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Denver Health

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Advocacy for you and patients, lessons in supply chain management, and more

Back to basics

Jerome C. Siy, MD, MHA, SFHM, SHM president

here does one begin as we charge into a third year of a pandemic? Hospitalists have leaped hurdle after hurdle to care for COVID-19 patients and those we cared for in congregate living and acute-care-at-home programs. Supply, bed, and workforce shortages weren't the only obstacles we faced. There's been a shortage of patience, compassion, empathy, and respect as well. All these are a toil to our spirits and a challenge to our identity as hospitalists.

Our shared mission has allowed us to emerge triumphant, but not without collateral damage. Our colleagues have left health care, retired early, or fallen ill to the virus. Burnout is rampant, a threat to the health of our specialty and our communities. There's a dire need to support our teams and our hospitalists.

As I entered the role of SHM president, I spoke to Robert Frost's poem "The Road Not Taken" and its message that our unique paths lead us to a common place. During the past two years, that common place is SHM, where we can come together and address our struggles, tackle our challenges, and celebrate our achievements. Yet, during surge after surge, hospitals and SHM struggled to find the tactics to support our teams. How do we lead through this epic struggle when nothing ever seems to be enough? How should SHM support us on the front line?

I'm taken back to my niece's 8th-grade graduation. Her math teacher gave the best graduation address I've ever heard. His advice rang true for me then, as I hope it rings true for you now.

- 1. The world is full of many views. Don't be afraid to express yourself.
- 2. Learn a team sport. Witness the power of shared goals.
- 3. Learn an individual sport. Discover your potential.
- Accomplish something first 4. thing in the morning. It sets the tone for the day.
- 5. Learn to cook, do laundry, and be independent. These practical life skills teach you responsibility.
- Read the classics. Learn 6. about the human condition.
- Have a mentor. Grow. 7.
- Emulate others. Role models 8. inspire you to be a better person.

This is advice to lead us through our growth journey, and perhaps further, as we begin to emerge



from this devastating pandemic.

In many ways, it's back to the basic fundamentals we must build, or rebuild, into our lives and our hospital practices. So many of us have built walls around ourselves, and this advice can help break down those walls. With these words of wisdom, we can emerge, albeit battered, hopefully not broken.

Wave after wave of the pandemic has left me weary and spent, full of shame and guilt for not solving our problems or soothing our pains. No matter the model we devised or the resources we obtained, the pandemic continued to take its toll. I confessed to a colleague that I felt I'd failed my team. They were tired and disillusioned. He said, "We know you're trying, and that's enough...seeing your face here already makes me feel better."

In these and future times, lean on your mentors. My mentor, a retired hospital CEO, was there for me every time I reached out. When we met last, hearing my despair, he wept for me—a vulnerability I didn't expect, and one I often hold back. His tears gave me strength. We need that strength to find our way, again.

Frost and my niece's teacher would have celebrated the way our unique paths and divergent roads have allowed us to develop our individual potential. They'd also be elated we've found a common space in hospital medicine and at SHM, a place where we become a team with shared goals. Without realizing our individual potential and without the power of shared goals, we would not have gotten through these past two years.

Change and adaptation are ever part of hospital medicine. It's time to forge new paths. Continue setting the tone for a meaningful day and developing the life skills we need to care for ourselves and others. Reflect on these past experiences, yours, and everyone's around you. Hold dear the human condition. COVID-19 will not be our last challenge.

Be here for our patients. Be here for yourself. Be here for each other. #HowWeHospitalist

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Allister Crowley

SHM's Leadership Academy

By Samantha C. Shapiro, MD

HM's Leadership Academy was created to address an education gap common among physicians—leadership skills. These skills are not uniformly taught in medical school or post-graduate training programs but they're vital to the success of aspiring hospital medicine leaders. In this article, we share insights on the value of Leadership Academy via shared experiences of participants and faculty.

Insight from a PA

Ilaria Gadalla, DMSc, PA-C, associate professor,

interim assistant dean, physician assistant (PA) department chair, South University, West Palm Beach, Fla., and hospital medicine PA, at Treasure Coast Hospitalists, Stuart, Fla., attended SHM's Leadership Academy a few years ago.



Dr. Gadalla

"I became interested in advocating for PAs in hospital medicine after accepting a new position," Dr. Gadalla said. "There were different opinions about the competency level of advanced practice providers and how best to use us in hospital medicine. Leadership Academy helped me to better communicate, advocate, navigate, and network—especially with upper-level management. I now serve as an interim assistant dean and PA department chair at a university, helping manage several campuses across the nation."

Aside from the new skills she acquired by attending Leadership Academy, Dr. Gadalla also appreciated the welcoming environment. "I was treated equally with physician participants. There was no bias. I was allowed to cultivate the same skills," she said.

From participant to faculty

Kierstin Cates Kennedy, MD, MSHA, FACP,

SFHM, clinical associate professor, interim chief medical officer, at the University of Alabama at Birmingham, Birmingham, Ala., experienced Leadership Academy from both sides of the lectern—participant and faculty. After a wonderful experience with



Dr. Kennedy

her first course, Dr. Kennedy advocated for funds to be built into the budget in her division so that all leaders could participate. She attended a second course, and thereafter transitioned to course facilitator.

"The Strategic Essentials level gives you some perspective about what the executives in the C-suite are concerned about, and what their pressures are," Dr. Kennedy said. "This was eye-opening. It helped me put our requests as frontline hospitalists into context."

"In courses like Mastering Teamwork, you learn more about what goes into building effective teams and the role we play as leaders. Sometimes people don't understand how little things like the way we speak and manage conflict can have an impact on long-term culture. If not done well, this can limit our ability to be effective as

Invest in yourself and the leader you want to be

hospitalist groups," she continued.

Dr. Kennedy also lauded the space the course provides for self-reflection and personal growth. "This is a dedicated block of time to invest in yourself—to think about what your strengths are, and where you have opportunities to grow. If you can just block off three to four days, you can get a ton of professional development information handed right to you. Also, this is a way to network outside your institution so when you come up for promotion, you have colleagues to ask for letters."

As the interim chief medical officer, Dr. Kennedy plans to push for every hospitalist at the University of Alabama at Birmingham to participate in Leadership Academy. She said, "Some of the grumpiest leaders I know have returned from Leadership Academy and said 'Wow—I needed that perspective.' You realize that problems aren't just specific to your group. They're shared by hospitalists everywhere. You see how other institutions approach things and crowdsource information. Then, you bring that home and really innovate."

Insight from a pediatric hospitalist

Kheyandra D. Lewis, MD, MEd, assistant profes-

sor of pediatrics, Drexel University College of Medicine, associate program director of the pediatric residency program, and attending physician, section of hospital medicine at St. Christopher's Hospital for Children in Philadelphia,



shares her experience as a faculty presenter.

Like many of you, Dr. Lewis has participated in faculty development programs through her own institution. However, Leadership Academy offers additional benefits that local programs might not. She said, "SHM's Leadership Academy allows you to grow your sphere of influence. It can be helpful to get perspectives of people outside your own institution since you can learn about other resources out there."

Dr. Lewis also enjoyed the collegiality of the program. "It's a nice experience since I work in a free-standing children's hospital and don't often get to collaborate with adult hospitalists."

Insight from a leadership guru

Leonard J. Marcus, PhD, the director of the

program for health care negotiation and conflict resolution, and founding co-director of the National Preparedness Leadership Initiative, Harvard T.H. Chan School of Public Health and Harvard Kennedy School of Government,



Cambridge, Mass., offered Dr. Marcus an expert perspective on why the Leadership Academy is so valuable to hospitalists, especially in the post-COVID-19 era. The theme of Dr. Marcus's leadership instruction is Meta-Leadership—which is designed to provide the tools leaders need to act and direct others in emergency situations. It's also the basis for Dr. Marcus's and his colleagues' book, "You're It—Crisis, Change, and How to Lead When it Matters Most."

Dr. Marcus said, "Often physicians will move

SHM's Leadership Academy 2022

SHM's Leadership Academy is the only leadership program tailored specifically to hospitalists.

It includes four courses running concurrently over four days:

- **Strategic Essentials** recommended for residents, early career hospital medicine professionals, first-time hospitalist leaders, hospitalist leaders who want to strengthen or broaden their leadership skills and advance their career.
- **Influential Management** recommended for early to mid-level career hospitalists and hospitalist leaders who want to enhance their leadership skills in specific areas.
- **Mastering Teamwork** recommended for hospitalists with three plus years of experience and hospitalist leaders who want to advance their career to the organizational strategy level.
- **Capstone** to attend this course you must have attended at least one previous Leadership Academy course.

