



## Hospitalists combat COVID burnout

Riding in the right direction

By Richard Quinn

Sometimes well-being is as simple as a last-minute bike ride. At the 2021 virtual Pediatric Hospital Medicine (PHM) annual meeting in July, someone on the planning committee asked Mike Tchou, MD, MSc of the University of Colorado and the Children's Hospital Colorado in Aurora, Colo. to plan a quick group Peloton ride for the conference.

"We got a lot of enthusiasm, a lot of people who enjoyed that," Dr. Tchou said. "It was just a nice time for our whole field to reconnect. That sort of built some momentum around, 'Hey, we should see if we can continue this feeling,' as well as provide a venue for people to have some healthy connections."

One ride turned to three. Now it's a weekly event where anyone can join.

Maybe it sounds like a small thing, but the weekly wheels-up is just another new example of how hospitalists are focusing on well-being

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Dr. Mike Tchou is a hospitalist at the University of Colorado and the Children's Hospital Colorado.

ERIN STENSON, MD

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WILEY



EDITOR'S CORNER

# Helping others find their joy

By Weijen Chang, MD, FAAP, SFHM

My last editor's column focused on crisis leadership, specifically the example of Sir Ernest Shackleton's doomed attempt to cross the Antarctic, which nonetheless proved to be a unique example of crisis leadership.<sup>1</sup> But the acute urgency of the initial COVID-19 crisis has waned and morphed into a slog through the trenches of successive COVID-19 waves during a storm of health care provider vilification. Gone are the cheering crowds, raining down song and accolade upon us as we entered the arena to battle the dread COVID virus.<sup>2</sup> In their place stand the vaccine deniers, conspiracy theorists, and mask revilers, belittling attempts of the Centers for Disease Control and Prevention (CDC) and state and local governments to walk the fine line between ignoring unforeseen consequences of pandemic controls and unleashing yet another wave of a variant virus.

In this acrimonious environment, how can we blame physicians, nurses, and other health care workers for leaving their professions in droves? Ingrained in our decision to choose a career in health care is the desire to work with our patients to improve their health, with our communities to optimize the social conditions, and with our local governments to build a framework that supports population health. But we've seen patients, even in our care, turn against us, communities turn against the very measures that would improve health, and local governments turn against the regulatory and legal framework designed to combat COVID-19. It's no wonder about one in five health care workers have left their jobs since the pandemic began.<sup>3</sup>

As hospitalists and leaders, how can we stem the tide? We can start by rebuilding our work communities. Although there are exceptions, many hospitalists consider their groups and divisions to be a family of sorts. The pandemic drove many of us to be closer to our actual families and loved ones for good reasons, from lack of childcare and caring for ill loved ones, to renewed or newfound interests outside of work. All these are necessary and laudable reasons but engaging in a team effort toward a positive shared goal reengage one in the joy of work.

According to Dr. Rebecca Newton, an organizational and social psychologist at the London School of Economics and faculty member



Dr. Chang

Weijen W. Chang, MD, FAAP, SFHM, the physician editor of The Hospitalist, is a pediatric and adult hospitalist at Baystate Medical Center and Baystate Children's Hospital in Springfield, Mass., where he is an associate professor of pediatrics at the University of Massachusetts Medical School Baystate, chief of pediatric hospital medicine, and vice-chair for clinical affairs at Baystate Children's Hospital.

of the Accelerated Leadership Program at Harvard Law School, "Joy is not just an individual phenomenon; it's also what psychologists call 'affiliative,' which means that it has to do with strengthening our bonds with others through positive behaviors such as being kind and friendly or actively peace-making."<sup>4</sup>

The Institute of Healthcare Improvement (IHI) agrees—finding joy, engagement, and productivity helps fight burnout that drives people out of health care careers. Jessica Perlo, MPH, a director at IHI, urges leaders to take a four-step approach to increase joy in work for their groups:<sup>5</sup>

- Ask staff, "What matters to you?" This requires asking the right questions, such as:
  - What makes a good day for you?;
  - What makes you proud to work here?;
  - When we are at our best, what does that look like?
- Identify unique impediments to joy in work in the local context. This often occurs at the same time as Step 1.
- Commit to a systems approach to making joy in work a shared responsibility at all levels of the organization. Leaders at all levels have a role in this process, although not everyone does everything.
- Use improvement science to test

approaches to improving joy in work. This requires measuring tests of change and having the time to devote effort to interventions and assessments of change.

The question posed in Step 1 is inexorably linked to whether people find meaning in their work, and this in turn is a deeply personal issue. Finding out what gives people meaning in their work can be challenging, requiring time regularly set aside specifically to ask this question, as the answer can evolve. It's also possible that individuals on your team haven't been able to clearly define what gives meaning to their work. As a result, you might need to mentor individuals to develop a "mission statement" for their careers.

As Patrick Conway said in a 2019 *Journal of Hospital Medicine* article, "So please, decide on your criteria and mission for career and life. When things are going well, review them. Are you still aligned with what is important to you? When you are at a crossroads to make a decision, review them again."<sup>6</sup>

But as we often say as hospitalists, don't ask questions you don't want the answers to. Once you've asked what someone's "mission statement" is for their career, as a leader, it's your job to provide the tools and environment that allows



them to succeed in achieving their goals. This doesn't mean you need to mentor them personally throughout this process, but you should have a mentoring process in which they can participate. You also need to allow flexibility in their job, whether it's through full-time equivalent (FTE) reduction or sharing FTE with other groups or divisions so they can achieve their goals. This might lead to temporary imbalances in your group's staffing but keeping team members engaged in their career "mission" prevents group turnover.

Hospitalists are frequently their own worst enemy with Step 2. Drs. Andrew Dunn and Vinh-Tung Nguyen point out in their 2020

*JHM* article that well-meaning hospitalist-led quality improvement projects often produce excessive burden for an unknown benefit.<sup>7</sup> This can add to the already growing burden of external tasks. Worse yet, hospitalist leaders are often driven by hospital or health-system leaders to set and achieve arbitrary relative value units (RVUs) or value goals, which can both waste precious team effort and undermine work towards true north goals.

As we enter this perfect winter storm of successive COVID-19 waves, resurgent non-COVID-19 illnesses, and staffing crises, remember that keeping your group intact depends on finding, on an individual level, reasons why each

person finds joy at work. Make sure you continue to nurture and grow those reasons and pull out the weeds that would suck the joy from your team. ■

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# Hospitalist Movers and Shakers

**Malik Merchant, MD** recently joined Del Sol Medical Center (El Paso, Texas) as its chief medical officer. Before joining Del Sol, Dr. Merchant was the section chief of hospitalists and post-acute care at Austin Diagnostic Clinic (Austin, Texas) where he also served as a consultant for hospital-based programs. He is board-certified by the American Board of Internal Medicine and earned his medical degree from Aga Khan University Medical Center (Karachi, Pakistan). Dr. Merchant completed his residency and internship in internal medicine at the Peoria Illinois Medical Center at the University of Illinois (Peoria, Ill.).



Dr. Merchant

Cox Monett Hospital (Monett, Mo.) has welcomed **Karissa Merritt, DO** to its hospitalist team. Dr. Merritt earned her degree in osteopathic medicine from Liberty University College of Osteopathic Medicine (Lynchburg, Va.) and completed her residency at Cox Family Medicine Residency (Monett, Mo.).



Dr. Merritt

While in training, Dr. Merritt pioneered a system-wide initiative on food insecurity screening, collecting data on its use as a predictor of risk-lives and chronic disease burden. Additionally, she has served as a policy scholar with the American Academy of Family Physicians. Professionally, her interests are social contributors to health, advocacy and legislation, population health initiatives, point of care ultrasound, and medical education.

WellMed (San Antonio, Texas) has promoted **Beth Chmelik, MD** to chief of enterprise hospitalist services; WellMed is an Optum care delivery organization focusing on Medicare Advantage patients in Texas, Florida, and New Mexico. She will continue her role as regional medical director for Greater Texas Care and Value, working on population management, health care costs, and data analytics.



Dr. Chmelik

Dr. Chmelik completed medical school and residency at the University of Florida (Gainesville,

Fla.) and has been a hospitalist for more than 20 years. She is a member of the inaugural class of fellows for the Society of Hospital Medicine, is now a senior fellow in hospital medicine, and she's working with SHM to establish a special interest group for value-based hospitalist practice. She has served on various local and national committees relating to quality, safety, and utilization of medical care. Dr. Chmelik was the founding chair of the Optum Hospitalist Forum, supporting all Optum care delivery organizations with hospitalist groups across the nation.

She joined WellMed in 2012 and was tasked with helping to launch and grow the Austin hospitalist program; she's served as director of hospitalist services for WellMed since 2014.

Dr. Chmelik continues to lead the employed hospitalist services for WellMed across three markets in Texas and will now support all regions with contracted hospitalist relationships. She will liaison with outside hospitalist groups and market hospitals that care for WellMed Network patients, and she will continue to collaborate on hospital and skilled nursing facility contracting, in addition to other roles as needed.

*Charlotte* magazine named **Stephanie Murphy, DO**

among its 2021 Charlotteans of the Year. Dr. Murphy is a hospitalist, doctor of internal medicine, medical director of Atrium Health's Hospital at Home program, co-medical director of Atrium Health's Mobile integrated health program, and director of Carolinas Medical Center's transition clinic, part of Atrium Health based in Charlotte, N.C.



Dr. Murphy

Dr. Murphy was recognized for her success in getting the Hospital at Home program up and running in less than a week during the pandemic. This included training and coordinating physicians, paramedics, and nurses and adapting hospital-level care to patients' homes.

Dr. Murphy earned her medical degree from Lake Erie College of Osteopathic Medicine (Erie, Pa.) and completed her residency at the University of Kentucky College of Medicine (Lexington, Ky.). She is board-certified in internal medicine.

Cerner Corporation (North Kansas City, Mo.), named **Nasim Afsar, MD, MBA, MHM**, as the company's first chief health officer,

effective January 2022. In this new role, Dr. Afsar will lead Cerner's more than 1,000 health care professionals who provide insight and guidance to product development and improving the lives of patients and caregivers. She will also lead the quality and patient safety, regulatory, health policy, government affairs, and continuous improvement organizations.



Dr. Afsar

Dr. Afsar is an experienced physician and health care executive with more than a decade of leadership responsibilities in large, complex health care delivery systems, including UCLA Health and UCI Health. Previously, she has served as chief operating officer, chief quality officer, and associate chief medical officer, delivering large-scale, sustainable outcomes in quality, population health management, operations, finance, contracting, business development, and strategy. She is the past president of SHM and has served on the Board of Directors for eight years. Dr. Afsar received her MD from UC Davis, School of Medicine (Sacramento, Calif.) and completed her internal medicine residency at UCLA Health (Los Angeles). She received her MBA from UCLA Anderson School of Management (Los Angeles).

**Ryan Deweese, MD**, a hospitalist at Indiana University Health Arnett Hospital, Lafayette, Ind. has published his first book, "Where Rainbows Never Die". Based on his 16 years of experience as a physician, the young adult novel tells the story of a young girl with cancer, her doctor, and an adventurous treasure hunt.



Dr. Deweese

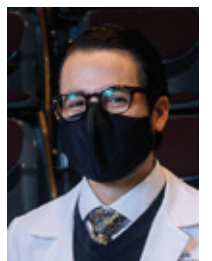
Aside from being an expression of Dr. Deweese's creativity, the book offers hope to people in difficult situations. Half the proceeds

from the sales of "Where Rainbows Never Die," are dedicated to the Caroline Symmes Children's Cancer Endowment, a non-profit that funds pediatric cancer research at Riley Hospital for Children in Indianapolis.

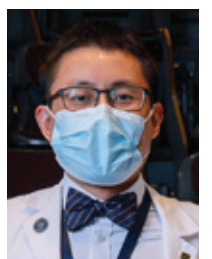
Dr. Deweese earned his medical degree from the Indiana University School of Medicine in Indianapolis and completed his residency at St. Vincent Hospital, Frankfort, Ind.

The Yale School of Medicine, New Haven, Conn., bestowed the 2021 Dr. Peggy Bia Award for Outstanding Clinical Teaching awards recently at Medical Grand Rounds. This recognition is awarded to the top intern, resident, and fellow for excellence in teaching clinical reasoning at the bedside and on the wards.

Candidates across medicine subspecialties are nominated and voted on by current clerkship medical students at the Yale School of Medicine. The PGY-1 winner was **Andrew Sanchez, MD**; the PGY-2/3 winner was **Nischay Rege, MD, PhD**; and the fellow (PGY-4) winner was **Ji-un-Ruey Hu, MD, MPH**.



