is the job description of the nocturnists at our institution, and what are the roles of that nocturnist?"

Dr. Chick

Dr. Chick: This study doesn't answer what the best thing is to do. But it really gets at a fundamental question, which is, are we doing enough? . . . The study says having nocturnal supervision is more about the quality of that supervision, not the specific job title of the person doing it. We need to make sure our residents have a support system that whoever it is, whether it's somebody in-house or out of the hospital, is clearly available and that there is a plan to support the patient's safety with the learner involved.

Q: What are your next steps?

A: Dr. Catalanotti: A question that this certainly makes me want to ask next is to ask hospitalist division directors, "If you have a nocturnist, what is that person's role?" Because I really wonder how much variety is out there, and I think if we all shared what we did, then we could perhaps come up with some best practices as they relate to hospitals that have trainees in them. ■

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The division of hospital medicine was founded by Mark Williams, 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.

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Lexington, KY is ranked as a Top 25 Place to Live per US News and is consistently ranked nationally in other top 10 lists including: top place 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).

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

UK University of Kentucky

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Hospitalist Opportunities

Gorgeous Lakes, Ideal Climate, Award-winning Downtown

Prisma Health-Upstate employs 16,000 people, including 1,200+ physicians on staff. Our system includes clinically excellent facilities with 1,627 beds across 8 campuses. Additionally, we host 19 residency and fellowship programs and a 4-year medical education program: University of South Carolina School of Medicine–Greenville, located on Prisma Health-Upstate's Greenville Memorial Medical Campus. Prisma Health-Upstate also has developed a unique Clinical University model in collaboration with the University of South Carolina, Clemson University, Furman University, and others to provide the academic and research infrastructure and support needed to become a leading academic health center for the 21st century.
Greenville, South Carolina is a beautiful place to live and work and is located on the I-85 corridor between Atlanta and Charlotte and is one of the fastest growing areas in the country. Ideally situated near beautiful mountain ranges, beaches and lakes, we enjoy a diverse and thriving economy, excellent quality of life and wonderful cultural and educational opportunities. Check out all that Greenville, SC has to offer! #yeahTHATgreenville

Ideal candidates:

- BC/BE Internal Medicine Physicians
- IM procedures highly desired, but not required. Simulation center training & bedside training available if needed.
- Comfort managing critically ill patients.

Details Include:

- Group comprised of career hospitalists with low turnover
- Relocation allowance available
- EPIC Electronic Medical Record system
- 7 on/7 off schedule with 1 week of vacation per year
- Additional shifts paid at a premium

Available Opportunities:

Nocturnist, Greenville Memorial Hospital

- $340K base salary with $10K incentive bonus and CME stipend
- Up to $40K sign on bonus
- Minimum of 3 physician night coverage team
- Academic appointment and resident supervision opportunity
- Codes run by critical care team
- Full subspecialist back up

Nocturnist or Traditional Hospitalist, Baptist Easley Hospital

- $240-260K base salary with 45K incentive bonus and CME stipend for Traditional Hospitalist
- $340K base salary with $10K incentive bonus and CME stipend for Nocturnist
- Up to $40K sign on bonus

Nocturnist or Traditional Hospitalist, Oconee Memorial Hospital

- $273K base salary with 45K incentive bonus and CME stipend for Traditional Hospitalist
- $340K base salary with $10K incentive bonus and CME stipend for Nocturnist
- Up to $40K sign on bonus

Public Service Loan Forgiveness (PSLF) Program Qualified Employer

Please submit a letter of interest and CV to:
Natasha Durham, Physician Recruiter,
Natasha.Durham@PrismaHealth.org
ph: 864-797-6114

HOSPITALIST POSITION

Position available in tertiary care center in Metro Detroit. H1B Visa accepted

Email CV to Iulniculescu@yahoo.com

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Encompass Physicians is seeking a Hospitalist and Nocturnal Intensivist to join our group based in Chicago, IL. Position includes rounding on daily census, code/rrts, intubation, and collaboration with ICU team.