Leadership Academy 2022 will be held May 23-26, in Scottsdale, Ariz.

SHM's Leadership Academy is a unique opportunity to hone leadership skills, network, and learn from the shared experiences of colleagues in hospital medicine. It prepares clinical and academic leaders with vital leadership skills traditionally not taught in medical school or typical residency programs.

In the post-COVID-19 era, these skills will be more important than ever, especially for those looking to step into leadership roles in their divisions.



into positions of leadership because they are the best practitioner in their division, but they don't necessarily focus on building their leadership skills. So, they find themselves leading their group without the training on how to do it, or how to do it well."

"Right now, health care systems are facing challenges that have never been faced before due to COVID-19. Both clinicians and patients are feeling vulnerable. Health care systems are in distress. In the future, we're going to have to translate these experiences into how we deliver care and assure the health of the population via public health. Strong leadership skills will be crucial for hospitalists, and the Leadership Academy is an opportunity to focus on those skills," he continued.

Dr. Marcus said, "Questions of resilience, recovery, and change will be key on the other side of the pandemic, so strong leadership skills and capabilities will be absolutely essential for hospitalists going forward."

Samantha C. Shapiro, MD, is a board-certified internist, rheumatologist, and affiliate faculty member of the Dell Medical School at the University of Texas at Austin. She received her training in internal medicine and rheumatology at Johns Hopkins University, Baltimore. This advertisement is not available for the digital edition.

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Denver Health research reviews

the Literature

By Kimberly A. Indovina, MD; John Cunningham, MD; Anna Munoa, MD; Nicholas Scaletta, MD; Julie Knoeckle, MD; Sahar Taghvaei, MD

Division of internal medicine, University of Colorado School of Medicine, Denver

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By Kimberly A. Indovina, MD

Consider post-discharge VTE prophylaxis for COVID-19 patients

CLINICAL QUESTION: Should extended

post-discharge venous thromboembolism (VTE) prophylaxis be prescribed for patients with COVID-19?

BACKGROUND: While VTE

prophylaxis during hospi-

talization for COVID-19 is

widely recommended, the

role of extended, post-dis-

charge VTE prophylaxis is

unclear.



Dr. Indovina

STUDY DESIGN: Open-label, multicenter, randomized trial

SETTING: 14 centers in Brazil

SYNOPSIS: 320 patients hospitalized with COVID-19 and at increased risk for VTE (IM-PROVE score ≥4 or 2-3 plus D-dimer >500 ng/ mL) were randomized to receive rivaroxaban 10 mg daily or no anticoagulation for 35 days after discharge. Patients were monitored for symptomatic VTE and underwent bilateral lower extremity doppler ultrasound and computed tomography pulmonary angiogram at day 35 to evaluate for asymptomatic VTE. The primary efficacy outcome, a composite of thromboembolism events, occurred in 3% of the rivaroxaban group versus 9% of the control group (RR 0.33, 95% CI 0.12-0.9; P=0.0293). No major bleeding occurred in either group.

BOTTOM LINE: In patients at high risk for VTE, prophylactic rivaroxaban for 35 days after hospitalization for COVID-19 improved clinical outcomes.

CITATION: Ramacciotti E, et al. Rivaroxaban versus no anticoagulation for post-discharge thromboprophylaxis after hospitalization for COVID-19 (MICHELLE): an open-label, multicentre, randomised, controlled trial. Lancet. 2022;399:50-59.

Midline catheters may be safer than PICCs

CLINICAL QUESTION: Are midline catheters safer than peripherally inserted central catheters (PICCs)?

BACKGROUND: Use of midline catheters instead of PICCs has grown, but evidence of their comparative safety is inconclusive.

STUDY DESIGN: Observational cohort study

SETTING: 48 hospitals in Michigan

SYNOPSIS: Multi-hospital registry data was examined for 5,758 patients with PICCs and 5,105 with midlines placed for either difficult venous access or short-term intravenous antibiotics. PICCs were more likely than midlines to be associated with a composite of major complications (OR 1.99; 95% CI, 1.61-2.47). Specifically, PICCs had higher rates of catheter occlusion (7% versus 2.1%; P<0.001) and bloodstream infection (1.6% versus 0.4%; P<0.001) than midlines, but a similar rate of VTE. However, in time-to-event models, midlines had greater daily hazard of DVT than PICCs.

BOTTOM LINE: Compared to patients with midlines, patients with PICCs were nearly twice as likely to experience a major complication.

CITATION: Swaminathan L, et al. Safety and outcomes of midline catheters vs peripherally inserted central catheters for patients with short-term indications: a multicenter study. JAMA Intern Med. 2022;182(1):50-58.

Dr. Indovina is a hospitalist at Denver Health, Denver and an assistant professor in the division of internal medicine, University of Colorado School of Medicine.

By John Cunningham, MD



CLINICAL QUESTION: Does measurement of ultrasound jugular venous pressure (JVP) height by ultrasound (uJVP) in the semi-upright position accurately predict right atrial pressure (RAP) based on invasive hemodynamics?

BACKGROUND: Bedside JVP assessment is limited by body habitus and neck thickness. Point of care ultrasound (POCUS) assessment of

inferior vena cava (IVC) diameter and collapsibility is a suboptimal test. Assessment via uJVP is reliable but has not been validated against invasive right-heart pressure measurements.



STUDY DESIGN: Conve-

nience sample of adults greater than 18 undergoing right heart catheterizations.

SETTING: Two academic hospitals

SYNOPSIS: 100 patients underwent a POCUS uJVP quantitative measurement and a qualitative upright uJVP assessment (a binary assessment of elevated RAP versus normal) prior to measurement of RAP on right-heart catherization. Ultrasound JVP was measured at the point where the internal jugular vein was smaller than the adjacent carotid artery throughout the respiratory cycle; 5 cm was added to the vertical distance to the sternal angle.

The interclass correlation coefficient was 0.97, indicating good interobserver agreement. There was a correlation between uJVP and invasive RAP measurement (r = 0.79) and the receiver-operating characteristic analysis of the uJVP predicted RAP with an area under the curve (AUC) of 0.84 (95% CI, 0.76- 0.92). Qualitative upright uJVP had a sensitivity of 54.5% and specificity of 94.6% for predicting elevated RAP. uJVP was assessed in all 100 patients whereas visual JVP was possible in 42/69 patients examined.

BOTTOM LINE: Assessment via uJVP accurately predicts RAP with good interobserver agreement.

CITATION: Wang L, et al. Accuracy of ultrasound jugular venous pressure height in predicting central venous congestion [published online ahead of print, 2021 Dec 28]. Ann Intern Med. 2021 Dec 28. doi: 10.7326/M21-2781.

Improved cardiovascular outcomes with CABG compared to FFR-guided PCI in patients with three-vessel CAD

CLINICAL QUESTION: How does fractional flow reserve (FFR)-guided percutaneous intervention (PCI) with second-generation drug-eluting stents compare with coronary artery bypass grafting (CABG) in patients with three-vessel coronary artery disease (CAD)?

BACKGROUND: Randomized trials show that CABG improves outcomes when compared to PCI in patients with three-vessel CAD. However, these studies rarely used second-generation drug-eluting stents or FFR-guided PCI. Second-generation stents and FFR-guided PCI both improve cardiovascular outcomes compared with angiography-guided PCI or medical therapy.

STUDY DESIGN: Multi-center, international,



IN THE LITERATURE

randomized, controlled trial using intention-to-treat analysis.

SETTING: International multi-center trial with 48 sites.

SYNOPSIS: 1,500 patients with angiographically identified three-vessel CAD not involving left main disease were randomly assigned to undergo CABG or FFR-guided PCI. Only stenoses with an FFR of 0.80 or less were treated with PCI. Patients with recent ST-elevation myocardial infarction, cardiogenic shock, and an ejection fraction less than 30% were excluded. The primary composite end point was the occurrence of death from any cause, myocardial infarction, stroke, or repeat revascularization within one year.

At one year, the composite primary end point occurred in 10.6% versus 6.9% (hazard ratio, 1.5; 95% CI, 1.1-2.2; P=0.35) in the FFR-guided PCI group versus the group who underwent CAGB. This did not meet the prespecified cutoff for non-inferiority.

BOTTOM LINE: CABG resulted in a lower incidence of the composite of death, myocardial infarction, stroke, and repeat revascularization at one year compared to FFR-guided PCI in patients with three-vessel CAD.

CITATION: Fearon WF, et al. Fractional flow reserve-guided PCI as compared with coronary bypass surgery. N Engl J Med. 2022 Jan 12;386(2):128-137. doi: 10.1056/NEJMoa2112299.