Dr. Sanchez



Dr. Hu

Dr. Sanchez is an internal medicine intern; he received his medical degree from Columbia University Vagelos College of Physicians and Surgeons, Manhattan, N.Y. Dr. Rege is an internal medicine resident; he received his medical degree from Case Western Reserve University, Cleveland, Ohio. Dr. Hu is a cardiology fellow; he received his medical degree from Vanderbilt University School of Medicine, Nashville, Tenn., where he also completed his internal medicine residency. Dr. Hu previously placed first at the 2020 Nashville SHM resident poster competition for his abstract on immune checkpoint inhibitor-related myocarditis. ■

## Share Your News

### Are you an SHM member with good news to share?

If you or someone on your team has recently been promoted, changed jobs, or has other good news to share, we'd like to hear from you. Send your information and headshot to us at [lcasinger@wiley.com](mailto:lcasinger@wiley.com).

We hope to see you in an upcoming issue!



# Clinician reviews of HM-centric research

By Mel Anderson, MD, MACP; Tyler Miller, MD; Bryan Lublin, MD;  
Michelle Knees, DO; Andrew R. Berry, MD; Caitlin Winget, MD

University of Colorado School of Medicine hospital medicine  
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By Mel Anderson, MD, MACP

### 1 Empiric therapeutic anticoagulation for severe COVID-19

**CLINICAL QUESTION:** For patients hospitalized with COVID-19, does empiric therapeutic-dose, versus prophylactic-dose, anticoagulation with enoxaparin affect clinical outcomes?

**BACKGROUND:** Patients hospitalized with COVID-19 are at risk for venous and arterial thromboembolism. Multiplatform adaptive and randomized trials have not clearly shown efficacy.

**STUDY DESIGN:** Randomized multicenter active control trial (HEP-COVID) of therapeutic versus standard/intermediate-dose enoxaparin in hospitalized adults with COVID-19 and D-dimer levels more than four times the upper limit of normal or sepsis-induced coagulopathy scores of four or more.

**SETTING:** Twelve U.S. hospitals enrolling 257 patients.

**SYNOPSIS:** The primary outcome of 30-day venous or arterial thromboembolism or all-cause



Dr. Anderson

death was reduced in non-ICU patients (36.1% versus 16.7%,  $P=0.004$ ) but not in ICU patients (55.3% versus 51.1%,  $P=0.71$ ). Major bleeding occurred in 1.6% with standard-dose versus 4.7% with therapeutic-dose enoxaparin ( $P=0.17$ ).

**BOTTOM LINE:** Therapeutic-dose enoxaparin reduces thromboembolism and death at 30 days compared to standard/intermediate-dose among adults hospitalized with COVID-19 and elevated D-dimer levels. This effect was not seen among ICU patients.

**CITATION:** Spyropoulos AC et al. Efficacy and safety of therapeutic-dose heparin vs standard prophylactic or intermediate-dose heparins for thromboprophylaxis in high-risk hospitalized patients with COVID-19. *JAMA Intern Med.* 2021 Oct 7;e216203. doi: 10.1001/jamainternmed.2021.6203.

### 2 Effective therapy for heart failure with preserved ejection fraction

**CLINICAL QUESTION:** What effect do sodium-glucose cotransporter 2 (SGLT2) inhibitors have on outcomes in adults with heart failure with preserved ejection fraction (HFpEF)?

**BACKGROUND:** SGLT2 inhibitors improve clinical outcomes in patients with heart failure with reduced ejection fraction. The effect on patients with HFpEF is unknown.

**STUDY DESIGN:** Double-blind randomized controlled trial (EMPEROR-Preserved) of 10 mg once-daily empagliflozin or placebo in 5,988 patients with class II-IV heart failure, ejection fraction  $>40\%$ , and elevated N-terminal-pro hormone B-type natriuretic peptide levels.

**SETTING:** Multicenter international trial in approximately 22 countries enrolling 5,988 patients.

**SYNOPSIS:** Over a median of 26.2 months, the primary composite outcome of death due to cardiovascular causes or hospitalization for heart failure was reduced from 17.1% in the placebo group to 13.8% in the empagliflozin group ( $P<0.001$ ), driven mainly by a reduction in heart failure hospitalizations. The effect was similar between those with and without diabetes. Overall serious side effects were similar.

**BOTTOM LINE:** In patients with HFpEF, empagliflozin lowered the combined risk of cardiovascular death or hospitalization for heart failure, independent of the presence of diabetes.

**CITATION:** Anker SD et al. Empagliflozin in heart failure with a preserved ejection fraction. *N Engl J Med.* 2021; 385:1451-1461. doi: 10.1056/NEJMoa2107038.

Dr. Anderson is associate professor of medicine, University of Colorado School of Medicine, and executive director, VHA National Hospital Medicine Program hospital medicine section, Rocky Mountain Regional VA Medical Center, Aurora, Colo.

By Tyler Miller, MD

### 3 Maintenance or discontinuation of antidepressants

**CLINICAL QUESTION:** For patients on long-standing antidepressant therapy who feel well enough to discontinue antidepressants, what is the risk of relapse with maintaining or discontinuing antidepressants?

**BACKGROUND:** Patients with depression may receive antidepressants for prolonged periods. Data are limited on the effects of maintaining or discontinuing antidepressant therapy in this setting.

**STUDY DESIGN:** Randomized, double-blind trial enrolling patients who had been taking antidepressants for two years or longer and felt well enough to consider stopping antidepressants.

**SETTING:** At 150 general outpatient practices in the U.K. enrolling 1,466 patients.

**SYNOPSIS:** The primary outcome of relapse of depression by 52 weeks occurred in significantly more patients in the discontinuation group compared to the maintenance group. (56% versus 39% respectively; HR 2.06,  $P<0.001$ ).

**BOTTOM LINE:** Among ambulatory patients who felt well enough to discontinue antidepressant therapy, those who were assigned to stop their medication had a higher rate of relapse by 52 weeks. These findings may inform clinical decisions by hospitalists about discontinuing pre-existing antidepressant therapy.

**CITATION:** Lewis G et al. Maintenance or discontinuation of antidepressants in primary care. *N Engl J Med.* 2021 Sep 30;385(14):1257-1267. doi: 10.1056/NEJMoa2106356.

### 4 Effect of vasopressin and methylprednisolone versus placebo on return of spontaneous circulation in patients with in-hospital cardiac arrest

**CLINICAL QUESTION:** Does administration of vasopressin and methylprednisolone during in-hospital cardiac arrest improve the likelihood of return of spontaneous circulation (ROSC)?

**BACKGROUND:** Previous trials have suggested improved outcomes when vasopressin and methylprednisolone are administered during in-hospital cardiac arrest.

**STUDY DESIGN:** Multicenter, randomized, double-blind trial comparing a combination of vasopressin plus methylprednisolone versus placebo.

**SETTING:** Ten hospitals in Denmark enrolling 512 adult patients with in-hospital cardiac arrest.

**SYNOPSIS:** The primary outcome of ROSC



Dr. Miller



sustained for more than 20 minutes occurred in significantly more patients in the vasopressin plus methylprednisolone group compared to the placebo group. (42% versus 33% respectively; HR 1.3,  $P=0.03$ ). No difference was observed in secondary outcomes of death, favorable neurologic status, or quality of life at 30 or 90 days.

**BOTTOM LINE:** Among patients with in-hospital cardiac arrest, administration of vasopressin and methylprednisolone increase the likelihood of ROSC. It is uncertain whether this drug combination has an impact on survival, reduced neurologic disability, or quality of life.

**CITATION:** Andersen LW et al. Effect of vasopressin and methylprednisolone vs placebo on return of spontaneous circulation in patients with in-hospital cardiac arrest: A randomized clinical trial. *JAMA*. 2021;326(16):1586-1594. doi: 10.1001/jama.2021.16628.

Dr. Miller is an assistant professor of medicine at the University of Colorado School of Medicine hospital medicine section, Rocky Mountain Regional VA Medical Center, Aurora, Colo.

By Bryan Lublin, MD

5 Active diagnostic strategy for pulmonary embolism in COPD exacerbations does not significantly alter a composite clinical outcome compared to usual care

**CLINICAL QUESTION:** Can an active diagnostic protocol including a D-dimer and computed tomography pulmonary angiogram (CTPA) for pulmonary emboli (PE) improve outcomes for patients presenting with COPD exacerbations?

**BACKGROUND:** PE are common in patients with COPD exacerbations. It is unknown if an active search for PE in every COPD exacerbation can improve outcomes.

**STUDY DESIGN:** Randomized clinical trial.

**SETTING:** Eighteen hospitals across Spain, September 2014 to July 2020.

**SYNOPSIS:** The 746 patients hospitalized for COPD exacerbation were randomized to the active diagnostic strategy or usual care. The primary composite outcome was symptomatic venous thromboembolism, readmission, and death within 90 days. There was no significant difference in the primary outcome between the two groups. Similarly, there were no significant differences between the groups for individual



Dr. Lublin

SHORT TAKES

**Oral diuretics before discharge do not reduce heart failure readmissions**

This retrospective cohort study showed that a trial of oral diuretics prior to discharge is correlated with an increased length of stay while not significantly impacting 30-day mortality or readmission rates for patients with decompensated systolic heart failure.

**CITATION:** Mohammad A et al. Trial of oral diuretics prior to discharge is not associated with improved outcomes in decompensated heart failure. *Cardiol Res*. 2021;12(4):244-250.

Bryan Lublin, MD

components of the primary outcome. The study may have been underpowered to detect differences in secondary outcomes.

**BOTTOM LINE:** Compared to usual care alone, an active diagnostic protocol for PE does not improve clinical outcomes in patients with acute COPD exacerbations.

**CITATION:** Jimenez D et al. Effect of a pulmonary embolism diagnostic strategy on clinical outcomes in patients hospitalized for COPD exacerbation: A randomized clinical trial. *JAMA*. 2021;326(13):1277-1285.

Dr. Lublin is an assistant professor of medicine at the University of Colorado School of Medicine hospital medicine section, Rocky Mountain Regional VA Medical Center, Aurora, Colo.

SHORT TAKES

**Morning discharges do not lead to shorter ED or hospital length-of-stay**

This retrospective cohort study of nearly 190,000 patients admitted to internal medicine services in Canada found that morning discharges did not impact emergency department or hospital length-of-stay, in-hospital mortality, or 30-day readmission rates.

**CITATION:** Kirubarajan A et al. Morning discharges and patient length of stay in inpatient general internal medicine. *J. Hosp. Med*. 2021 June. 16(6):333-338. doi: 10.12788/jhm.3605.

Michelle Knees, DO, MD

By Michelle Knees, DO

6 Many hospitalized patients with type 2 diabetes and mild hyperglycemia on admission can be managed with sliding scale insulin alone

**CLINICAL QUESTION:** In patients with mild hyperglycemia on admission, can sliding scale insulin (SSI) alone be used for blood glucose (BG) control?

**BACKGROUND:** Prior randomized controlled trials (RCTs) have demonstrated better glycemic control with basal-bolus insulin protocols for hospitalized patients with type 2 diabetes (T2D). However, SSI-only regimens remain common. This study questioned whether SSI alone may be appropriate for a subset of hospitalized patients.



Dr. Knees

**STUDY DESIGN:** Retrospective cohort study.

**SETTING:** Emory Healthcare hospitals in Atlanta.

**SYNOPSIS:** In patients with T2D admitted to non-critical care settings, 31.4% received SSI alone. Within the SSI cohort, if admitted with BG <140 mg/dL, 86% achieved target glycemic control (BGs 70–180 without hypoglycemia <70). If admitted with BGs 140–180, 83% achieved glycemic control. However, if admitted with BGs 180–250 only 53% achieved control, which further declined to 18% with BGs ≥250. No cohort was treated initially with basal-bolus insulin, so comparisons to traditional basal-bolus regimens were not possible.

**BOTTOM LINE:** In patients with T2D who are

admitted to non-critical care services with mild hyperglycemia, management with SSI alone may be sufficient.

**CITATION:** Migdal AL et al. Inpatient glycemic control with sliding scale insulin in noncritical patients with type 2 diabetes: Who can slide? *J Hosp Med*. 2021 Aug; 16(8):462-468. doi 10.12788/jhm.3645

Dr. Knees is chief resident in quality and patient safety at the University of Colorado School of Medicine hospital medicine section, Rocky Mountain Regional VA Medical Center, Aurora, Colo.

By Andrew R. Berry, MD

7 Administration of probiotic did not reduce ventilator-associated pneumonia in critically ill patients requiring mechanical ventilation

**CLINICAL QUESTION:** Does administration of probiotic *L rhamnosus* GG to critically ill patients requiring mechanical ventilation decrease ventilator-associated pneumonia (VAP) events?

**BACKGROUND:** Previous trials in critically ill patients suggest that probiotics may reduce VAP and other ICU-acquired infections and may be a cost-effective solution to prevention, but uncertainty remains.



Dr. Berry

**STUDY DESIGN:** Randomized placebo-controlled trial.

**SETTING:** Conducted in 44 intensive care units (ICUs) in Canada, the United States, and Saudi Arabia in 2,650 patients with >72 hours of mechanical ventilation.