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  dental/vision,
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  worker's compensation

Please send cv to encompassphysicians@gmail.com

Internal Medicine Hospitalist Opportunity

The University of Iowa Department of Internal Medicine is recruiting part-time and full-time BC/BE physicians for clinical faculty positions that offer a dynamic mix of activities within the Division of General Internal Medicine. Based upon individual's interest, hospitalists can rotate on resident based teaching teams, attending only teams, transition of care follow up clinic, virtual hospitalists providing care at distant hospitals at both the University of Iowa Hospitals and Clinics (UIHC) and the Iowa City VA Medical Center (VAMC), physician led Advanced Practice Provider (APP) inpatient teams, staff the APP run observation unit, or the resident based surgical co-management services. We recently opened the University of Iowa Health Network Rehabilitation Hospital, a venture with Encompass Health, where our hospitalists co-manage patients with PMR staff. Additionally, general medicine hospitalists can rotate on two subspecialty services, the hem-onc service, in collaboration with hematologists, oncologists, the cardiology service, which provides collaborative care with cardiologists, and we plan to introduce a third subspecialty service, gastroenterology hospitalist.

Candidates must have a M.D. degree or equivalent. Applications will be accepted for positions at the rank of Associate, no track, or Clinical Assistant Professor, commensurate with experience and training. Position requires completion of an ACGME-accredited Residency Program

Primary practice sites are the University of Iowa Hospitals and Clinics (UIHC), which is consistently recognized as one of the top health care employers by Forbes and has consistently ranked as one of the top 15 medical centers in the U.S. by US News and World Report. Iowa City is a diverse and family-friendly community located in the heart of the Midwest. As the site of the University of Iowa, it combines access to many of the cultural amenities of a larger city with the ease of living in a smaller town.

For further information, contact
Evelyn Kinne at evelyn-kinne@uiowa.edu

Interested candidates are invited to search the Jobs@UIOWA site: https://jobs.uiowa.edu/content/faculty/ and search for requisition # 73980

The University of Iowa is an equal opportunity/affirmative action employer. All qualified applicants are encouraged to apply and will receive consideration for employment free from discrimination on the basis of race, creed, color, national origin, age, sex, pregnancy, sexual orientation, gender identity, genetic information, religion, associational preference, status as a qualified individual with a disability, or status as a protected veteran. The University also affirms its commitment to providing equal opportunities and equal access to University facilities. Women and Minorities are encouraged to apply for all employment vacancies.

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.

OFFERING

- Comprehensive liability insurance *(no tail required)*
- 403b Retirement, with match
- Flexible, block schedule
- Teaching opportunities available
- Competitive base salary
- Health, dental, vision
- Professional allowance
- Bonus eligibility

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 hospitals by *US News & World Report*.

This position is not J-1 eligible. 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".

Washington University in St. Louis Physicians

sunrise MEDICAL ASSOCIATES

Sunrise Medical Associate 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. **Mandarin speaking physicians are strongly encouraged to apply. Please send CV to smamedoffice@gmail.com or fax to 951-339-8461 for consideration. Multiple positions available.**

ACP Internal Medicine Meeting 2021

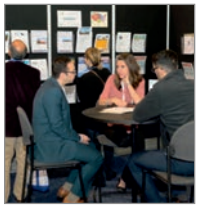
Internal Medicine Meeting 2021:
Virtual Experience
April 29-May 1, 2021

Looking For A NEW CAREER OPPORTUNITY?

Submit your physician profile and CV to the **ACP Job Placement Center** and reach participating employers.

The ACP Job Placement Center allows you to:

- Submit a physician profile and/or CV to: **annualmeeting.acponline.org/jpc/physician-profile**
- View open positions nationwide
- Meet with potential employers



We will be collecting profiles from **January 13 – May 8** and will be distributing them to participating employers during **Internal Medicine Meeting 2021: *Virtual Experience***.