Dr. Cunningham is a hospitalist at Denver Health, Denver and an assistant professor in the division of internal medicine, University of Colorado School of Medicine.

By Anna Munoa, MD

Inpatient addiction-medicine consultation services decrease 90-day mortality and seven-day readmission rates, but not 30-day readmission rates or ED utilization

CLINICAL QUESTION: Do inpatient addic-

tion-medicine consultation services (AMCS) affect patient mortality and medical utilization post discharge?

BACKGROUND: AMCS are increasingly common in inpatient medical settings, but there is limited research on their impact on patient outcomes.

STUDY DESIGN: Propensity-score-matched case-control study

SETTING: Large urban academic hospital with a large suburban and rural catchment area across Western Pennsylvania

SYNOPSIS: Each patient with an addiction-medicine consult was paired with a control patient with a similar propensity score. The main outcome was readmission rates, emergency department visits, and mortality within 90 days.

Patients referred to AMCS had reduced 90day mortality by 2.35%; sub-analysis showed a decrease by 4.08% with exclusively an alcohol use disorder (AUD) and 3.21% with exclusively an opioid use disorder (OUD). The authors identified the potential role of OUD medications as the likely cause of decreased post-discharge mortality; however, the mechanism by which mortality was decreased for AUD is unclear.

There was a significant reduction in the seven-day readmission rate, but no reduction in readmissions at 30 days. Patients with polysubstance use disorder saw the least impact from AMCS.

Interestingly, there was an increase in emergency-department visits of 5.32%. The authors postulated that patients who previously avoided care due to poor experiences and stigma were now more open to seeking care due to positive interactions with the AMCS.

BOTTOM LINE: AMCS significantly reduced mortality at 90 days and short-term seven-day readmissions with the greatest impact on patients with only AUD or OUD.

CITATION: Wilson J, et al. Inpatient addiction medicine consultation service impact on post-discharge patient mortality: a propensity-matched analysis. J Gen Intern Med. 2022 Jan 25. doi: 10.1007/s11606-021-07362-8.

Higher-than-expected recurrent VTE found in patients with isolated SSPE

CLINICAL QUESTION: What is the recurrence rate of venous thromboembolism (VTE) in patients with isolated subsegmental pulmonary embolisms (SSPE) managed without anticoagulation?

BACKGROUND: Despite increasing frequency of acute pulmonary embolism, the mortality rate has not changed. The clinical significance and need for anticoagulation in SSPE is unknown.

STUDY DESIGN: Multi-center prospective cohort study

SETTING: 18 international sites between February 2011 and February 2021

SYNOPSIS: This study enrolled patients with a new diagnosis of isolated SSPE without evidence of deep venous thrombosis. Those with distal thrombosis received anticoagulation at the treatment discretion of the physician. Patients with increased risk of thrombosis or alternative need for anticoagulation, such as active cancer, history of VTE, and pregnancy were excluded.

The primary outcome was recurrent VTE. The authors hypothesized the recurrence rate would be 1%. This study found a cumulative reoccurrence rate of 3.1% (8 of 266 patients). Sub-analysis showed a recurrence rate of 2.1% for a single SSPE and 5.7% for multiple SSPEs. Those with distal venous thrombosis had a recurrence rate of 12.5%. The lowest reoccurrence rate was 1.8% in patients under 65 years old with a single SSPE identified. No patients had a fatal recurrent pulmonary embolism during the study period.

BOTTOM LINE: There were higher rates than expected of recurrent VTE after SSPE, especially in patients >65 years old or with distal venous thrombosis.

CITATION: Le Gal G, et al. Risk for recurrent venous thromboembolism in patients with subsegmental pulmonary embolism managed without anticoagulation: a multicenter prospective cohort study. Ann Intern Med. 2022;175(1):29-35. doi: 10.7326/M21-2981.

Dr. Munoa is a hospitalist at Denver Health, Denver and an assistant professor in the division of internal medicine, University of Colorado School of Medicine.

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By Nicholas Scaletta, MD

Effectiveness of an analytics-based intervention for reducing sleep interruption in hospitalized patients

CLINICAL QUESTION: Can a clinical-deci-

sion-support tool enable physicians to identify hospitalized patients who are stable enough to have their nighttime vital-sign checks discontinued?

BACKGROUND: Sleep

disturbance is a common and unwelcome aspect of hospitalization. Previous



studies show that iatrogenic sleep disruption is common in hospitalized patients. Prior evidence suggests that nighttime vital-sign checks could safely be eliminated in lower-risk medical patients.

STUDY DESIGN: Randomized controlled trial

SETTING: Single-center academic hospital

SYNOPSIS: The study group developed a clinical-decision-support tool to identify patients at low risk of developing abnormal vital signs overnight. Clinicians randomized to the intervention arm received an electronic health record (EHR) order prompt for low-risk patients to potentially receive "sleep promotion vitals." Although the intervention did not lead to a difference in the primary outcome of incidence of delirium, it did lead to a difference in nighttime vital-sign checks and a clinically significant increase in sleep opportunity (4.95 hours versus 4.57 hours). There was no increase in ICU transfers (49 [5%] versus 47 [5%]) or code blues (2 [0.2%] versus 9 [0.9%]) in the intervention group.

BOTTOM LINE: A prediction algorithm embedded in a clinical-decision-support tool can be used to help physicians identify low-risk patients who can safely have nighttime vital-sign checks discontinued.

CITATION: Najafi N, et al. Effectiveness of an analytics-based intervention for reducing sleep interruption in hospitalized patients: a randomized clinical trial. JAMA Intern Med. 2022;182(2):172-177. doi: 10.1001/jamainternmed.2021.7387. PMID: 34962506; PMCID: PMC8715385.

Safe to treat mild acute diverticulitis without antibiotics outside the hospital?

CLINICAL QUESTION: Can clinicians successfully manage mild acute diverticulitis on an outpatient basis without antibiotics?

BACKGROUND: Incidence of diverticular disease is increasing, with as many as 25% of patients with diverticulosis suffering an episode of acute diverticulitis in their lifetime; 75% of these cases present without complications. Previous evaluation has shown that patients with mild acute diverticulitis can achieve good outcomes with conservative management.

STUDY DESIGN: Randomized, controlled, noninferiority trial

SETTING: 15 hospitals throughout Spain

SYNOPSIS: 480 patients with mild acute diverticulitis as defined by stable clinical status, no significant comorbidities, and a Neff 0 acute diverticulitis on CT scan (local swelling of the colon without evidence of perforation or



abscess) were randomized in the emergency department after achieving successful symptom control. Patients in the experimental arm were discharged with symptomatic control consisting of ibuprofen 600 mg alternating with acetaminophen 1 g every eight hours for seven days. Patients in the control group were discharged with a seven-day course of amoxicillin/clavulanic acid 875mg/125 mg. There was no statistically significant difference in the antibiotic versus non-antibiotic groups in ED revisits (16/236 [6.72%] versus 14/238 [7.02%]), hospitalization (14/238 [5.8%] versus 8/242 [3.3%]) or pain control at 90 days. None of the patients who were readmitted in either group required emergent surgical intervention.

BOTTOM LINE: Mild acute diverticulitis treated outside the hospital without antibiotics is a safe and effective strategy that does not lead to increased emergency-department visits, hospitalizations, or complication rates when compared to outpatient management with antibiotics.

CITATION: Mora-López L, et al. Efficacy and safety of nonantibiotic outpatient treatment in mild acute diverticulitis (DINAMO-study): a multicentre, randomised, open-label, noninferiority trial. Ann Surg. 2021;274(5):e435-e442. doi: 10.1097/ SLA.000000000005031. PMID: 34183510.

Dr. Scaletta is a hospitalist at Denver Health, Denver and an assistant professor in the division of internal medicine, University of Colorado School of Medicine.

SHORT TAKES

Factors associated with primary non-responsiveness to antibiotics in adults with uncomplicated acute appendicitis

In a secondary analysis of the APPAC II randomized controlled trial comparing oral antibiotic monotherapy versus IV followed by oral antibiotics for CT-confirmed uncomplicated acute appendicitis, appendiceal diameter ≥15 mm had an adjusted relative risk (ARR) of 5.5, and a body temperature >38 °C had an ARR of 4.1 for antibiotic non-responsiveness in patients initially managed with antibiotics.

By Julie Knoeckle, MD

No difference between balanced multi-electrolyte solution versus saline in critically ill adults

CLINICAL QUESTION: Does use of a balanced

multi-electrolyte solution (BMES) for fluid resuscitation in adults admitted to an intensive-care unit (ICU) impact 90-day mortality?