**SYNOPSIS:** VAP developed in 21.9% versus 21.3% of intervention and placebo patients respectively (HR 1.03, 95% CI -2.5% to 3.7%,  $P=0.73$ ). No difference was noted in secondary endpoints of ICU-acquired infections (including *C. difficile*), diarrhea, antimicrobial use, mortality, or length of stay. More adverse events were found in the probiotic group with the organism detected in sterile sites or as the predominant organism from non-sterile sites (OR 14.02, 95% CI, 1.79-109.6,  $P<0.001$ ).

**BOTTOM LINE:** Routine use of probiotics did not decrease VAP events or other ICU-acquired infections in critically ill mechanically ventilated patients and adverse events were more common.

**CITATION:** Johnstone, J et al. Effect of probiotics on incident ventilator-associated pneumonia in critically ill patients. *JAMA*. 2021; 326(11):1024-33.

8 No benefit for immediate intervention for infected necrotizing pancreatitis

**CLINICAL QUESTION:** Is drainage within 24 hours of diagnosis of infected necrotizing pancreatitis superior at preventing complications?

**BACKGROUND:** Diagnosis of infected necrotizing pancreatitis often leads to invasive intervention. Treatment guidelines support a minimally invasive approach and withholding antibiotics until necrosis is encapsulated to prevent unnecessary procedures and complications. Yet, early catheter drainage remains a subject of debate.

**STUDY DESIGN:** Randomized controlled trial.



**SETTING:** Conducted in 22 centers associated with the Dutch Pancreatitis Study Group.

**SYNOPSIS:** The 104 patients with confirmed or suspected infected necrotizing pancreatitis with <35 days of symptoms and no prior interventions were randomized to immediate catheter drainage or delayed intervention. All were treated with antibiotics and supportive care. The primary endpoint was the Comprehensive Complication Index score (0: asymptomatic, 100: death) at 6-month follow-up. Scores were 57 and 58 in the respective groups (mean difference -1 (95% CI -12 to 10;  $P=0.90$ ). Secondary endpoints of mortality, mean number of interventions, and adverse events were similar without significant differences. Of the postponed drainage group, 39% did not require intervention.

**BOTTOM LINE:** An immediate drainage strategy in patients with infected necrotizing pancreatitis did not improve primary or secondary outcomes and resulted in more procedures compared to a postponed drainage group.

**CITATION:** Boxhoorn, L et al. Immediate versus postponed intervention for infected necrotizing pancreatitis. *N Engl J Med* 2021; 385:1375-81.

*Dr. Berry is an assistant professor of medicine at the University of Colorado School of Medicine hospital medicine section, Rocky Mountain Regional VA Medical Center, Aurora, Colo.*

By Caitlin Winget, MD

**9 A 12-month implantable loop recorder detects more atrial fibrillation than 30-day external monitoring after ischemic stroke**

**CLINICAL QUESTION:** In patients with recent ischemic stroke, does monitoring for 12 months with an implantable loop recorder (ILR) detect more atrial fibrillation (AF) than 30 days with an external loop recorder (ELR)?

**BACKGROUND:** ILRs and ELRs have AF detection rates of 12-16%, but no head-to-head comparisons have been completed.



Dr. Winget

**STUDY DESIGN:** Open-label RCT: the PER DIEM clinical trial.

**SETTING:** Three hospitals in Alberta, Canada in 300 adults with ischemic stroke but no known AF.

**SYNOPSIS:** Patients received

either 12 months of ILR or 30 days of ELR. The primary outcome of AF >2 minutes within 12 months occurred in 15% of the ILR versus 4.7% of the ELR group (HR 3.36, 95% CI 1.44-7.84). Patients with new AF were started on anticoagulation. A post-hoc analysis found only age as a significant risk factor associated with AF detection. Clinical outcomes with ILR versus ELR monitoring strategies were not assessed.

**BOTTOM LINE:** ILR monitoring for 12 months in patients with ischemic stroke is superior at detecting AF compared to ELRs for 30 days, but the effect on clinical outcomes is unclear.

**CITATION:** Buck BH et al. Effect of implantable vs prolonged external electrocardiographic monitoring on atrial fibrillation detection in patients with ischemic stroke. The PER DIEM randomized clinical trial. *JAMA* 2021; 325(21) 2160-2168.

**10 No difference in outcomes comparing the treatment of cardiogenic shock with dobutamine versus milrinone**

**CLINICAL QUESTION:** Is there a benefit to selecting milrinone over dobutamine for inotropic support in patients with cardiogenic shock?

**BACKGROUND:** Inotropes, particularly milrinone and dobutamine, are a mainstay of treatment for cardiogenic shock, but there is little data to support using one over the other.

**STUDY DESIGN:** Randomized, double-blind clinical trial.

**SETTING:** Single quaternary care cardiac institute in Ottawa, Canada.

**SYNOPSIS:** The 192 patients with cardiogenic shock (Society for Cardiovascular Angiography and Interventions shock stages B-E) were randomized to receive dobutamine or milrinone; doses were adjusted by the blinded treatment

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team. The primary outcome (composite of in-hospital death, resuscitated cardiac arrest, receipt of a cardiac transplant or mechanical circulatory support, nonfatal myocardial infarction, TIA, stroke, and/or the initiation of renal replacement therapy) occurred in 49% with milrinone versus 54% with dobutamine treatment, with no statistically significant difference. No differences between the groups were found for secondary outcomes. Limitations include evaluation of only in-hospital outcomes, a single-center design, and dose adjustments by individual physicians rather than by protocol.

**BOTTOM LINE:** This study did not identify any advantages of milrinone over dobutamine for cardiogenic shock treatment.

**CITATION:** Mathew R et al. Milrinone as compared with dobutamine in the treatment of cardiogenic shock. *N Engl J Med.* 2021;385(6): 516-524.

*Dr. Winget is a clinical instructor at the University of Colorado School of Medicine hospital medicine section, Rocky Mountain Regional VA Medical Center, Aurora, Colo. ■*

# Substantial drop in blood pressure control during the pandemic

By Megan Brooks

**NEW YORK (Reuters Health)—**The massive disruption in day-to-day health care during the COVID-19 pandemic led to a decline in blood pressure (BP) control among adults with hypertension in the U.S., according to the BP Track study.

“We observed large variability across health systems in blood pressure control metrics,” Dr. Alanna Chamberlain of the Mayo Clinic in Rochester, Minn., told attendees at the American Heart Association Scientific Sessions, where she presented the results.

“Our results showed suboptimal blood pressure control even before the COVID-19 pandemic, and show substantial opportunity for improvement,” she said.

“Blood pressure control decreased substantially during the COVID-19 pandemic, accompanied by a reduction in follow-up health care visits among persons with hypertension. Blood pres-

sure control has not rebounded to pre-pandemic levels,” Dr. Chamberlain said.

She and her colleagues analyzed trends in BP control in the pre-pandemic year of 2019 and the pandemic year of 2020 across 24 health systems participating in the National Patient-Centered Clinical Research Network (PCORnet).

The 2019 data included more than 8.2 million health care encounters with 1.7 million patients and the 2020 data included almost 6.6 million encounters with 1.7 million patients, with no significant differences in age, sex, or race/ethnicities between the two periods.

The percentage of hypertensive patients whose BP was controlled to < 140/90 mm Hg at last measurement was lower in 2020 than in 2019 (53% versus 61%). BP control was also lower in the pandemic than the pre-pandemic year when using the more stringent BP definition of < 130/80 mm Hg.

Likewise, the percentage of hypertensive patients with an improvement in BP control—defined as the percentage of patients with previously uncontrolled systolic BP who achieved a systolic BP < 140 mm Hg or an improvement of at least 10 mm Hg was also lower in 2020 than 2019 (24% versus 30%).

Repeat visits, defined as percentage of visits by people with uncontrolled BP that were followed by another visit within four weeks, also declined in 2020 compared to 2019 (32% versus 37%), Dr. Chamberlain said.

There was no marked difference in the rate of medication intensification, defined as percentage of visits by patients with uncontrolled hypertension where a different class of BP medication was prescribed.

Dr. Chamberlain said, “Continued surveillance is needed to determine whether this decline in blood pressure control during the pandemic will result in future cardiovascular events.” ■



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# COVID burnout

Continued from page 1

and avoiding burnout as the prolonged waves of COVID-19 continue to pressure an already overtaxed health care system.

So, what are hospitalists doing to maintain wellness in the face of full hospitals, long shifts, and few breaks?

## Working on burnout and fulfillment

Back in November 2020, as the winter wave ramped up, a trio of hospitalists at Cleveland Clinic Children's in Cleveland, Ohio, finally had enough data in place to run a quality improvement (QI) project to measure and address burnout and fulfillment.

The goal was to decrease burnout among the group to 10% and raise fulfillment to 75%. The results saw burnout levels fall from 20% to 10%, but fulfillment decreased from 54% to 46%.

"We've actually had trouble determining why our fulfillment has gone down," said Colleen Schelzig, MD, FAAP, department chair in pediatric hospital medicine at Cleveland Clinic Children's. "We were, obviously, thrilled that we made headway on the burnout. And we were able to make some schedule changes and some changes in the work-life balance for our hospitalists. I think that's why the burnout showed some improvement. But fulfillment is something we continue to look at trying to improve."

Dana Foradori, MD, M.Ed, FAAP, who chairs Cleveland Clinic Children's wellness committee, said that undertaking a QI project on burnout and fulfillment in the middle of a pandemic is a sign to hospitalists that it's not only necessary but important to talk about job pressures.

"Giving them permission to talk about wellness was a huge piece to this project that I think can't be measured," she added. "Everybody in the medical profession is struggling right now, and so I wouldn't be too surprised if that was a confounding factor in our study."

Julie Cernanec, MD, FAAP, SFHM, medical director for continuous improvement at Cleveland Clinic Children's, said that while the pressure on hospital medicine right now may seem so big that nothing helps, the opposite is true.

"No intervention is too small," she said. "If it's just getting the permission of a departmental or institute chair to not work on your post-call day. It seems like a small thing to get them to say that out loud, but it's had such a huge impact. Or getting blackout curtains in our call room seems like such a small thing to do, but if that can increase the amount of rest that someone gets on a call night just by 30 minutes, it makes a big difference."

## Let's go for a ride

Dr. Tchou started coordinating the regularly scheduled rides with Tina Sosa, MD, a pediatric hospitalist and assistant professor of pediatrics at the University of Rochester Medical Center in Rochester, N.Y.

Now, @PelotonPHM is a Twitter account with 120 followers and a half-dozen riders weekly (with room for more, Dr. Tchou noted with a smile).

"There's a huge value just in seeing someone you know who you would normally see a few times a year at conferences, on the app," he added. "Whether it's a dopamine rush or something like that when they high-five you, or just seeing their name on the leaderboard, it just makes the exercise feel more meaningful."

"I think also, a lot of us are just trying to get



Dr. Tina Sosa is a pediatric hospitalist and assistant professor of pediatrics at the University of Rochester Medical Center; she helped Dr. Tchou coordinate regularly scheduled rides.

out there and be healthier and prioritize wellness...we don't often take time for ourselves in general, but especially when we're busy hospitalists and in the middle of different surges in the pandemic, carving a little time for yourself where you get a little exercise in feels kind of doubly impactful."

Drs. Tchou and Sosa are working on ways to increase ridership and engagement—treating the rides like a QI project. Ideas include creative scheduling of classes, creative prizes for attendance, or even formal competitions. Maybe an annual prize could be giving away a Peloton itself, Dr. Tchou joked (unless @onepeloton is reading, and then his email is michael.tchou@childrenscolorado.org).

"I think our goal is how we can continue this as long as possible and engage the most people as possible in whatever ways make it most beneficial for them," he said. "It may evolve over time. Maybe it'll turn into five or six smaller groups who can tailor their schedules more. Either way, hopefully, we can keep the momentum going because people have enjoyed it so far."

## Taking wellness to task

Over the last 18 months, SHM's Well-Being Task Force formed and focused on the day-to-day activities hospitalists and hospital medicine leaders can do to support each other.

Now, the task force is looking to the future.

"What sorts of programs and training can we create?" said Read G. Pierce, MD, hospital medicine division chief, associate professor, and associate chair for faculty development and well-being at Dell Medical School in Austin, Texas. "What sort of content can we create for individuals in hospital medicine who want to be a well-being champion or a well-being leader within their groups? We're just at the beginning of that work, and I think it's going to unfold in a lot of cool ways. This is about capacity building, more than just crisis response."

First, Dr. Pierce sees the task force creating "a

roadmap for leadership skills that help promote well-being so that people who are interested in becoming well-being champions can bring this into how they approach their work over time as leaders."