For more information, send your name, email, additional contact information and specialty to:
jobplacementcenter@acponline.org

ACP Internist

CHA Cambridge Health Alliance | AFFILIATED WITH Beth Israel Deaconess Medical Center · MassGeneral Hospital for Children · Harvard Medical School Teaching Hospital

Internal Medicine Opportunities – Cambridge & Somerville, MA Cambridge Health Alliance (CHA)

CHA, a Harvard Medical School (HMS) teaching affiliate, is an award winning, public healthcare system which receives national recognition for innovation and community excellence. CHA is currently recruiting internal medicine physicians for our primary care sites in Cambridge and Somerville.

CHA is currently seeking **Internal Medicine Physicians** for our various neighborhood health centers:

- Primary care clinics are NCQA certified level 3 Patient-Centered Medical Homes
- Fully integrated EMR (Epic)
- Opportunities to teach medical students and residents from HMS, and academic appointments available for those meeting HMS criteria
- Competitive, guaranteed base salaries commensurate with experience
- Comprehensive and generous benefits package available!

Please submit CV and cover letter to
Melissa Kelley at ProviderRecruitment@challiance.org

In keeping with federal, state and local laws, Cambridge Health Alliance (CHA) policy forbids employees and associates to discriminate against anyone based on race, religion, color, gender, age, marital status, national origin, sexual orientation, relationship identity or relationship structure, gender identity or expression, veteran status, disability or any other characteristic protected by law. We are committed to establishing and maintaining a workplace free of discrimination. We are fully committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment or career development. Furthermore, we will not tolerate the use of discriminatory slurs, or other remarks, jokes or conduct, that in the judgment of CHA, encourage or permit an offensive or hostile work environment.

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Outpatient Internal Medicine Physician
Upstate, SC

Prisma Health, the largest healthcare provider in South Carolina, seeks BC/BE Internal Medicine physicians to join our rapidly expanding Department of Internal Medicine. Our healthcare professionals adhere to a high standard of excellence in medical practice, making use of the best that evidence-based medicine, innovative technologies, and clinical research have to offer. Our goal is to transform health care across the Upstate utilizing a clinically integrated network, Prisma Health-Upstate Network. Clinical and Academic positions are available.

- Innovative competitive compensation plan
- Flexible schedules
- Full and Part-time opportunities available
- Nurse first call service/ Call is minimum
- Potential sign-on bonus, relocation, full health benefits for physician and family and retirement options
- Malpractice and tail coverage included
- Opportunity to teach residents/medical students (if desired) with an academic appointment

Prisma Health-Upstate employs 16,000 team members, including 1,200+ physicians on staff. Our system includes clinically excellent facilities with 1,627 beds across 8 campuses. Additionally, we host 19 residency and fellowship programs and a 4-year medical education program: University of South Carolina School of Medicine–Greenville, located on Prisma Health Greenville Memorial Medical Campus. Prisma Health also has developed a unique Clinical University model in collaboration with the University of South Carolina, Clemson University, Furman University, and others to provide the academic and research infrastructure and support needed to become a leading academic health center for the 21st century.

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We are a Public Service Loan Forgiveness (PSLF) Program Qualified Employer!*

Please submit a letter of interest and CV to:
Natasha Durham, Physician Recruiter,
Natasha.Durham@PrismaHealth.org
ph: 864-797-6114.

3RNet Healthcare Jobs Across the Nation

3RNet National Rural Recruitment and Retention Network

3RNet is a national network of state organizations dedicated to helping health professionals find jobs in rural and undeserved areas. Some of the medical professions we serve and the kinds of jobs posted may include:

- Residency and Fellowship
- Family Practice
- Pediatrics
- OB/GYN
- Internal Medicine
- Psychiatry
- General Surgery
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- Endocrinology
- Gastroenterology
- Geriatrics
- Rheumatology
- Neurology
- Hematology/Oncology
- Nephrology
- Pulmonary/Critical Care

Visit www.3RNet.org to search jobs 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.

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FOR DETAILS CONTACT:

Vera Bensch
215-351-2630
vbensch@acponline.org

Ryan Magee
215-351-2623
rmagee@acponline.org

For more information, send your name, email,
additional contact information and specialty to:

jobplacementcenter@acponline.org

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