BACKGROUND: Recent

evidence¹ suggests that use of saline, when compared to BMES, for resuscitation in critically ill patients leads to

increased rates of acute kidney injury and threeday mortality, yet clinical uncertainty remains.

Dr Knoeckle

STUDY DESIGN: Double-blind, randomized,

CITATION: Haijanen J, et al. Factors associated with primary non-responsiveness to antibiotics in adults with uncomplicated acute appendicitis: a prespecified secondary analysis of a randomized clinical trial. JAMA Surg. 2021;156(12):1179-1181. doi: 10.1001/jamasurg.2021.5003.

Julie Knoeckle, MD

controlled trial

SETTING: 53 ICUs in Australia and New Zealand

SYNOPSIS: Between September 2017 and December 2020, 5,037 patients admitted to the participating ICUs with a clinical indication for fluid resuscitation were enrolled. The treating clinicians were blinded to fluids used. All other treatment decisions, including amount and rate of fluid, were at the discretion of the clinician. Baseline characteristics of the two groups were well-matched and included surgical patients.

Physiologic outcomes, such as serum chloride, trended lower in the BMES group in the first seven days. However, there was no significant difference in any of the clinical outcomes assessed, including the primary outcome of 90-day mortality and secondary outcomes of peak serum creatinine in first seven days, maximum increase in creatinine level during ICU stay, and



while welcoming positive change and helping members continue to deliver high quality care to patients."

Steve Phillipson, MD, FHM

Treating Hyponatremia?





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IN THE LITERATURE

receipt of new renal-replacement therapy.

BOTTOM LINE: Resuscitation with BMES (Plasmalyte-148) compared to saline in ICU patients did not reduce the risk of death or acute kidney injury in this large, multi-center study.

CITATION: Finfer S, et al. Balanced multi-electrolyte solution versus saline in critically ill adults. *N Engl J Med.* 2022 Jan 18. doi: 10.1056/ NEJMoa2114464. Epub ahead of print. PMID: 35041780.

1. Semler, et al. Balanced crystalloids versus saline in critically ill adults. *N Engl J Med*. 2018;378(9):829-839.

Dr. Knoeckle is a hospitalist at Denver Health, Denver and an assistant professor in the division of internal medicine, University of Colorado School of Medicine.

By Sahar Taghvaei, MD Efficacy of remdesivir in high-risk non-hospitalized patients

CLINICAL QUESTION: Does the use of remde-

sivir therapy in symptomatic, non-hospitalized, COVID-19 patients reduce disease progression and hospitalization?

BACKGROUND: Remdesivir improves morbidity and mortality in hospitalized patients with moderate to severe COVID-19 infec-

tion; however, data regarding remdesivir use in



SHORT TAKES

Vitamin-D deficiency linked to severe COVID-19 infection

A large retrospective case-control study showed an inverse association between vitamin-D levels and both the risk of SARS-CoV-2 infection and also the severity of disease when infected.

CITATION: Israel A, et al. Vitamin D deficiency is associated with higher risks for SARS-CoV-2 infection and COVID-19 severity: a retrospective case-control study [published online ahead of print, 2022 Jan 9]. *Intern Emerg Med.* 2022;1-11. doi: 10.1007/s11739-021-02902-w.

Sahar Taghvaei, MD

non-hospitalized, high-risk, infected patients has been lacking.

STUDY DESIGN: Randomized, double-blind, placebo-controlled

SETTING: US, Spain, Denmark, and UK–infusion centers, skilled-nursing facilities, and at home

SYNOPSIS: Unvaccinated patients 12 years or older with at least one risk factor for severe COVID-19, or those older than 60 regardless of risk factor(s) were enrolled at 64 sites worldwide. Patients had at least one symptom of COVID infection for seven days by enrollment. 562 patients underwent 1:1 randomization to receive either remdesivir or placebo infusions. The remdesivir group received a three-day course of infusion at 200 mg on day one then 100 mg on days two and three. The primary efficacy endpoint was a composite of hospitalization related to infection or death from any cause by day 28. Patients who received remdesivir had an 87% lower risk of COVID-19-related medical visits or all-cause death. Notably, the effectiveness of remdesivir in non-hospitalized patients with COVID-19 was comparable to monoclonal antibody treatment, which has less widespread availability. Study limitations include a low number of patients with liver or kidney disease, lack of racial diversity with greater than 79% white patients in each arm, and the exclusion of vaccinated patients.

BOTTOM LINE: High-risk, non-hospitalized patients with COVID-19 treated with remdesivir had a significantly lower progression to hospitalization and death at 28 days.

CITATION: Gottlieb RL, et al. Early remdesivir to prevent progression to severe COVID-19 in outpatients. *N Engl J Med.* 2022;386(4):305-315. doi: 10.1056/NEJMoa2116846.

Dr. Taghvaei is a hospitalist at Denver Health, Denver and an assistant professor in the division of internal medicine, University of Colorado School of Medicine.





SHM's 2022 Awards of Excellence Winners

Thank you to these extraordinary members for the contributions they have made to hospital medicine this year.

Clinical Leadership for Physicians Marisha Burden, MD, SFHM

Clinical Leadership for NPs/PAs Kasey Bowden, MSN, FNP, AGACNP

Diversity, Equity, & Inclusion Leadership Amira del Pino-Jones, MD

Excellence in Humanitarian Services Ingrid Pinzon, MD, CHCQM-PHYADV

Excellence in Teamworl The Buprenorphine Team, Dell Medical School

hospitalmedicine.org/awards

Excellence in Research *Derek Williams, MD, MPH*

Excellence in Teaching *Christopher Moriates, MD*

Junior Investigator Micah T. Prochaska, MD, MSc

Outstanding Service in Hospital Medicine Amith Skandhan, MD, SFHM

The evolution of the hospitalist

By Vivek S. Ramanathan, MD, MBA, CPE, FHM and Elizabeth Chmelik, MD, FAAFP, SFHM

he term hospitalist was coined in 1996 in a New England Journal of Medicine article written by Dr. Robert Wachter—often considered the father of the field. The need was clear: hospitals wanted a physician dedicated to the care of inpatients on a 24/7 basis. Hospitals and patients have benefited tremendously, and hospital medicine has become the fastest-growing medical specialty in U.S. history. But were we ever meant to belong to the hospital as our name and title suggest?

The goals have shifted

With the advent of value-based care, the goals have shifted and are now financially aligned with quality in the continuum of care rather than just one venue. With more than 25 years of being champions of the hospital, we're uniquely positioned to help drive this change and evolve professionally in the process.

As a part of a larger medical community, are we generating value for our patients? If value were defined as an increase in quality and a decrease in cost. the answer would be "no" on both counts. As a nation, a commonly vaunted statistic is that U.S. health care spending is growing two to three times that of the nation's Gross Domestic Product.¹ Still, in terms of quality outcomes (age-adjusted mortality, disability-adjusted life years, health care access and quality, etc.), we rank far below comparably developed countries.

But as hospitalists, how accountable are we for the state of our current health care system? Undoubtedly, in terms of quality within the hospital, we've improved patient safety and satisfaction.

Today's hospital is unrecognizable from the hospital of 20 years ago, thanks in large part to the hospitalists that drove change. But, in terms of *measured* cost, we've reduced it by reducing length of stay, but increased it through documentation and consultation. If we take post-discharge planning as an example, why are we not more engaged in where the patient goes next? Put simply, because it doesn't affect us anymore. We've become hospital-centric and not patient-centric.

Coordinating with PCPs

The forgotten person in this whole endeavor has been the

Embracing value-based care

primary care physician (PCP). Once held in awe by the patient (as carer-in-chief) and hospital (as supplier-in-chief) alike, PCPs have been relegated to the role of someone looking in from the outside. The notion of that all-encompassing PCP, who knew their patients well and followed them to every medical setting, was a fallacy of course, but was a dream worth dreaming.

The holy trifecta in industry and health care is time, quality, and cost. Because of lack of time, PCPs wanted to be in the hospital but couldn't. Hospitalists want to coordinate care beyond the hospital but don't. The cost goes up, and the quality goes down. Clearly, practice patterns have changed, and we cannot go back to the past; with the gains we've had within the hospital, we wouldn't want to.

Value-based health care represents an opportunity for the hospitalist community to be a change agent in our current health care crisis through delivering quality and not quantity to our patients.

Patient value

If 50% of Medicare spending is in the acute episode of care (anchor admission plus post-acute stay, Part B, durable medical equipment, and readmissions), hospitalists are in a prime position to affect that spending if we change our goals and thought processes to that of patient value, not just hospital value.² A growing number of provider organizations-private, hospital, and primary-care groups-are now committing to educating their hospitalists in value-based care. This is not to diminish the tremendous value they have already brought to the hospital, but now the goal is to create value beyond those four walls. But how will this evolution into value-based hospitalists occur?