Second, Dr. Pierce hopes to build a well-being network where like-minded colleagues can connect. And lastly, he foresees the task force presenting a recommendation to SHM on what it "can build in terms of infrastructure to make hospital well-being a key strategic focus for the next five to 10 years. If we can do those things, it'll be a great contribution."

As a first step, SHM's well-being website ([www.hospitalmedicine.org/practice-management/staffing/Wellbeing/](http://www.hospitalmedicine.org/practice-management/staffing/Wellbeing/)) has links to three burnout intervention tools:

- COVID-19 Check-in Guide for Self & Peers, which was the group's first resource.
- AMA STEPS Forward module for hospitalists, including a five-step process to address well-being developed by SHM in collaboration with the American Medical Association (AMA) and the American College of Physicians (ACP).
- American Hospital Association (AHA) Well-Being Playbook, which offers seven steps leaders can take to promote wellness.

To Dr. Pierce, wellness isn't just about daily living. It's about the future of the field.

"If we put this on the periphery of what we're working on, we're going to have a lot of people leave," he said. "We're going to have a lot of people cut back their discretionary effort. And our ability to be creative and innovative is really going to dissipate because people are too tired."

"One of the things that makes hospitalists great, in my opinion, is the fact that we've been multidimensional...I personally think that attention to the well-being of the hospitalist workforce is the thing that is going to make or break our capacity to be an innovative field over the next decade." ■

*Richard Quinn is a freelance writer in New Jersey.*



# More evidence that midline catheters are safer than PICCs for short-term use

By Lisa Rapaport

**(Reuters Health)**—Hospital patients with difficult venous access or intravenous antibiotic therapy who require catheter placement for 30 days have a significantly lower risk of major complications with a midline catheter than with a peripherally inserted central catheter (PICC), a recent study suggests.

Researchers examined data from the Hospital Medicine Safety Consortium on 10,863 patients admitted to one of 48 hospitals in Michigan from December 2017 through January 2020. All patients were 18 years or older (median age 64.8 years) and had either a PICC (n = 5,758) or midline catheter (n = 5,105) indicated due to venous access difficulty or to intravenous antibiotic therapy.

The composite primary endpoint of the study was major complications associated with catheter use after adjustment for patient and device characteristics. This composite endpoint included symptomatic catheter-associated deep vein thrombosis (DVT), catheter-related bloodstream infection, and catheter occlusion.

Compared with patients who received midline catheters, patients who received PICCs had a significantly greater risk of developing a major

complication (odds ratio 1.99) in adjusted analysis that accounted for patient characteristics, comorbidities, catheter lumens, and dwell time.

“The finding that midlines were associated with a lower risk of infection compared to PICCs was not surprising,” said senior study author Dr. Vineet Chopra, a professor of medicine at the University of Colorado Anschutz Medical Campus in Aurora, Colo.

“What was interesting was how dramatic the reduction in risk was,” Dr. Chopra said by email.

Two types of complications appeared to drive the difference in safety outcomes between the two types of catheters, the study team notes in *JAMA Internal Medicine*.

Midline catheters had significantly lower rates of occlusion than PICCs (2.1% versus 7.0%). Midline catheters also had significantly lower rates of bloodstream infection than PICCs (0.4% versus 1.6%).

However, there was no significant difference between PICCs and midlines in the risk of symptomatic deep vein thrombosis (OR 0.93) or pulmonary embolism (OR 1.29).

The risk of DVT events was lower in patients who received PICCs versus midlines (hazard ratio, 0.53), which researchers concluded might be

due to the higher number of events over fewer total days of catheter utilization among patients with midlines.

The median dwell time was significantly longer for PICCs (14 days) than for midline catheters (six days).

More patients with midlines than with PICCs had catheters inserted due to intravenous access difficulty (72.4% versus 40.1%). More patients with PICCs had their catheters inserted for short-term intravenous antibiotics.

The majority of catheters placed were single lumen devices, which accounted for 63.2% of PICCs and 84.9% of midlines.

One limitation of the study is that the analysis didn’t account for any differences in device manufacturers, coatings, or features that might influence the risk of major complications, the authors note.

“Clinicians should use midlines when they need shorter-term access—less than 14-days—especially for patients who need a short course of antibiotics or have veins that are difficult to access,” Dr. Chopra said. “Midlines have a risk of thrombosis that appears similar to PICCs, but this is not trivial and should be considered carefully when you select a midline.” ■



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# The hidden pandemic

Could it be the catalyst for change?

By Richard Quinn

In the eyes of Anand Sekaran, MD, division head of hospital medicine, and medical director of inpatient services at Connecticut Children's Medical Center in Hartford, Conn., it's a hidden pandemic.

Not the physical toll of COVID-19, which blares across cable-television shows and newspaper headlines daily.

It's the mental toll on children, adolescents, and teenagers.

"I often coin it as the second pandemic, the pandemic of the mental health care crisis in children," Dr. Sekaran said. "It's truly occupied my team's life over the last one and a half to two years now. Our clinical work-life has been dominated by the mental health crisis seen during COVID."

Pediatric hospitalists aren't alone.

In October, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Children's Hospital Association (CHA) declared a "child and adolescent mental health emergency."

"We are caring for young people with soaring rates of depression, anxiety, trauma, loneliness, and suicidality that will have lasting impacts on them, their families, and their communities," the statement read in part. "We must identify strategies to meet these challenges through innovation and action, using state, local, and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment (see sidebar).

The public statement acknowledges what pediatric hospitalists have endured for more than a year: pediatric patients are filling up emergency departments and hospitals while they wait for a bed in a mental health care facility.

For Dr. Sekaran, that declaration is further validation of what he and his team see on a daily basis. Connecticut Children's, for example, has seen roughly a 40% increase in eating disorders in children since the beginning of the COVID-19 pandemic in March 2020. He also sees a higher rate of suicide attempts in teenagers, mirroring the national trend.

As a hospitalist in an academic setting, the medical treatment so often tied to mental illness isn't the issue, Dr. Sekaran said.

"We're quite good at the medical care," he said. "We've done it, and we know how to do it. The challenge comes when they become medically cleared, and then those children who need further inpatient psychiatric care, unfortunately, have nowhere to go.

"And that speaks to the overall societal crisis in the lack of appropriate and sufficient mental health inpatient beds. So, imagine what happens. We admit many, many more children. We clear them medically, and then they have nowhere to go because they have no inpatient psychiatry placements."

The situation is even more precarious in community hospitals, where HM practitioners don't have the staffing or the resources to handle the increased pipeline of pediatric mental health patients.

Pediatric hospitalist and regional clinical director Beth Natt, MD, MPH, SFHM, who practices at several community hospitals in Connecticut, said that one way she's adjusted is to work



Dr. Sekaran

*"I often coin it as the second pandemic, the pandemic of the mental health care crisis in children. It's truly occupied my team's life over the last one and a half to two years now."*

with the emergency department for consults to "facilitate the medical clearance of more complex children." It doesn't solve all issues, but it can help, especially as she's seen the number of pediatric mental health admissions for medical treatment such as non-accidental ingestions rise from one every month or two to almost weekly.

Dr. Natt noted that in addition to the medical issues including increased length of stay and inpatient flow, the pediatric mental health crisis also weighs on hospitalists themselves.

"These are difficult situations for families, and we are having to regularly have hard and emotionally challenging conversations on a frequent basis. The intensity of emotional support these situations require, just in terms of the face-to-face kind of conversations, are really tough on our staff," she said. "In the community hospital setting, those kinds of kids are challenging to support. We don't have the depth of pediatric resources in the community hospital setting."

Even with the strength and support of an academic setting, Dr. Sekaran said it's not enough to keep pace. The pediatric mental health crisis has put a spotlight on the broader issue that even before COVID-19, there were not enough inpatient mental health beds for children. In addition, the reimbursement for those psychiatric services needs to increase, he said.

"If the incentive is there, these beds and programs will get created," he added. He believes there is also a need for improved "upstream interventions," such as school-based services and access to outpatient mental health visits.

This leaves the question for pediatric hospitalists: is the current crisis and the formal recognition of it from groups like AAP, AACAP, and CHA enough to move the needle?

"It is my hope," Dr. Sekaran said, "that this will be the catalyst and the new attention and spotlight that is needed, exacerbated by the pandemic, and ultimately will result in real change." ■

Richard Quinn is a freelance writer in New Jersey.

## A call for change

The recent crisis declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association calls for policymakers to advocate for:

- Increased federal funding to ensure all families and children can access evidence-based mental health screening, diagnosis, and treatment, with particular emphasis on under-resourced populations.
- Addressing regulatory challenges and improving access to technology to assure the continued availability of telemedicine.
- Increasing implementation and sustainable funding of effective models of school-based mental health care, including clinical strategies and models for payment.
- Accelerating adoption of effective and financially sustainable models of integrated mental health care in primary care pediatrics, including clinical strategies and models for payment.
- Strengthen emerging efforts to reduce the risk of suicide in children and adolescents through prevention programs in schools, primary care, and community settings.
- Address the ongoing challenges of the acute care needs of children and adolescents, including shortage of beds and emergency room boarding by expanding access to step-down programs from inpatient units, short-stay stabilization units, and community-based response teams.
- Fully funding comprehensive, community-based systems of care that connect families in need of behavioral health services and supports for their child with evidence-based interventions in their home, community, or school.
- Promoting and paying for trauma-informed care services that support relational health and family resilience.
- Accelerate strategies to address long-standing workforce challenges in child mental health, including innovative training programs, loan repayment, and intensified efforts to recruit under-represented populations into mental health professions as well as attention to the impact that the public health crisis has had on the well-being of health professionals.
- Advancing policies that ensure compliance with and enforcement of mental health parity laws.

Source: [www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/](http://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/) ■



# SHM celebrates 25<sup>TH</sup> anniversary as the home for hospital medicine

By Larry Beresford

A little more than a quarter-century ago the emergence of the new medical specialty of hospital medicine was signaled in a New England Journal of Medicine article that defined it by the location for its practice: within the acute hospital.

Practitioners of this new specialty were dubbed hospitalists in the 1996 article by Robert Wachter, MD, MHM, an internal medicine doctor at the University of California San Francisco, and colleague Lee Goldman, MD.<sup>1</sup> They brought widespread attention to this new style of medical practice that was already emerging in hospitals around the country where primary care physicians were leaving the hospital, no longer willing or able to manage the care their patients needed while hospitalized.

Two other pioneers in this new type of medicine, John Nelson, MD, MHM, then practicing in Gainesville, Fla., and Winthrop P. Whitcomb, MD, MHM, in Springfield, Mass., had independently answered the call to start managing hospitalized patients in their own facilities—but without knowing if they were alone in doing so.

“Man, did I ever want to talk to other people who were doing this,” Dr. Nelson said. “I took it upon myself to find these people by attending meetings of organizations like the American College of Physicians and making cold calls to hospitals.” An article

describing Dr. Nelson as “an internist without an office” led Dr. Whitcomb to call him.

When Dr. Wachter’s article came out, Drs. Nelson and Whitcomb contacted him to discuss their mutual interest in coming together face to face and forming a medical society that could help guide, support, and define this new specialty. At the first educational conference dedicated to hospital medicine, convened by Dr. Wachter in San Francisco in April of 1997, Drs. Nelson and Whitcomb asked for some time at the end of a long day of medical information exchange to raise the possibility of forming a society to represent the nascent specialty. The response was overwhelming.



Dr. Wachter

### How a society emerged

Nobody left the room, Dr. Nelson said. “Everybody wanted to talk about a society. One guy even opened his wallet and handed us some money for his dues.” The society that emerged is also celebrating its 25<sup>th</sup> anniversary, alongside the field to which it’s intimately connected. Originally incorporated in 1997 as the National Association of Inpatient Medicine, it changed its name to the Society of Hospital Medicine in 2003. Soon there was a mailing list and a newsletter, with the first national meeting held in conjunction with the American College of Physicians conference in 1998.

The new board met with a strategic planning consultant, Laurence D. Wellikson, MD, MHM, a physician engaged in building managed-care entities in California. “I told them health care is going to change. I said hospitalists could be like pathologists—just ordered when needed. But I had a bigger vision of what they should be,” Dr. Wellikson said.

“I said in order to get there, you have to form an identity. What is a hospitalist? What is the Society of Hospital Medicine? You need to hire

staff and get your act together. They called me back the next year to do another strategic plan.” Then they offered Dr. Wellikson the job of SHM Chief Executive Officer, starting in January 2000.

And while the society was having these discussions, Dr. Whitcomb said, the field was exploding. “It was like somebody flipped a switch. We weren’t waiting for everybody to catch up. We just did it.”

### Erecting a big tent

SHM has fostered the growth of hospital medicine with education, advocacy, and a professional home for the doctors who wanted to practice hospital medicine. It’s helped define the field and scope of practice for a professional community that’s been described as the fastest-growing medical specialty in history.