We have to start with determining if admission to the hospital is even warranted. This would include observing, working with our PCP partners in turning patients around in the emergency department (ED), obtaining close follow-up, and referring patients into their network of specialists as outpatients. For those who do require admission, the advent of teleservices will give patients lower-cost alternatives, such as hospital at home and skilled-nursing facility at home directly from the ED.

Hospitalists' incentives must be aligned with metrics that bring actual value to the patient. Examples would include total length-of-stay (LOS)/spend (in 90 days), readmissions, and post-acute utilization/ next site-of-care. Using proxy measures for these end goals like advanced-care planning discussions, the number of PCP warm hand-offs and a reduction in the number of consultations will help drive some of those more traditional numbers. We could then do away with key performance indicators that add little to actual patient care, such as case mix index and the resultant over-focus on documentation, hospital LOS, and Hospital Consumer Assessment of Healthcare Providers and Systems, better known as HCAHPS (which we all know is an imperfect measure of patient satisfaction at best).

Maybe a partial return to our roots is in order. We could get there by working in different settings, much like a traditional internist or family physician would. To understand and appreciate the care journey patients and families endure, we should struggle along with them. We believe this will make us better holistic physicians. As often mentioned with the advent of more advanced teleservices, we wouldn't have to be physically in a rehab or post-acute discharge clinic, per se, but could connect with those same patients remotely.

We cannot have a carte-blanche approach to all our patients. We should identify and focus on highrisk, high-opportunity patients. We need to have targeted interventions and workflows that pertain to the key metrics discussed. Examples could include early goals-of-care conversations, "meds to beds," and an increased focus on scheduling transition appointments before leaving the hospital for those patients with multiple comorbidities, previous readmissions, and/or for the elderly.

Value-based care

Lastly and most importantly, our own self-value as a profession is at stake here. As a highly subsidized group of specialists, we've become detached from the hospital's contribution. Hospitals and hospital systems can no longer sustain this level of spending, and our daily census continues to rise as a result.

We continue to live in a fee-forservice world, but salaries can no longer be sustained by volume. The hospitalist community has banded together during the pandemic like never before and should have felt thoroughly appreciated. But



Dr. Ramanathan Dr. Chmelik

Dr. Ramanathan is the regional medical director of value-based care, northeast division, at Sound Physicians in Upland, Pa.

Dr. Chmelik is the senior medical director at Greater Texas Care & Value, and the chief of enterprise hospitalist services at WellMed Medical Management, Inc. in San Antonio.

there is a disconnect between that perception and the reality, exemplified by the statistic of only a third of hospitalists belonging to our national society and a large proportion reverting to per diem or locum tenens work.

To address this new and exciting landscape for care delivery, SHM has established a special interest group (SIG) for value-based hospitalists. The goal is to discuss freely ways in which hospitalists can start bringing value to the entirety of patients' journeys. The group will include a wealth of physician expertise flowing from payers to providers. We hope to define what quality truly is, while generating ideas for the reduction in cost for the population as a whole. To get involved with the Value-Based Hospitalist SIG and explore other SIGs, visit hospitalmedicine.org/ SIGs.

Value-based health care represents an opportunity for the hospitalist community to be a change agent in our current health care crisis through delivering quality and not quantity to our patients. Our horizons have just broadened beyond what our title suggests.

References

1. CMS. National Health Expenditure Data. https://www.cms.gov/Research-Statistics-Data-and-Systems/ Statistics-Trends-and-Reports/National-HealthExpendData/NationalHealthAccountsHistorical. Accessed 3/8/2022.

2. Sound Physicians. Medicare Limited Dataset, 2020. ArborMetrix analysis.

Learn more about SIGs and the Value-Based Care Group.





Workforce Issues

Silver linings emerge for hospitalists

By Karen Appold

or Elisabeth Souther, MD, chief of hospital medicine at Dartmouth-Hitchcock Medical Center, a rural, academic hospital with almost 400 beds in Lebanon, N.H.,

the last two years have been challenging beyond belief. "In the spring of 2020, we were dealing with a disease we knew virtually nothing about,

we didn't know if personal protective equipment (PPE) would protect us, we had no idea if we had enough PPE, we were concerned that members of our own ranks would die from COVID-19, and we didn't know how long the pandemic would last," she said.



Dr. Souther

"We did what we do best as doctors—we cared for patients, and we kept going even though every step was hard."

The tolls and challenges related to the coronavirus have certainly changed over the past two years, Dr. Souther continued. "In the beginning, we were concerned about our own personal safety and the fear of what we didn't know," she said. "Now, we worry about compassion fatigue in our hospitalists, given the politicization of COVID-19 vaccines and therapies. It's hard to be a compassionate, caring doctor when patients insist on alternate therapies or when dying COVID-19 patients' families refuse to believe that COVID-19 is a real disease."

Dr. Souther also worries about the long-term effects of burnout. "Our team has tried to maintain the mantra of 'this is a marathon, not a race,' but the pandemic is turning into an ultramarathon and many of us are tired," she said.

Likewise, Daniel J. Brotman, MD, MHM, division director of hospital medicine at Johns Hopkins Hospital in Baltimore, an academic hospital with more than 1,000 beds, said the pandemic is getting old and tiring. "Burnout was already an issue pre-pandemic," he said. "Now, hospitalists have to deal with additional person

al and professional challenges such as: trying to

do clinical work while caring for children who lack reliable childcare; social isolation at work and home; added friction in clinical care including the challenges of discharging patients with COVID-19; and having fewer staff

members in the hospital to help with care coordination and covering for sick colleagues."

Dr. Brotman

Additionally, Dr. Brotman said the controversy and polarization around vaccination have led to compassion fatigue and bitterness. "It's easy to get angry at patients who are overflowing our hospitals and the ill-informed social media forces that brainwashed them," he said.

Effects on leadership

With the ongoing challenges that resulted from the pandemic, some hospitalists remained capable leaders while others felt a need to step down. Dr. Souther said her leadership team remained strong and intact. "We watched out for each other and worked well as a team," she said. "If one team member seemed down, another picked up the slack. Regular, honest communication saved us. Our administration has supported us every step of the way and we've had a seat at the table to discuss and support COVID-19 policy changes."

Albert I. Soriano, MD, FACP, director of medical operations for the department of hospital medicine at Sentara Medical Group in Hampton Roads, Va., has seen existing leaders become better leaders. "Hospitalist leaders helped create solutions, assisted in crisis management, and have improved



seen informal leaders step up to help find clinical and process solutions." Soriano oversees seven of the group's 12 hospitalist programs, approximately 1,800 beds.

On the flip side, Venkatrao Medarametla, MD, MBA, medical director of

hospital medicine at Baystate Health in Springfield, Mass., an academic facility with 750 beds, has seen hospitalist leaders resign or retire early due to the pressures of hospital capacity issues and not having enough staff to



Dr. Medarametla

manage the increasing census. "A paucity of resources, inadequate empathy toward our struggles, and the relentless pressure to free up capacity from management have affected the morale of many capable and strong leaders, causing them to step down from leadership roles," he said.

While Tomas Villanueva, DO, MBA, FACPE,

SFHM, principal of clinical operations and quality at Irving-Texas based Vizient, Inc., a health care performance-improvement company where he consults with hospitals nationwide, hasn't seen the "great resignation" among hospital medicine leadership nor



Dr. Villanueva

faculty within the hospital's teams. However, he has seen more seasoned hospitalists transition into part-time positions. This has worsened staffing issues and affected operational efficiencies because they're more dependent on less-experienced physicians.

Ramesh Adhikari, MD, MS, SFHM, a hospitalist and geriatrician in the department of hospital medicine at Franciscan Health in Lafayette, Ind., who works at three rural hospitals with 25 to 200 beds, said that due to a huge surge in hospitalizations during the delta and omicron waves, hospitalist leaders have had to

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work almost daily to help with staffing shortag-

es. Consequently, he saw leaders work every single day. Given these demands, hospitalist leaders around the country have stepped back from their roles. Some leaders are sharing the responsibility with co-directors to reduce burnout.



Clinical challenges

At the beginning of the pandemic, protocols on how to treat COVID-19 were limited. Hospitalists collected data on each patient and developed the best possible treatment plans. "Some hospitalists had to perform procedures that they hadn't done since their residency training," said Brooke Meadors, director of provider strategy at Vivian Health, a national health care hiring marketplace based in San Francisco. "They had to freshen up their skills or practice outside their scope of practice."