One of the reasons for SHM’s success, said its founders, is a strategic decision to build a big tent that welcomed multiple stakeholders with a shared interest in acute-care medicine. Early on it was important to have academicians in major medical centers and hospitalists practicing in community hospitals feel equally at home, because they both had something important to contribute to the mission.

“With a lot of quality and safety issues emerging, we made the strategic decision to build the big tent for a specialty whose agenda is not only the individual patient but also the health care system where the hospitalist works and how to make the system work better,” said Dr. Wachter, who now chairs the 900-member department of medicine at the University of California, San Francisco. There was a need to organize practice and payment models, learn how to demonstrate hospital medicine’s value, and simultaneously, pay attention to system issues, quality, and patient safety.

Other hospital medicine clinicians, including nurse practitioners, physician assistants, pharmacists, and other members of the team, also were welcomed into SHM and supported



Dr. Nelson



Dr. Whitcomb



Dr. Wellikson

## HISTORY of HOSPITAL MEDICINE



### SHM IS FOUNDED

January 1997, SHM is founded by two hospitalists, John R. Nelson, MD, MHM and Winthrop P. Whitcomb, MD, MHM



### LENGTH OF STAY REDUCED

A September 2007 study from the Archives of Internal Medicine found that hospitalist reduced acute length of stay by approximately half a day.

1996

1997

2002

2007



### HOSPITALIST FIRST COINED

The term “hospitalist” is first coined in a 1996 New England Journal of Medicine article by Robert Wachter, MD, MHM



### PROGRAMS PROVEN EFFECTIVE

A January 2002 study on the hospitalist model showed improved quality of care and efficiency.



with specialized resources. Hospitalists trained in family medicine, although less common than internists, have their own special interest group (SIG) at SHM, one of many. Pediatric hospitalists, practicing a similar model but with different clinical concerns, have played important leadership roles throughout the Society's history, including the development of quality initiatives such as a set of core competencies in pediatric hospital medicine, completed in 2010 and revised in 2020.

"I'm a pediatric hospitalist and I believe SHM has a very important role in connecting physicians from different disciplines," said Anika Kumar, MD, who practices at the Cleveland Clinic in Ohio. "I learn every day from colleagues about changes in inpatient safety and quality metrics and billing. It's important in this day and age for people to feel included and that they have a home. SHM also does a lot to advocate for us. SHM may have been founded by internists, but it was also a home for those of us in pediatrics, med/peds, and family medicine."

SHM has been recognized for its leadership in quality initiatives such as BOOST—Better Outcomes for Older Adults through Safe Transitions—the first of several comprehensive, evidence-based, mentored implementation programs offered to its members through its Center for Quality Improvement. BOOST helped cement SHM's reputation as a quality-oriented organization. The Society was recognized with the

Joint Commission's 2011 John M. Eisenberg Award for Innovation in Patient Safety and Quality.

SHM's Center for Quality Improvement continues to support HM clinicians with personalized approaches to quality and safety on topics ranging from care transitions and a variety of disease-specific areas to palliative care. A second Eisenberg Award was bestowed in 2016 for SHM's I-PASS Study Group—Illness severity, Patient summary, Action list, Situational Awareness, Synthesis by research—which works to improve patient safety by standardizing practitioner communication in transitions of care.

### A mission-driven organization

Dr. Wellikson's leadership lasted until his retirement in July 2020, when he passed the baton to Eric E. Howell, MD, MHM, a hospitalist pioneer at Johns Hopkins Bayview Medical Center in Baltimore, Md., and one-time president of SHM.

Dr. Howell was fresh from the experience of opening a field hospital for COVID-19 patients in Baltimore and said he chose to come to SHM because he considered it a mission-driven organization, putting the needs of patients and its members over the needs of the organization. "SHM truly is a big tent, full of people from different backgrounds sharing the same vision," he said.

But in an uncertain world, what's next for SHM? "We're starting to get a better picture of that," Dr. Howell said. As the field has grown

in size and importance, some of its traditional boundaries in the acute-care hospital—originally defined as the setting for hospital medicine—have been stretched as hospitalists answered the call to provide a similar kind of acute medicine in post-acute settings like skilled nursing facilities, rehabilitation hospitals, and more recently the hospital-at-home model.

"Hospitalists are taking care of acutely ill patients regardless of setting. I did that when I opened the COVID-19 field hospital at the Baltimore Convention Center," Dr. Howell said. "More and more, acute care is occurring outside of the hospital setting. It may still be called hospital medicine, although we have changed our name before. But I think the pivot will be out of the hospital to wherever acute care is provided, regardless of setting. And I think SHM will be involved in that."

Elizabeth Chmelik, MD, FAAFP, SFHM, joined the National Association of Inpatient Medicine (NAIP) back in 2001 as a family medicine resident who loved the inpatient rotation. "Joining the association was about looking for who is going to guide us. It was a lifeline." More recently, Dr. Chmelik went to work for WellMed Medical Management, a company that promotes value-based health care, and she's starting an SHM SIG for this topic of growing importance.

### Challenges never envisioned

Today, SHM has approximately 15,000 members, of whom 83 to

85% are physicians, and most of the rest are hospital medicine nurse practitioners and physician assistants, or residents and medical students. Estimates suggest that 50,000 to 60,000 hospitalists currently practice in the United States.

But the field is now confronted by challenges never envisioned at the time of its founding, including high rates of job stress and burn-out by hospitalists—along with all other medical specialties—and the impact of the COVID-19 pandemic on hospital care. In hospitals across the country, it was hospitalists who responded first to COVID-19, often providing the lion's share of medical care for seriously ill COVID-19 patients, said Flora Kisuule, MD, director of hospital medicine at Johns Hopkins Bayview Medical Center.

More recently, attention has grown for the pressing issues of diversity, equity, and inclusion, particularly in the wake of the reckoning for America sparked by the tragic death of George Floyd in police custody in Minneapolis, Minn., on May 25, 2020. "Right before I came on board, everything pivoted around George Floyd," Dr. Howell said.

"SHM had made a deliberate choice to be more diverse, with a Diversity, Equity, and Inclusion (DEI) task force, and changed how our annual meeting was developed and its speakers recruited. Our board was also becoming more diverse." But when George Floyd died, that pushed the organization to be even more deliberate. "We realized that the diversity journey



Dr. Kumar



Dr. Howell



Dr. Chmelik



Dr. Kisuule

## INCREASE OF MEDICARE PATIENTS

A 2009 report in *The New England Journal of Medicine* revealed that the number of Medicare patients seen by hospitalist and general internists increased.



## REDUCTION IN READMISSIONS

A 2009 study on teamwork coordinated by hospitalists during discharge showed a reduction in rehospitalizations.

2009



## LENGTH OF STAY REDUCED AGAIN

A 2009 Loyola University Health System Study showed patients who were co-managed by a hospitalist had an average length of stay of 3.8 days.

2016



## TWENTIETH ANNIVERSARY

A 2016 article from *The New England Journal of Medicine* was penned by Bob Wachter celebrating the 20th anniversary of the specialty.



is a journey,” Dr. Howell said. That included looking more closely at the organization’s staff and seeking opportunities to partner with historically black colleges and medical schools to identify future hospitalists.

In 2020, SHM’s Board of Directors empaneled its second Diversity, Equity, and Inclusion task force, charged with making recommendations for how SHM can continue to create a respectful environment for all. This task force recommended supporting the enhanced engagement of underrepresented minorities in medicine and empaneling a permanent Diversity, Equity, and Inclusion committee of the Board of Directors. SHM also just hired its first diversity officer.

The committee, which met for the first time in November, “... will be doing the work of the Board—helping us to be better with the diversity of our membership—which starts with knowing how diverse they are,” Dr. Howell said. The organization is also addressing other forms of equity, including gender. “But we want to make sure we don’t dilute the message of investing in people of color,” Dr. Howell said.

Dr. Kisuule said she believes SHM is doing what it needs to be doing to address diversity issues. She helped lead the society’s initial DEI task force, starting in 2018.

Legacy of hospital medicine

Jerome O. Siy, MD, CHIE, SFHM head of the department of hospital medicine at HealthPartners in St. Paul, Minn., and SHM’s current president, said the last couple of years of the COVID-19 pandemic and a broader geopolitical divide in this country have profoundly affected health care and hospitalists. “Since SHM’s 20th anniversary, all of health care has experienced much more stress. What does that mean for us as a society? SHM has faced these issues head-on, which is a strong testament to what we have accomplished, but how do we move forward?”



Dr. Siy

There’s always a need for more education and more research to figure out how to support the field and address its members’ needs, Dr.



Siy said. “With the pandemic, we were tested, 34and we did a good job. But it reminds us that we have to be ever-ready for the next big crisis.” Other looming challenges include getting a handle on emerging information technologies, addressing health care regulation and payment models, and looking at how the work of hospital medicine can be sustainable for the arc of a career.

“When I first started working there, I wasn’t sure the specialty would achieve the dynamism and impact that I felt was possible,” Dr. Welikson said. “It far exceeded my vision. We are in the middle of everything that’s happening in health care—as important as any medical specialty. I think the secret sauce of SHM was the incredibly bright people who were attracted to hospital medicine and SHM, and who gave so

much.” Dr. Whitcomb said he is both proud and grateful for being involved in the field’s founding. “We saw a need, and we were lucky to be the ones who addressed it. But I think the biggest legacy is for all the patients who benefitted from having a doctor present in the hospital at their time of need to have a skilled clinician who would show up for them in real-time.” ■

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- Larry Beresford is an Oakland, Calif.-based freelance medical journalist, specialist in hospice and palliative care, and long-time contributor to *The Hospitalist*.

HISTORY of HOSPITAL MEDICINE



NATIONAL HOSPITALIST DAY

In March 2019, SHM celebrated the first National Hospitalist Day—which is set to occur every first Thursday in March.



25TH ANNIVERSARY

SHM celebrates 25 years with features in each issue of *The Hospitalist*.

2017

2019

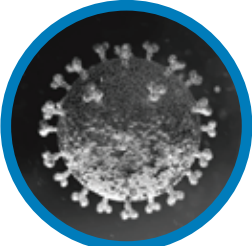
2020

2022



ENTER C6 BILLING CODE

In 2017, Hospitalist billing code C6 is implemented by CMS to better benchmark hospitalists against other specialties.



COVID-19 PANDEMIC

SHM partners with Hilton to provide rooms for hospitalists working around the clock on the front lines of the COVID-19 pandemic.



# Practicing broad-spectrum pediatric HM in the Alaska Native community

Respecting the culture and tackling the terrain

By Whitney Elliott, MD, FAAP; Anna Ogena, MD, FAAP; Matthew Hirschfeld, MD, PhD, FAAP

**T**he Department of Pediatric Hospital Medicine at the Alaska Native Medical Center (ANMC) in Anchorage, Ala. has served the Alaska Native community since 1999. Our group works with the community to provide broad-spectrum pediatric tertiary care. The group includes 15 pediatric hospitalists and four pediatric nurse practitioners, with a combined total of 15 full-time equivalents (11.75 MD and 3.25 NP). We cover a 19-bed inpatient pediatric unit (including intermediate care patients and post-operative pediatric surgery patients) and a 12-bed level 2b NICU.

Equally important to the care we provide is our respect for the cultures and traditions of the Alaska Native people we serve. As a result of historical trauma to indigenous people in the U.S., some patients and families distrust the medical system. Our group at ANMC strives to provide culturally sensitive and relevant care, ensuring that patients and their families feel comfortable, are involved in the process, and understand what's happening every step of the way. We're committed to the hospital's mission of providing the highest quality health services for all Alaska Native people.

## Caring for patients

We provide consultative services in pediatric trauma care and other subspecialty services at ANMC, including consultations with the ANMC ED practitioners. We cover newborn care, including circumcisions, in family birthing services where there are about 1,600 deliveries per year. We also attend high-risk deliveries. We provide phone consultative services to clinic, hospital, and emergency department practitioners caring for Alaska Native patients throughout rural Alaska, including those transporting children from rural areas of the state into Anchorage for both urgent and routine concerns.

We run hospital-based sedation and infusion clinics. We also maintain pediatric field clinics in rural Alaskan regions, working with primary care practitioners who lack regular in-person access to pediatricians to provide non-urgent consultations and continuity of pediatric care for children with complex medical needs. We're supported by a separately organized pediatric critical care group at ANMC. This care group is available 24/7 and enables us to care for higher acuity patients whom we might otherwise need to refer to outside hospitals.

In addition to our clinical duties, we participate in a wide range of hospital-based committees. We're active members of local, state, and national professional organizations and we're involved in quality improvement and research projects. Our team also engages in many aspects of health care practitioner education within Alaska, including community health aide, physician assistant, nurse practitioner, medical student, and resident education.



About 1,600 babies are delivered each year at ANMC, Dr. Elliott and her team are there to assist.