For Dr. Villanueva, who is also a hospitalist and internal medicine physician at a Florida community hospital with 1,000 beds, a big challenge is treating coronavirus patients with chronic conditions. "Oftentimes, we don't know if a COVID-19 infection will further complicate a chronic condition and if treating COVID-19 will complicate or contradict a chronic condition's treatment," he said.

Hospitalists at Franciscan Health were challenged with caring for complicated patients who, pre-COVID-19, would have been transferred to higher-level centers. This wasn't possible, however, because other centers were at capacity. To care for these patients, Dr. Adhikari and his colleagues consulted specialty physicians via telemedicine within their health system and other hospitals through transfer centers for phone consults, who advised them on how to make the most of their limited resources.

Constantly changing practice standards and treatment guidelines, as well as insufficient time to keep up with updates, inhibited maintaining a work/life balance, Dr. Medarametla said. He also grappled with testing delays and insurance-coverage issues.

Furthermore, Dr. Medarametla had to follow resource-allocation policies and couldn't offer lifesaving treatments such as ventilators to certain patients. "Having challenging conversations about the end of life with patients and families due to inadequate resources added stress that I never experienced before," he said.

Career challenges

The pandemic paused career growth for many hospitalists. With increased stress levels and a focus entirely on clinical management, most hospitalists didn't have enough time to attend continuing-medical-education events and professional-development courses, said Dr. Medarametla, who is also the president of the Western Massachusetts chapter of SHM. Hospitalists' attendance at SHM chapter events

remained low despite providers making them virtual, allowing non-members, and expanding offerings to residents and advanced practitioners. He also noticed decreased attendance at national meetings.



Dr. Kennedy

Kierstin Cates Kennedy, MD, MSHA, FACP, SFHM, interim chief medical officer of hospital medicine at the University of Alabama at Birmingham, an academic hospital with 1,200 beds, said clinical-care demands significantly affected hospitalists' ability to devote energy to non-clinical activities, such as teaching, research, quality-improvement efforts, and leadership roles. "This can impact job satisfaction, increase risk of burnout, and negatively impact progress toward academic promotion," she said.

Dr. Medarametla said some hospitalists became sick with the coronavirus and developed post-COVID-19 syndromes of varying severity. "Some don't have the same energy as before and feel tired, but still have to come to work because the hospital will shut down without hospitalists," he said.

A lack of outpatient service options

Challenges associated with discharging patients

have also plagued hospitalists. Throughput is a major issue nationwide, said Bartho Caponi, MD, FHM, clinical professor of medicine in the department of internal medicine at the University of Wisconsin, an academic facility with 500 beds in Madison, Wis. Due



Dr. Caponi

to an insufficient supply of outpatient services and facilities, patients can't get the care they need in a non-acute setting. Consequently, they occupy hospital beds unnecessarily while others wait to be admitted.

Outpatient venues are lacking due to staffing shortages and some facilities refuse to accept COVID-19 patients until their infections have cleared—forcing them to stay in the hospital longer than might be necessary, Dr. Brotman said.

A lack of outpatient services or patients' unwillingness to seek outpatient treatment out of fear of being exposed to the virus often results in patients with a dire need for attention flooding emergency rooms, Ms. Meadors said.

Effects on medical students

In addition to the pandemic affecting hospitalists' careers in a variety of ways, some medical students' and residents' career paths were also impacted. "Some medical residents witnessed hospitalists in action as frontline health care heroes, and were inspired to pursue hospital medicine," Dr. Medarametla said. Conversely, some residents saw how stressful a hospitalists'

job can get and decided against pursuing hospital medicine as a career. Instead, they chose a specialty or primary care.

Ilaria Gadalla, DMSc, PA-C, FHM, a hospital medicine PA with Treasure Coast Hospitalists who practices at community hospitals in



Stuart, Fla., said that many hospitalist groups have had difficulty recruiting physician assistants and nurse practitioners into the field of medicine. "Due to COVID-19, the number of students permitted into hospitals for inpatient training and clinical rotations has decreased, and in some cases, they're completely excluded," she said. "If students don't experience inpatient medical care, they can't be inspired to pursue it."

In addition to not seeing hospitalists on the job, students had limited exposure to the other ways that hospitalists impact the health care system, such as serving on hospital committees, doing quality and patient safety work, helping to improve systems, and engaging in research and

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mentorship, said Daniel Ricotta, MD, SFHM, a

hospitalist and assistant professor of medicine at Harvard Medical School in Cambridge, Mass., and associate program director of medicine at Beth Israel Deaconess Medical Center in Boston. The urban academic medical center has approximately 650 beds.



Dr. Ricotta

Brian Kwan, MD, a hospitalist in the department of medicine at VA San Diego Healthcare System, an academic adult hospital with almost 300 beds, however, doesn't think COVID-19 has negatively influenced medical residents' deci-

sions to become hospitalists. "If anything, the pandemic has solidified the importance of hospitalists' roles in addressing surge planning, disseminating information quickly across national forums and networks to inform the latest practice guidelines, strengthening



communities of practice, and developing novel research questions and targets," he said.

Promoting the profession

Considering some students being deterred from pursuing hospital medicine, hospitalists need to communicate that hospital medicine is synonymous with adaptability and resilience. "During the pandemic, hospitalists have been the primary team members caring for COVID-19 patients," Dr. Medarametla said. Sometimes they even ventured beyond their capabilities and practiced at the top of their licenses by working in intensive-care units when those teams were overwhelmed.

During the pandemic, most health care systems realized the value of hospitalists. "In the next five years, I think hospitalists will take center stage in health-system operations and leadership and maintain a crucial role in all divisions, such as safety, quality, operations, finances, and patient satisfaction," Dr. Medarametla said.

Given their minimal exposure, Dr. Ricotta said it's key for hospitalists to mentor students and have one-on-one conversations explaining what a career is like and what to expect daily.

Forward thinking

Dr. Soriano believes that hospitalists will come out of this crisis better than when they started. "In the past, it was almost taboo to talk about burnout and work/life balance," he said. "Moving forward, we need to be mindful of this and address it proactively. We're looking at how we can leverage technology to provide innovative staffing solutions. For instance, we are developing a centralized 'e-hub' to provide remote solutions to support our providers."

Dr. Souther also foresees many silver linings emerging from the pandemic. "We've learned that with good communication, an open mind, and trust, we can solve just about any problem," she said. "We've made changes to our schedules and workflows repeatedly over the last two years and realize that some changes we previously would never have considered, actually work. We've also learned that change is actually not always hard. The pandemic has undoubtedly made us stronger and tougher than ever before."

Karen Appold is an award-winning journalist based in Lehigh Valley, Pa. She has more than 25 years of editorial experience, including newspaper reporter and newspaper and magazine editor. Reach her at kappold@msn.com.

Volunteers—making SHM an educational, scientific, and advocacy powerhouse for 25 years

By Larry Beresford

or Ramesh Adhikari, MD, MS, FHM, a hospitalist with Franciscan Alliance in Lafayette, Ind., volunteering for SHM seemed like the right thing to

do. "My motivation was to advance the field of hospital medicine and help other hospitalists as well as myself. It allowed me to grow professionally, meet hospital-



Dr. Adhikari

ists, and help bring them together." Dr. Adhikari serves on SHM's digital learning committee and the editorial board of The Hospitalist. He's participated in advocacy efforts, particularly around the permanent residency status of foreign-trained physicians. He helped found the Indiana Chapter of SHM and served as its vice president and president. He also chaired the planning committee for its first chapter conference held virtually for two days in November 2020.

Like many of his colleagues, he's conducted a peer review of an article submitted to the Journal of Hospital Medicine (JHM), an important way physicians can contribute to the field of medicine. "I have made many friends with hospitalists from different health systems and learned what they do and how they work as teams," Dr. Adhikari said. "I have found mentors senior to me in this field, and I have mentored others. Overall, it has been a great experience to get involved in something outside of and beyond where I work."

Celebrating volunteers

Volunteers support SHM in myriad ways, from serving on committees and the Board of Directors, to participating in special interest groups (SIGS) and chapters. They also serve as educational and conference speakers, writers, editors, and reviewers for SHM's publications—The Hospitalist and JHM.

"From a clinician perspective,

SHM is almost entirely made up of volunteers, although well-supported by an excellent staff," said Robert P.



Dr. Zipper

Zipper, MD, MMM, SFHM, physician advisor and senior policy advisor for Sound Physicians, a hospitalist company in Tacoma, Wash. "I think it's safe to say SHM wouldn't exist in its present form if not for the work of volunteers."

And 2022 Volunteer Appreciation Week, April 17-23, is a good time to celebrate all the volunteers who make things happen at SHM.

Dr. Zipper, who's been a hospitalist for 23 years, began contributing his time to SHM soon after joining the field. "Twenty years ago, it was an emerging organization for an emerging field. We had to constantly explain to people what a hospitalist was," he said. "I applied for two committees and was surprised to be accepted for both. I'm still on SHM's public policy committee, whose work I find fascinating—advocating for the field and for the patients we serve."

He joined SHM's Board of Directors a year ago—during the pandemic. "The board role is different

than it used to be," he said. "We're not traveling like we used to. Our meetings are all virtual."

Though everyone in the field feels overtaxed by the pandemic, it's just as important and rewarding to volunteer now.

Just raising one's hand becomes its own reward, making a huge difference to the volunteer, particularly over time, Dr. Zipper said. "My philosophy is to try to do things a little outside your comfort zone, but not too far. If the work is outside of your job description, even better. Anything that stretches you in that way can teach valuable lessons. There are skills you can really only develop by working on committees or other groups with a common goal. Leadership is taught, but not followership. How can I learn to be a better follower?"

Covering all the details

Nilam Soni, MD, MS, FACP, FHM is a professor of

medicine and academic hospitalist at the University of Texas School of Medicine and the South

Texas Veter-



Dr. Soni

ans Health Care System in San Antonio, Texas. He's also an internationally recognized leader in point of care ultrasound (POCUS) and he leads the development of a national POCUS training program for the Department of Veterans Affairs (VA) and serves as the director of the VA Point-of-Care Ultrasound Patient Safety Center. Dr. Soni estimates that he's done more than a hundred ultrasound training workshops around the world while finding ways to contribute his expertise to SHM and the U.S. hospitalist field.

"Ultrasound has evolved quickly, especially with advances in portable devices and ultrasound applications for tablets and cell phones," Dr. Soni said. "It's a non-invasive modality that provides a lot of information rapidly. That can change the conversation at the bedside." But using POCUS requires training and practice.

SHM offers a POCUS certificate of completion for learning its fundamentals, combining classwork, online learning modules, and a comprehensive assessment of skills and knowledge. Dr. Soni also helped draft several SHM position statements on POCUS.

"I represent a large group of hospitalists who are passionate about POCUS and active in SHM's POCUS steering committee, SIG, and faculty group. We've been leading ultrasound training and integration for hospitalists over the past decade. Most of our POCUS faculty are champions for its use at their own institutions," Dr. Soni said. "It's rewarding as clinicians and educators to see the field progressing for hospitalists."

From 2006 to 2008, ultrasound was included in the procedures for the hospitalist pre-course at SHM's annual conference. Demand led to giving POCUS its own precourse the following year. When registration requests exceeded the planned seats, Dr. Soni led the way to identify additional volunteer faculty, increase the number of sessions, arrange for loaned ultrasound machines, and gather needed supplies. The POCUS workshop consistently gets high evaluation

ratings and is always sold out.

Adam Gray, MD, a hospitalist and clerkship

director at the University of Kentucky, Lexington, serves on SHM's physicians in training committee



and devotes time to reviewing clinical vignettes and quality improvement abstracts for SHM's annual meeting. He also co-edits the Future Hospitalist RoundUp blog on SHM's members-only site, where he rounds up and edits articles submitted by medical students and residents sharing their experiences and perspectives—most recently around the pandemic.

"I enjoy and learn a lot from colleagues by reading the conference abstracts and blog posts," Dr. Gray said. "I'm glad to help out, and it's a great experience to learn all the interesting things being done around us in this field." He also advises students and residents pursuing grant-funded quality improvement projects.

Building better science

Samir S. Shah, MD, MSCE, MHM is

a pediatric hospital medicine and infectious diseases physician at Cincinnati Children's Hospital Medical



Dr. Shah

Center where he's the director of the division of hospital medicine. Dr. Shah is also the editor-in-chief of the *JHM*. He says volunteer peer reviewers are essential to the journal's ability to advance scientific knowledge and understanding to the field. "I view peer reviews as

Making a difference matters

Amira del Pino-Jones, MD is a hospitalist and associate professor, division of hospital medicine

at the UCHealth University of Colorado Hospital in Aurora, Colo, She's

also the

chair for



Dr. del Pino-Jones

SHM's diversity, equity, and inclusion (DEI) committee and this year's winner of the Diversity Leadership Award.

When she's not seeing patients, or teaching, advising, and mentoring medical students, she's working on DEI initiatives for UCHealth's Internal Medicine Residency Program and the Colorado Clinical and Translational Sciences Institute (CCTSI).

As the chair of SHM's DEI committee, Dr. del Pino-Jones says she not only enjoys the role—"it's been great as I've had the opportunity to work with other committee members...to help inform DEI efforts within SHM"—but says the DEI committee and SIG are important to SHM and "have been instrumental in helping define the mission and vision for DEI within the organization. We've helped develop tangible goals in DEI as it relates to creating an inclusive environment and integrating DEI into quality improvement, patient care, research, education, and professional development."

The ultimate goal of any of SHM's DEI efforts is referenced in the DEI SIG's mission statement: "To this end, the Society of Hospital Medicine will work to eliminate health disparities for our patients and foster inclusive and equitable cultures across our care teams and institutions with the goal of moving medicine and humanity forward."

Dr. del Pino-Jones said she volunteers on the DEI committee because "DEI should be interwoven into all we do. I thought this

one to three hours on a review. "We ask them to focus on the importance of the work and its relevance to the field, along with three to four major and three to four minor critiques, all aimed at helping the author improve the manuscript. We may then ask for revisions. If we don't end up using the article, the comments still help the author pursue publication elsewhere."

Peer review typically is not taught in medical training. "We ask our peer reviewers if they would like to mentor folks. We do workshops on it at SHM." The publication also works hard to celebrate its peer reviewers, Dr. Shah said. It identifies top reviewers based on the number and quality of their reviews. "We send them a certificate, and we encourage them to would be a wonderful group of people to work with to share ideas about DEI in hospital medicine and ensure that we are not all working in silos. This work is important but hard, and it sometimes takes a long time to see change. However, it is well worth it and I wanted to work with a group of people who were motivated and dedicated to making these changes happen."

She encourages others to volunteer as well, saying it helps "remind me why we do what we do as health care professionals."

While the pandemic showed the world the value hospitalists bring to the table, it also exposed the challenges hospitalists faced both before and during the pandemic.

Dr. del Pino-Jones sees volunteering and getting involved in different aspects of organizations as a way to help provide more meaning and fulfillment to one's life, and to make a difference in the world.

share this information with their mentors and department chairs."

JHM also tries to promote its top reviewers on social media, tweeting their names and publicly thanking them, he said. "We're always looking for ways to credit them and to offer as much recognition as we possibly can."

Volunteers like Drs. Adhikari, Zipper, Soni, Gray, and Shah, and hundreds of other SHM members are the reason the Society has not only grown, but flourished, over the last 25 years. And it's volunteers like them who will fuel SHM's success for years to come.

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

an important service to the journal and the society—but also for health care generally. It is instrumental for us to build better science, and to help authors improve the quality of their work."

When an article is submitted to the journal. Dr. Shah determines if it's likely to be published. If so, it is sent out for peer review by two to five expert reviewers. JHM keeps a database of individuals who have offered to do peer reviews, organized by their specialties. Nearly 400 of them wrote reviews in the past year, some multiple times. "For the journal, we could not be as successful without them. We couldn't do it all ourselves or hope to cover all the domains of expertise with any degree of insight and nuance." Peer reviewers typically spend

he Society of Hospital Medicine is proud to announce its 2022 class of Master in Hospital Medicine, Senior Fellows, and Fellows in

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SHM

Drinking from the fire hose of emerging medical literature

By Mary Manley, MD; Maria Maldonado, MD; Alan Hall, MD; Eileen Barrett, MD. MPH

e've all said to ourselves hundreds of times, "I need to stay more up to date on the medical literature." For hospitalists with ever-increasing patient care and administrative responsibilities, it can be challenging to keep up with the updates in our field. If you, like us, have the best intentions but sometimes find yourself falling behind on medical literature and expert recommendations, we want to share tips and resources to help you stay current without being overwhelmed.

The volume of medical literature has grown exponentially; even more so because of the pandemic. Despite the overwhelming amount of information, this pandemic may be the best illustration of why remaining informed is imperative. We can harm our patients by providing or promoting unproven treatments like ivermectin or hydroxychloroquine instead of evidence-based treatments such as remdesivir and dexamethasone. We can also unwittingly perpetuate misinformation if we share uninformed opinions. such as on vaccination or mask mandates. To help us sleep at night, we all want to know we're providing evidence-based, high-level care to our patients. Keeping up with the evidence and guidelines can help ensure our future selves don't have regrets or lost sleep about our past clinical practice.