## A look at ANMC's history

In 1975 the Indian Self-Determination and Education Assistance Act allowed tribes to choose to self-govern, including management of health care. Alaska Native-owned and operated health care organizations have taken over all contracts from the Indian Health Service (IHS) and are now responsible for all health care delivery to Alaska Native people.<sup>1,2</sup> The Alaska Native Medical Center is the flagship tertiary hospital for all Alaska Native people and was built in 1997, replacing the Alaska Native Service Hospital, which had served Alaska Native people since 1953.

In 1999, the management of ANMC was transferred from IHS to shared ownership and management by the Alaska Native Tribal Health Consortium (ANTHC) and Southcentral Foundation (SCF).

ANTHC is a nonprofit tribal health organiza-

tion governed by representatives from all of the tribal health organizations in Alaska. It provides comprehensive health care services, wellness programs, disease research and prevention, rural provider training, and rural water and sanitation systems to Alaska Native people across the state.<sup>2</sup>

SCF is a nonprofit Alaska Native-owned and operated health care organization serving Alaska Native people living in Anchorage, the largest city, and other south central Alaska communities.

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of 35 Alaska tribes and tribal organizations providing health services for the more than 177,000 Alaska Native and American Indian people residing in the state. The ATHS is a network of 171 village clinics, 27 regional clinics, six hospitals, and a tertiary care medical center.



Geographic challenges

These facilities are in the most remote settings across a service area comprised of 20% of the landmass of the entire U.S.<sup>2,3</sup> Alaska is 570,640 square miles in size, which is more than the next three largest states of California, Texas, and Montana combined.<sup>4</sup> The 2020 census determined that Alaska Native people are 21.9% of the total population of Alaska (this number includes those people who identify as Alaska Native alone or in combination with another race).<sup>5</sup> Of those Alaska Native people in Alaska, 50,221 are under 18 years of age.<sup>5</sup>

The ATHS is organized into tribal health regions, which are further subdivided into tribal health organizations (THOs). The THOs manage health care for Alaska Native people living in communities within their geographic area. The ATHS is often described as a hub-and-spoke model, where care within each THO starts in a person's small community.

Each small community has a clinic staffed primarily by community health aides/practitioners (CHA/Ps), working in collaboration with practioners at subregional and regional health care facilities (larger clinics or hospitals). If escalation of care is needed, the patient is referred to a subregional or regional center. Some regional health care facilities have established pediatrics groups, though most are staffed primarily by family medicine physicians. If a higher level of care is required, the patient is transferred outside of the THO, typically to ANMC in Anchorage. Some subspecialty care is not available in Anchorage, and in these cases, people are referred to facilities in the lower 48.

The majority of small rural communities in Alaska (more than 80%)<sup>2</sup> don't have access to roads so when escalation of care from a small community to a regional center or from a regional center to Anchorage is needed (for both urgent and routine care), people access that care via plane. These isolated communities rely entirely on air transport to the nearest inpatient medical facility. As more than half the population served through the ATHS lives in rural and remote locations<sup>2</sup> and 50% of Alaska Native people 19 years of age and younger live in a community off the road system,<sup>6</sup> air transportation is, by necessity, the primary means of travel to access health services.

The average Alaska rural community has 350 residents, limiting the level of health care available locally. Distance and weather make air travel unreliable and expensive. To receive basic medical care, a patient may fly in multiple aircraft, for as many as 1,100 miles. For comparison, the distance from many communities to the nearest medical facility is equivalent to the



The pediatric HM group at ANMC is committed to providing the highest quality care to all Alaska Native people.

By the Numbers



- Department of Pediatric HM at ANMC includes 15 pediatric hospitalists and 4 pediatric nurse practitioners
- They cover 19-bed inpatient pediatric unit and a 12-bed level 2b NICU
- ATHS provides health services for more than 177,000 Alaska Native and American Indian people
- The ATHS network includes 171 village clinics, 27 regional clinics, 6 hospitals, and 1 med center
- Alaska = 20% of the U.S. landmass; it's bigger than California, Texas, and Montana combined
- Alaska Native people = 21.9% of Alaskan population
- More than 80% of small rural communities don't have access to roads
- 1,100 miles = distance some patients travel to receive basic medical care (from NYC to Chicago)

distance from New York to Chicago.<sup>2</sup>

Why we do it

With this background in mind, picture a 4-month-old infant with two days of high fevers who's described by the community health aide as irritable and whose mother described two minutes of shaking at home, during and after which her baby was not responsive.

Think of a 2-month-old infant brought to the community clinic because he's been sweaty when he eats and seems to have no energy for the last couple of weeks. In the clinic, the community health aides/practitioner hears a loud murmur not reported in the birth record.

Imagine a 15-month-old who had a cold two weeks ago, and now presents to the clinic with trouble breathing and fatigue, and whose lung sounds are not consistent with bronchiolitis or pneumonia.

Envision a pregnant woman at 32 weeks of gestation who walks

into the community clinic and reports that her water broke and she's having regular contractions.

These patients' journeys to definitive care take them across a vast state often affected by harsh and unpredictable weather. They'll travel from a small rural community clinic through their regional centers and likely to ANMC via two medevac flights, all while receiving excellent pediatric care in a system carefully designed to serve even the most rural Alaskan children.

As pediatric hospitalists in this unique health care system, our practice of wide-ranging pediatric hospital care, supported by our appreciation of health care, traditions, and culture in the Alaska Native community, provides us with a deep understanding of medicine as practiced here that allows us to provide thoughtful and high-quality care to the infants, children, and young adults we serve. Our work also guides us in further developing programs tailored to

this community as it grows and changes with time. ■

*Dr. Elliott is a pediatric hospitalist who has practiced community pediatric hospital medicine at ANMC for the last seven years.*

*Dr. Ogena has been a pediatric hospitalist at ANMC since 2005 but initially came to rural Alaska in 2004 to work as a locum tenens physician at the Yukon Kuskokwim Health Corporation in Bethel, Ala. She is the current medical director for inpatient pediatrics at ANMC and serves as the Alaska chapter president of the American Academy of Pediatrics.*

*Dr. Hirschfeld has been a pediatric hospitalist at ANMC for the past 16 years and is also the medical director of maternal child health services at ANMC.*

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# A different kind of leadership rounds

System thinking to the bedside and bedside to systems thinkers

**By Christopher Moriates MD; Read Pierce MD; F. Parker Hudson MD, MPH; Lysbeth Miller MD; Kirsten Nieto MD; Elizabeth Schulwolf MD; Michael Pignone MD, MPH**

In the early 2000s, the Institute for Healthcare Improvement helped popularize the idea of Leadership WalkRounds, encouraging health care leaders to regularly visit frontline clinical units to hear directly about safety concerns.<sup>1</sup> With the subsequent proliferation of Lean methodologies in health care, the promotion of leaders “going to Gemba” became widespread.<sup>2</sup> However, leadership rounds are variably applied at different institutions and have yielded mixed results regarding their effectiveness to improve patient safety and culture.<sup>3,4</sup>

At Dell Medical School and Dell Seton Medical Center at The University of Texas (DSMC-UT), in Austin, Texas, our leadership rounds model was created and has evolved to be structurally and functionally different from traditional Leadership WalkRounds. Led by our internal medicine associate chair for quality and safety, members of the leadership team from the hospital, medical school, and the department of internal medicine (*see sidebar*) join different medical wards teams for one hour of patient rounds at



Dr. Moriates



Dr. Pierce



Dr. Miller



Dr. Nieto



Dr. Pignone

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*Dr. Pierce is chief of the division of hospital medicine, associate chair for faculty development and well-being, and associate professor in the department of internal medicine at the Dell Medical School at the University of Texas at Austin.*

*Dr. Hudson is an assistant professor of internal medicine and infectious disease, and the program director for the internal medicine residency at the Dell Medical School at the University of Texas at Austin.*

*Dr. Miller is associate chair for education, a professor, and interim chief at the Dell Medical School at the University of Texas at Austin.*

*Dr. Nieto is an associate professor in the departments of internal medicine and pediatrics, and associate chief for the division of hospital medicine at the Dell Medical School at the University of Texas at Austin.*

*Dr. Schulwolf is an associate professor in the department of internal medicine at the Dell Medical School at the University of Texas at Austin.*

*Dr. Pignone is the Dr. Lowell Henry Lebermann endowed chair in internal medicine, assistant dean for veterans’ affairs, and professor at the Dell Medical School at the University of Texas at Austin.*

least twice per month. Most of our leadership rounds participants are physicians. While leadership rounds are not a new concept, this article aims to describe some of the experiences and insights from our unique model. Our approach brings both systems thinking to the bedside and the bedside to

systems thinkers. This bidirectional learning embodies and enables core functions of learning health systems.<sup>5</sup>

## Bidirectional health systems insights

“Farming looks mighty easy

when your plow is a pencil, and you’re a thousand miles from the cornfield.” – President Dwight D. Eisenhower

DSMC-UT is a level-1 trauma center, safety-net hospital in a non-Medicaid expansion state (Texas). It’s common for hospitalized patients to lack access,



coverage, and resources necessary for ongoing care. Additionally, the health care landscape in Austin is particularly complex with multiple partner organizations that don't share electronic health records (EHRs), secure messaging platforms, evidence-based protocols, or value-based purchasing agreements.

During leadership rounds, rather than focus solely on having executives observe daily work, we encourage teams to round as usual and the leaders engage as more active participants in discussions of medical complexity, clinical conundrums, health-related social needs, and structural barriers to effective care.

Medical ward teams often choose to present patients facing seemingly unsolvable puzzles to achieving appropriate discharge and follow-up care. Such discussions allow systems leaders to gain greater awareness of individual patient-level challenges while simultaneously creating opportunities to provide further context to help our physicians and trainees understand the bigger picture, key drivers, and root causes contributing to the problem in front of them. From their vantage point of the larger health system landscape, our leaders also can share resources or solutions that may be hidden or less obvious to frontline clinicians and learners.

For example, during the early stages of the COVID-19 pandemic, discussions with the clinical team highlighted gaps in processes for obtaining home oxygen and for providing patients with pulse oximeters at the time of discharge. These issues were quickly addressed by the leadership team, enabling our social workers, outpatient pharmacists, and oxygen suppliers to eliminate barriers across all three domains within days. This intervention is more akin to traditional leadership rounds, in which problems raised by those doing the work are solved by leaders who have resources, authority, or convening power to address them.

In another instance, a clinical team attempting to obtain apixaban for an underinsured patient at the time of discharge had no roadmap for navigating around the cost-prohibitive standard process. The leadership rounds participants imparted their institutional knowledge of the nuances of outpatient formularies for underinsured patients, funding assistance programs, and bridges for gap coverage models between the hospital and primary care clinics. This contribution is, we believe, relatively unique: leaders supporting and enhancing the team's clinical reasoning and care planning in real-time, rather than solving issues raised by the team later.

Recurring themes in the real-life

Making the Rounds

Regularly invited attendees for internal medicine leadership rounds at Dell Medical School/Dell Seton Medical Center

- Chair of the department of internal medicine
- Associate chairs of the department of internal medicine
- Division chief and associate division chief of hospital medicine
- Chief medical officer
- Dean of Dell Medical School
- Internal medicine residency program director
- Department of internal medicine administrator

problems our leaders encounter on rounds represent persistent gaps and ongoing blind spots in our current care-delivery model that will inevitably require higher-level improvement interventions championed by the executive rounding team. Repeated instances of patients having difficulty accessing necessary and expensive outpatient care for chronic rheumatologic or oncologic conditions require systems-level solutions.

For example, leaders can spend a lot of effort trying to address readmissions, only to hear from a team about a patient readmitted overnight because when she returned to her apartment, the building elevator was out of order and there was no way to get up the stairs; the ambulance returned the patient to the hospital. These discussions help build empathy and shared understanding among all attendees for the daily challenges that patients, frontline physicians, and our leaders face in striving to better serve our community.

Teaching attendings could, in theory, do all of this without leadership rounds. Many of our leadership rounds participants are also attending physicians on the hospitalist service at DSMC-UT. We have noticed, however, that listening to patient presentations during leadership rounds with the distinct lens of systems thinking (rather than as the attending of record responsible for the case) provides a catalyst for seeing different opportunities and insights related to both the patient and the systems of care. Our dedicated leadership rounds structure provides a mechanism to ensure we incorporate big-picture perspectives even on busy clinical services, which additionally furthers the systems-based practice competencies of our trainees.

Real-time super consults enhance clinical care and teaching

"Alone we are smart. Together we are brilliant." – Steven W. Anderson, educator

Our leadership rounds also allow the sharing of experiential knowledge from senior internists and master clinicians. Learners and hospitalist attendings have likened them to a "super consult."

Clinical teams often choose to present clinical conundrums or interesting medical cases during leadership rounds, generating active discussions that incorporate team consensus, expert opinion, and novel clinical approaches that augment patient care. Harnessing the collective intelligence of multiple physicians has been shown to improve diagnostic accuracy.<sup>5</sup>

Recently, a medical student presented a young patient with a headache who was found to have new-onset malignant hypertension, severe acute renal failure, diastolic heart failure, and an intracranial hemorrhage. The initial differential diagnosis was broad with concern for primary hyperaldosteronism in the setting of low potassium and an incidental adrenal nodule. The leadership team helped focus on the profound nephrotic-range proteinuria as evidence of glomerular damage, refining the differential diagnosis and management prioritization. While the clinical team continued to round, a leadership team member returned to his office after rounds and sent an article to the team further informing their care for this complicated patient.

Lessons and next steps

This model of leadership rounds provides a rich array of clinical, operational, and educational insights. An added bonus is that our frequent observation of the clinical learning environment allows us to detect and respond expeditiously to changes in hospital culture that may impact care optimization. Noting practice variation, system biases, multidisciplinary team dynamics, and trainee performance trends inform potential focus areas for curricular and process improvement opportunities. Following leadership rounds, we repeatedly found ourselves huddled in the hallway summarizing our observations and prioritizing future steps. This led us to formalize a scheduled debrief immediately following each leadership rounds to ensure that unresolved action items are appropriately delegated for rapid resolution.

It would have been easy to abandon leadership rounds early in the COVID pandemic. Instead, our leaders leaned into this

well-established means of gaining on-the-ground situational awareness as a conduit for direct feedback and resource requests from frontline providers. For example, teams raised concerns early in the pandemic about availability of consultants, timeliness of diagnostic studies and procedures, and variation from standard practice resulting from a combination of fear, uncertainty, infection prevention, and personal protective equipment-conservation strategies. Our chief medical officer quickly addressed this through her authority overseeing the medical staff. Engaging health care worker concerns during leadership rounds early in the pandemic enhanced trust and dialogue among providers and leaders sustaining the cohesion of our teams throughout uncertain times.

As our leadership rounds model matures, we're expanding to include other clinical sites, including our ambulatory clinics, which we expect will broaden the impact of our model across the spectrum of care. We continue to refine and standardize mechanisms for follow-up and feedback on actions taken as a result of leadership rounds.

Our experience with a redesigned model for leadership rounds suggests this can be an effective mechanism to provide situational awareness for leaders in our department, school, hospitals, and clinics regarding the experiences of our residents and faculty, as well as visible leadership, presence, and support in our clinical learning environments. By bringing systems thinking to the bedside, we are helping our teams treat the patient in front of them as well as the system around us. ■

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# Addressing the nursing shortage

Fiscal incentives, perks, training, and mentoring help

By Karen Appold

With the onset of COVID-19, the existing nurse shortage only worsened at many hospitals throughout the country. “COVID patients require an extra level of care due to the virus’s infectious nature and the need for isolation,” said Andrew C. Hannapel, MD, chief medical officer, director of medical education, and clinical provider in the emergency department, and hospitalist maternity care services for Chatham Hospital in Siler City, N.C. “Staff have to put on PPE each time they enter a COVID patient’s room. These patients require additional personnel and resources to care for them.”



Dr. Hannapel

All these extra demands impact nurses and other staff members over time. “Nurses are leaving bedside nursing and switching to outpatient nursing, non-patient care nursing jobs, or leaving nursing altogether,” Dr. Hannapel said. “Other nurses have left to become traveling nurses because of the substantial salary increase.” As a result of the COVID-19 vaccine requirement, the hospital lost close to 10% of its nurses.

Nurses’ burnout and frustration increased when challenges to mask mandates and vaccinations resulted in COVID-19 case surges over the summer. “Some nurses felt that the very people they sacrificed themselves for had failed them by not getting vaccinated,” said Barbara S. Jacobs, MSR, RN-BC, NEA-BC, vice president of nursing and chief nursing officer at Luminis Health Anne Arundel Medical Center in Annapolis, Md., an academic regional medical center with 380 beds.



Barbara Jacobs

The dramatic spike in COVID-19 cases in certain parts of the U.S. resulted in a tremendous demand for nurses and highly augmented hourly rates for temporary nurses, which contributed to fewer experienced nurses at the bedside in Jacobs’ hospital. Further, many female nurses had to provide childcare at home during the pandemic, which limited their availability to work, and another large group of nurses reached retirement age.

Now that the pandemic has significantly impacted the pediatric population, burnout has increased among the nursing staff at Akron Children’s Hospital in Ohio, an urban pediatric hospital with more than 400 beds. “More nurses are deciding to retire, while others are leaving the profession for other roles that are not direct care, especially hospital care,” said Christine Young, MSN, MBA, RN, NEA-BC, chief of hospital-based services and chief nursing officer. “Some nurses have taken assignments as traveling nurses, enticed by the financial incentives that travel agencies are offering, even though we have offered incentive bonuses.”



Christine Young



Chris Wessien & Shutterstock.com

## Effects on hospital medicine and patient care

Having fewer nurses increases demands on the hospital medicine department and negatively affects patient care. For example, Chatham Hospital, a rural critical access hospital with 25 beds, is unable to consistently keep all its beds open and staffed. Consequently, admitted patients are boarded in the emergency department until an inpatient bed is available, creating longer wait times there.

The hospital also hasn’t been able to keep its four-bed ICU open due to nursing shortages, which increases its transfers to larger community and academic hospitals. “But these referral hospitals have their own problems with staffing inpatient beds, so sometimes they can’t accept transfers or there are delays in accepting transfers,” Dr. Hannapel said.

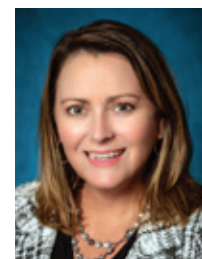
At Akron Children’s Hospital, the primary impact on patient care because of the nursing shortage is occasional limits on access. “We monitor the staffing situation continually and fortunately have rarely had to limit bed availability,” Young said. “When this does occur, we work closely with regional pediatric hospitals to ensure patients receive necessary care.”

The nursing staff works in close collaboration with its pediatric hospital medicine department. “Staff make every effort to work together so any shortage doesn’t impact its ability to deliver high-quality care,” Young said. “This shortage has strengthened our team; our hospital medicine colleagues are always willing to pitch in and work together with the nursing staff.”

For the first time in its history, Anne Arundel Medical Center brought in a lot of temporary staff. Consequently, team members were less familiar with each other than in the past. “Resource nurses are available to support less experienced or less familiar nurses, but there is a loss of experience that comes from team members who have worked together for long periods of time,” Jacobs said.

Health care practitioners in the department of medicine at Providence Mission Hospital in Mission Viejo, Calif., a community hospital with 502 beds, have been very supportive during the nursing shortage by conducting more frequent rounding, expanding training for new caregiv-

ers, and providing ongoing education about COVID-19 practice changes to the clinical team, said Cherie Fox, RN, MSN, CCRN-K, executive director of acute care services. “We provide and support the clinical team to push on and provide the same level of care regardless of the nursing shortage, COVID, or any other factors,” she said. All leaders are asked to round on patients, including everyone from its finance department to its quality team. “While care delivery is for the clinical team, checking on patients is everyone’s responsibility.”



Cherie Fox

## Alleviating nursing shortages

There is good news as hospitals report some success in retaining and recruiting nurses. Chatham Hospital started offering sign-on bonuses for two-year commitments and relocation assistance for out-of-area candidates. It increased nurse salaries across the board by \$2 per hour and will be giving a 2.5% raise to all employees beginning in January, said Eric Wolak, DNP, MHA, RN, NEA-BC, chief operating officer, and chief nurse officer. All nurses received an incentive bonus of 2.5% at the end of October. While it has tried not to become dependent on travelers, Chatham Hospital will be recruiting some for the ED to help ensure essential care. “It has become clear that graduate nurses will be our focus for recruiting new talent, so we have forged a strong relationship with an area community college with an RN program,” he said.



Eric Wolak

Chatham Hospital is also bringing back licensed practical nurses (LPNs) to inpatient and ED positions. “They are a community resource and have augmented our staff,” Dr. Hannapel said. “While they can’t do everything an RN can do and they require nursing staff to supervise and mentor them, they perform vital nursing functions. We also incentivize LPNs who earn an RN degree in four years by providing tuition



assistance.”

Providence Mission Hospital has embraced a program called Transition into Practice (TIP), which has allowed it to onboard more new graduate nurses with better retention and clinical skills after orientation. The hospital offers sign-on and referral bonuses to recruit experienced nurses, but the bulk of the new positions are being filled with new graduate nurses who are provided lengthy, robust training, Fox said.

Fox said the hospital also created a patient care technician role for nursing students, which has helped with recruitment. This feeder program offers the flexibility of part-time work and schedule accommodations to cater to a nursing student’s needs.

Anne Arundel Medical Center offers tuition assistance and loan forgiveness programs in its effort to entice nurses. It also has an aggressive weekend program, both to reward nurses who work weekends and to build a team on those shifts, Jacobs said. This reduces the number of weekends that other staff need to work. The hospital has also adjusted its benefits. Its short-term disability waiting period has been reduced to seven days and staff members can receive full-time health benefits when working a 24-hour workweek.

At Akron Children’s Hospital, bonus incentive-pay programs are offered for staff who are willing to work extra hours, Young said. The

hospital has reached out to retired nurses and other previous employees to recruit and rehire them. It created a Helping Hands program in which nurses working in non-clinical settings, such as information services, quality, research, and accreditation, have been offered refresher training to support clinical care delivery at the bedside. The hospital also actively reaches out to nursing students to offer them positions as patient care assistants to support care delivery at the bedside. “We use this strategy as a recruitment tool to retain and transition them to nursing positions when their schooling is complete,” she said.

Akron Children’s Hospital is also conducting accelerated market reviews to ensure its compensation is competitive, focusing on hard-to-fill and hard-to-retain positions throughout the organization including nursing, especially critical care nursing.

### Forward thinking

Knowing the nursing shortage won’t be over any time soon, some hospitals are working on strategies to alleviate future shortages.

Capturing nursing students early in their schooling is key to lessening future nursing shortages, Young said. Akron Children’s Hospital has a robust nurse tech program, called Assuring Success with a Commitment to Enhance

Nurse Diversity (ASCEND). It’s a 10-week program for nursing students from underrepresented groups before their senior year in nursing school.

It also has an accredited nurse residency program that supports new graduate nurses’ transitions to practice throughout the entire first year after graduation. “We know these transitions are difficult; this program has improved the first-year turnover rate for nurses significantly,” Young said.

Anne Arundel Medical Center is also looking to change some of the traditional ways of giving care and is exploring how it can provide optimal patient care with some innovative models. “We want to modify our models, adding increased and unique support staff roles,” Jacobs said. “We’re training a new generation of health care workers by partnering with various higher education institutions to offer a traditional and innovative educational pathway.” ■

*Karen Appold is an award-winning journalist based in Lehigh Valley, Pa. She has a BA in English (writing) from Penn State University and has more than 25 years of editorial experience. Karen freelances for various medical organizations, businesses, and media. She has also worked in a variety of capacities, including newspaper reporter, editor of a daily newspaper, and editor of a monthly magazine. Reach her at kappold@msn.com.*

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## The Division of Hospital Medicine at Cooper University Hospital is offering the 2021-2022 Advanced Hospital Medicine Fellowship July 1, 2021 to June 30, 2022

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- Three (3) letters of recommendation (one of which must be from your current or most recent Training Director)
- Personal Statement describing your training goals and future career plans
- Complete Transcript
- ECFMG Certification (IMG only)
- USLME Reports (1, 2 and 3)

### Contact Information

Program Director: **Naitik Patel, MD**

Program Contact: **Dottie Domalewski, Fellowship Coordinator**

Phone: **856-342-3150**

E-mail: **Domalewski-Dot@cooperhealth.edu**

Website: **cooperhealth.edu/hospitalmedicine**



**Cooper Medical School  
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# What I wish I knew before becoming a hospitalist

By Teela Crecelius, MD;  
Rachna Rawal, MD; Allison  
Ashford, MD

**F**inishing residency and beginning a career in hospital medicine is an exhilarating time of autonomy, unlike any time during residency. Now you can finally flex independent clinical skills. However, it can be scary knowing that you're the attending physician, the quarterback of a multidisciplinary team. Now that we have several years of work experience in different areas of the country, there are some concepts we wish we knew before starting our first job as a hospitalist. These concepts can be organized into four key topics with the mnemonic of TEAM: team dynamics, education, administrative tasks, and growth mindset.

## Team dynamics

As a hospitalist, you'll be coordinating patient care with nurses, consultants, care managers, and families. If a nurse is familiar with you and can put a name to your face, it can dramatically improve efficiency and coordination of care. When you start a new job as a hospitalist, we highly recommend introducing yourself to all charge nurses, unit directors, and bedside nurses. This will open the door for streamlined communication.

During rounds, ensure each bedside nurse is updated on the plan

for the day either by rounding with them or updating them immediately after finishing. This will enable the nurse to help enact the plan and reiterate it to the patient if needed. It also saves you and the nurse time by limiting questions that come up later in the day.

One unique aspect after completing training is that you may have the opportunity to collaborate with advanced practice practitioners (APPs), such as nurse practitioners or physician assistants. One common misunderstanding is that APPs are similar to residents, which can be misleading. Depending on the model at your hospital, APPs may practice independently (with a supervising physician available when needed) or they may work with a physician more directly.

In the hospitalist setting, an APP may round on several patients alone and bill independently. Depending on the acuity of the patient and/or your comfort level, you may opt to see the patient also and bill for your services. APPs can enhance patient care and efficiency in a team-based setting, and it's not uncommon to learn tips and tricks on patient care from them.

Starting as a hospitalist, you'll quickly realize how much you don't know. Medicine is an ever-changing landscape, and you are not expected to know it all or to know every piece of new evidence. Thankfully, medicine is a team sport. Hospitalists ask each



Dr. Crecelius



Dr. Rawal



Dr. Ashford

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other and consultants for feedback and advice constantly. Your reputation as a collegial teammate, willing to help others, will facilitate this process, and others will be more willing to help you in return. We cannot overstate that one of the keys to the success of being a hospitalist is communication and collaboration.

## Education

Defining your career is perhaps the most difficult aspect of the job. Deciding to pursue a career in hospital medicine is only the beginning of your career trajectory, given the myriad of options available within this specialty. You can

choose to pursue a career in academic hospital medicine, which lends itself to teaching, research, and scholarship, or you can opt for a career in the community setting, which may involve more time providing direct patient care.

Hospitalists inherently make excellent candidates for advanced degrees, such as a master's in public health or business administration, which have wide applicability within hospital medicine. Given that hospitalists are intricately involved in hospital operations, leadership opportunities are abundant via committee work, quality improvement projects, and specific roles, such as unit director.



Developing the skills and behaviors of an effective leader early in your career via leadership coaching or a specified curriculum (locally and/or through SHM's Leadership Academy) sets the stage for promotions and new opportunities within the hospital and, if applicable, the academic institution.

In the academic setting, it's even more important to understand the promotion process. With some variance between institutions, hospitalists can advance from instructor to assistant professor, then to associate professor, and finally to professor, through dedication to teaching, service, and scholarship.

Hospitalists also have an increasing presence in executive-level positions (also known as the C-suite) within hospitals. Hospitalists are systems-level thinkers and problem solvers with a keen understanding of hospital operations. This positions hospitalists for success within the C-suite. Choosing hospital medicine as a specialty opens the door to numerous pathways for a fulfilling career.

Administrative tasks

One aspect that's frequently foreign to a new hospitalist is the administrative or logistical aspect of being employed. Several com-

pensation models exist in hospital medicine. It can be helpful to know if you're paid via salary, Relative Value Units (more commonly known as RVUs), or a combination.

Additionally, some shifts, such as nights and weekends, may be worth more than others, which could mean higher pay for those shifts, the need to work fewer shifts, and/or more flexibility in scheduling. Most institutions also offer bonuses for meeting certain metrics, so familiarize yourself with these so you can obtain them. Some hospitalists also choose to work extra shifts, including overtime and moonlighting. Know how that plays into your schedule, your compensation, and your work/life balance, especially if you plan on switching shifts from days to nights.

Also, billing for your work and time can be complicated. There are specifics to observation versus inpatient, critical care time, procedures, and prolonged time that may not be explained during training. Familiarize yourself with billing expectations at your institutions and make sure you have a good understanding of billing when you start as a hospitalist.

In addition to clinical work, there are local, state, and national requirements for maintaining your

medical license. At the local level, each hospital and academic institution sets forth policies regarding annual training to remain in good standing and be credentialed to practice. These usually include modules addressing the Health Insurance Portability and Accountability Act (HIPAA), workplace safety, malpractice, and diversity/equity/inclusion, among others.

Each state has different annual continuing medical education (commonly known as CME) requirements with credits obtained via lectures, conferences, workshops, or any approved educational activity. Nationally, the American Board of Internal Medicine (ABIM) requires 100 Maintenance of Certification (MOC) credits every five years to ensure the ongoing process of lifelong learning, self-assessment, and clinical improvement. Additionally, ABIM mandates the 10-year traditional board exam (or, beginning in 2022, the Longitudinal Knowledge Assessment) to maintain board certification. If you are board-certified in pediatrics or family medicine, their respective boards have a similar process, and if your certification is in internal medicine/pediatrics, be sure to look at reciprocity between the two boards.

Growth mindset

Starting as a new hospitalist is exciting but terrifying. Working to understand the logistics of your job, your educational opportunities and requirements, and the team's dynamics can help make the transition smoother. Knowing that you can grow and change your career over time is exceptionally rewarding, especially if you invest in yourself and your career.

As a hospitalist, you have the luxury of developing your niche over time and tailoring your career accordingly. A tremendous piece of advice that each of us received was to find 'your people' and seek mentorship. Identifying good mentors can sometimes be difficult, but it's one of the most important tasks for your first year on the job. Good mentors can serve as the catalyst for your development, advancement, involvement in projects, and networking. Starting your job with a forward-looking vision and being open to things will help your career flourish.

We hope that by sharing these concepts we wish we had known before starting our jobs, we've helped make your foray into hospital medicine successful and enjoyable. And remember, hospital medicine is all about the TEAM. ■

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• Things We Do for No Reason

• High Yield POCUS Image Review

• So Sue Me! Navigating Medicolegal Waters for Hospitalists

• Getting to Cashville: Financial Planning for Hospitalists

• Pediatric Update: Top 10 Articles

• Bless Your Heart: Physician Wellbeing

• Studio B Presents: Perioperative Updates

• Harnessing Your Superpower: Negotiation Strategies

• Only the Lonely: Inpatient Psychiatry

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# Get...and stay...connected in the new year

## SIGs and Chapters

Looking to connect with even more colleagues in the new year? One way to get the most out of your SHM membership is to get involved. You can join a SIG—special interest group—or get engaged with your local chapter.

SIGs are designed to create communities of hospitalists around topics of interest, practice areas, and/or care models. Joining one of SHM's 27 special interest groups allows you to collaborate, share experiences with your peers, and have meaningful discussions that can directly impact your practice. As an SHM member, you can belong to as many SIGs as you want, and if there's not a SIG on a particular topic you're interested in, you can apply to start one.

Chapters serve as your local SHM home to network with your peers, establish new relationships within the community, receive education, and grow in your profession as a hospitalist. As soon as you join SHM, you're automatically added to your local chapter, where you have the opportunity to attend chapter activities and participate at the local leadership level to influence and execute chapter goals and initiatives. More than 80% of SHM's total membership is represented by one of 68 U.S. chapters. If there's not a chapter in your area, you can apply to start one.

While the COVID pandemic has impacted the frequency of SIG and chapter meetings, the resiliency, passion, and dedication of volunteer leaders have been undeniable as they have continued to lend the time and energy they do have to support these communities. In upcoming issues of *The Hospitalist*, we look forward to spotlighting these communities and their ongoing efforts to promote exceptional patient care and advance the field of hospital medicine.

## Special interest groups

To join a SIG, visit the SHM store on the website at [hospitalmedicine.org/store](https://hospitalmedicine.org/store) and add the SIGs you're interested in to your cart. When you check out, you'll be added as a member.

Current SIG communities:

- **Care for Vulnerable Populations**—Share challenges and solutions related to improving the quality of hospital care for vulnerable and underserved patient populations.
- **Diversity, Equity, and Inclusion**—Partner with fellow hospitalists who are passionate about promoting diversity, equity, and inclusion within the field of hospital medicine. Working together we will improve other aspects

of practice, including patient care, education, research, quality improvement, and professional development.

- **Ethics**—Serves as a resource for discussion, coaching, and mentorship on common and challenging ethical concerns that hospitalists face. This SIG also supports SHM members in collaborating on ethics scholarship, quality improvement projects, and presentations that address ethics in clinical care, education, and policy.
- **Family Medicine**—Network, learn, discuss training, share best practices and challenges, and discuss trends related to hospitalists trained in family medicine.
- **Global Hospital Medicine**—Engage in conversations, networking, expertise, and resource sharing on the topics of global health and human rights work among hospitalists. This space is also a place for those practicing hospital medicine outside of North America to share issues and ideas. This SIG aims to build long-term collaborations in the US and abroad.
- **Healthcare Information Technology**—Share resources and ideas concerning all aspects of healthcare information technology related to patient care.
- **Hospital Medicine Administrators**—Voice your ideas and learn from the unique perspectives of key management and operational leaders in hospital medicine.
- **Hospital Medicine Disaster Preparedness and Management**—Connect with members looking to build a coalition of individuals to help address the role and challenges of hospital medicine in disaster preparedness and management at both a local and national level.
- **Hospital Medicine Fellowships**—This centralized community serves to connect members both interested and/or involved in a mosaic of fellowships across hospital medicine. The aim is to create a networking collaborative that socializes current curricular requirements and opportunities, provides resources for individuals or hospitals looking to start a fellowship or fellowship program, serves as a sounding board for ideas, and socializes the need for fellowship programs.
- **Humanities in Medicine**—A collaborative space to practice close reading of literature, art, and film as they relate to our work in hospital medicine. This space will aim to encourage reflective practice and writing, cultivate empathy, and build a community

of wellness and resilience.

- **Interdisciplinary Rounding**—Network with hospitalists who share an interest in the initiation and maintenance of interdisciplinary rounding (IR) while gaining expertise through structured discussions around implementation strategies, sustainability efforts, and evaluation methods of IR.
- **Med-Peds**—Explore the role of Med-Peds physicians in hospital medicine.
- **Multi-site HMG Leaders**—Network with physicians and administrative leaders responsible for managing multiple hospitalist practice sites within the same health system.
- **Night Medicine**—Join a network of night medicine care practitioners to share experiences and address obstacles unique to working overnight, including but not limited to best practices, teaching, career development, and wellness.
- **NP/PA**—Share collaborative opportunities, best practices, resources, and education to support the professional growth of NPs and PAs.
- **Palliative Care**—Network with hospitalists providing palliative care to share experiences, challenges, and training opportunities.
- **Patient Experience**—Join a group of hospitalists focused on co-designing patient-centered culture resources. Improve and demonstrate patient-centered service behaviors and communication skills. Develop implement and assess the success of strategies to improve the patient experience and care.
- **Pediatrics**—The pediatric hospitalist's home for networking and collaboration.
- **Perioperative/Co-Management**—Network with colleagues, discuss controversial or difficult patient management issues, receive literature and guideline updates, and share best practices for perioperative medicine curriculum, preop clinics, and co-management.
- **Physician Advisors**—Network, discuss challenges, and learn about workflow systems with members who serve as Physician Advisors within their institutions.
- **Point of Care Ultrasound (POCUS)**—Collaborate with other hospitalists who are learning, practicing, or teaching point of care ultrasound.
- **Quality Improvement**—Share resources and collaborate with others focused on quality improvement and patient safety programs.
- **Residents and Medical Students**—Engage with future hospital medicine pioneers, learn from peers, and access unique mentorship opportunities with hospital medicine thought leaders.
- **Rural Hospital Medicine**—Network with colleagues to find solutions to challenges in unique practice environments in underserved locations.
- **Substance Use Disorders**—This group aims to both increase awareness about and improve the quality of care provided to hospitalized patients with substance use disorders.
- **VA Hospitalists**—Connect with VA hospitalists to collaborate on opportunities and best practices, while supporting fellow clinicians' professional growth.
- **Value-Based Care**—This community provides a venue to explore and collaborate around concepts unique to value-based care and how it improves outcomes, patient satisfaction, and clinician satisfaction.

## Chapters

SHM has more than 60 national and six international chapters. The U.S. chapters are grouped in 12 geographic districts, each represented by a district chair who reports chapter business to the SHM Board of Directors.

You're assigned to a chapter based on your location and can easily find chapters by zip code on the SHM website at [hospitalmedicine.org/chapters](https://hospitalmedicine.org/chapters).

To learn about upcoming chapter activities and opportunities to get involved or network with other members online, visit the chapter's community on SHM's online discussion forum, HMX. You can find the community on your HMX Dashboard or under the Chapters tab in the HMX navigation at [hospitalmedicine.org/hmx](https://hospitalmedicine.org/hmx).

Chapters are tasked with setting annual goals and organizing activities that enhance overall membership satisfaction and grow membership. They are recognized for their outstanding work to carry out the SHM mission locally through the annual Chapter Excellence Awards Program.

The award program is comprised of exemplary and status awards, which you can learn more about on the chapter page of SHM's website listed above.

Make 2022 the year you get involved ... if you haven't already. You can learn more about SIGs and chapters on the SHM website.

Not a member of SHM? Join today at [hospitalmedicine.org/join](https://hospitalmedicine.org/join). ■





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