How do we stay up to date?

If we use the psychology of habit formation to help us, the best start is building time and space in our lives for medical literature review. We know motivation alone doesn't create long-term habits. Instead, going to bed with your workout clothes on or leaving your morning medication on your nightstand are ways to maintain habits for the long haul by making the tasks easier. See Table 1 for some of our trusted resources to help simplify the process of staying updated; many of them rely on learning from the work and analysis that others have done to streamline the process. You'll find suggested methods to make these resources become a habit in the third column of the table.

Keep in mind you need to choose what's manageable for you and remember that none of us can keep up with all the literature ourselves. Scheduling a defined time in your calendar to keep up with medical literature can help you stay on track and ensure you're breaking the task into manageable time commitments, much like planning a larger scholarly project. After spending time reviewing new evidence, reward yourself and reinforce this habit by having a snack, taking a walk outside, spending a few minutes online shopping, or whatever else you enjoy.

What's the role of journals, meetings, and guidelines?

For the limited number of journals, you want to pay extra attention to, subscribe to email notifications when new issues are released (e.g., Journal of Hospital Medicine, Hospital Pediatrics, Journal of the American Medical Association. Pediatrics, Annals of Internal Medicine, New England Journal of Medicine, etc.). National meetings such as SHM's Converge can also provide updates in clinical medicine. Journal clubs, local or regional, are another way to share the burden of detailed article reviews while sharing the wealth of information obtained. Guidelines (e.g., from the Infectious Disease Society of America, American Academy of Pediatrics, and American College of Physicians) can be especially helpful to provide high-level, vetted references for patient care







Dr. Manley

Dr. Hall

Dr. Barrett

Dr. Manley is a hospitalist in the department of pediatrics at the University of Kentucky College of Medicine, Lexington, Ky. Dr. Maldonado is a hospitalist in the department of internal medicine at Baylor College of Medicine, Houston. Dr. Hall is a hospitalist in the department of pediatrics and the department of internal medicine at the University of Kentucky College of Medicine. Dr. Barrett is a hospitalist (locum tenens) in New Mexico.

This content is provided by the SHM Physicians in Training (PIT) committee, which submits quarterly content to The Hospitalist on topics relevant to trainees and early career hospitalists.

that incorporate evidence from numerous studies and that reflect expert consensus—particularly in rapidly changing diagnoses, such as COVID-19. Social media, specifically Twitter (#medtwitter), can be a source for short reviews of clinical topics and articles (some referred to as tweetorials).

How to stay organized

As we review medical literature using any of the methods discussed, we try to maintain a system to save and organize literature we expect to reference, share, or teach. For those materials, using a cloud-based service (e.g., Dropbox, Google Drive. Office 365, etc.) can make them easy to access anywhere. Notes or annotation functions can make future reference easier and quicker. If you want to share evidence with your team when you're on teaching services, saving your notes can also make this process much more efficient. There are also phone apps like Read by QxMD that can be helpful organizational tools.

Why being up to date matters

We all want to provide the best care for our patients and not be fixated on outdated or erroneous diagnostic or management information. During the pandemic we've learned that a health care provider can be an agent of misinformation and that misinformation can spread like wildfire. It can also exacerbate patients' distrust in our medical system.

If you're working with trainees in any capacity, being current on the literature provides legitimacy to your teaching and recommendations (in addition to legitimacy to vour fellow faculty). It also allows vou to serve as a role model and potentially help others who are likely also struggling with managing the deluge of emerging medical literature. Your updated knowledge will keep you on track for board certification exams and may help avoid downstream medicolegal complications too.

For a lifetime of learning and growth, transform the process of keeping up with the medical literature into a habit, just as we hope to do when we try to build exercise into our routine. Long-term change takes intention as well as a willingness to adapt to what fits your schedule. We challenge you to try some of these resources, to find out what works well for you, and give yourself a reward when you do.

Table 1. Helpful resources to stay updated in clinical medicine and make it a habit

	RESOURCE	BRIEF DESCRIPTION	MAKE IT A HABIT!
COMPILED HIGH-YIELD ARTICLE RESOURCES	ACP Journal Club	A monthly feature of <i>Annals of Internal Medicine</i> , summarizing top evidence from more than 120 journals	1. When you receive an issue or get an email with a summary, make an appointment on your calendar to
	NEJM Journal Watch	Email alerts plus journal summaries relevant to hospital medicine (and other specialties, with audio podcast also available)	read them.2. Have a folder on your computer, email, and/or desk to keep these ready for quick perusal.
	The Hospitalist 'In the Literature' section	Recurring article series that summarizes high-yield articles for hospitalists	
	Evidence Alerts	Provides notifications with newly published studies relevant to the field, rated by clinical relevance and interest	
PODCASTS	Curbsiders (adults) + Cribsiders (pediatrics)	Entertaining podcasts with discussions of medical topics through interviews that often reference recent literature	 Download an interesting episode on Sunday night/ Monday morning.
	Core IM	High-yield podcast on adult clinical topics	 Pick 1-2 days per week to listen to it on your drive (or walk or bike ride) to work and/or during a work out.
	Peds Rap	High-yield podcast on pediatric clinical topics	3. Set a goal of listening to 1 episode a week (or more!).
ACP = American College of Physicians, NEJM = New England Journal of Medicine, IM = Internal Medicine, CME = continuous medical education; Note, paid subscriptions required for some.			

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Improving Outcomes for Complex Pulmonary Patients

By Sean R. Muldoon, MD, MPH, FCCP Chief Medical Officer, Kindred Hospitals

Recent research shows that the need for expertise in pulmonary care is increasing as the population of medically complex patients grows. Studies also reveal that long-term acute care hospitals (LTACHs) are playing a significant role in caring for these patients.

Understanding the Prevalence and Severity of Acute Respiratory Conditions

Despite advances in science, the fatality of acute respiratory distress syndrome (ARDS), remains consistent around 35-40%.¹ Studies have found that sepsis and pneumonia cause 40-60% of all ARDS diagnoses and that patients with chronic illnesses and comorbidities are more susceptible to developing ARDS.^{2,3}

There is currently no cure for ARDS. Rather, treatment involves addressing the immediate hypoxia, often through ventilation, thus allowing time to treat underlying conditions.⁴

The Increasing Demand for Respiratory Care

There are two key factors that are contributing to the rise in serious pulmonary diseases such as ARDS.

- **COVID-19:** COVID-19, and its variants, is a virus that can cause serious lung injury. Observational studies conducted in Wuhan, China, found that 42-67% of COVID-19 patients developed ARDS.⁵
- **Chronic Illnesses:** Currently, 64% of the population age 65 and older have at least two chronic conditions, which increase the likelihood of developing severe respiratory diseases such as ARDS.⁶

As the COVID-19 virus mutates and surges, and as the population ages and becomes more chronic, America's health systems can expect a greater demand for pulmonology expertise.

LTACH Expertise in Pulmonary Care and Recovery

Patients with acute lung conditions, including those with COVID-19, often require long-term respiratory support and weaning from mechanical ventilation. At an LTACH,

patients receive care from a team of pulmonologists and respiratory therapists. When respiratory therapists at an LTACH use ventilator weaning protocols, time on ventilator, mortality, and cost of care can all significantly decrease.⁷

LTACHs also treat underlying conditions. Their interdisciplinary care teams are trained to treat patients with chronic illnesses and multiple comorbidities and specialize in conditions such as pneumonia and sepsis which are significant causes of severe lung complications like ARDS.

How Kindred Can Help Your Respiratory Patients

Kindred Hospitals specialize in the treatment of medically complex patients who require intensive care and pulmonary rehabilitation in an acute hospital setting. With daily physician oversight, ICU- and CCU-level staffing, 24/7 respiratory care and specially trained caregivers, Kindred Hospitals help improve functional outcomes and reduce costly readmissions.

If you have a patient in need of pulmonary care after a hospital stay, please visit **recoveratkindred.com** or call **1.866.215.9857** to speak to a Registered Nurse.

References

- 1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7912364/
- 2. https://www.yalemedicine.org/conditions/ards
- 3. https://www.yalemedicine.org/conditions/ards
- 4. https://doi.org/10.1016/S0140-6736(21)00439-6
- 5. https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30079-5/fulltext
- 6. https://www.cdc.gov/pcd/issues/2020/20_0130.htm
- 7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7774095/



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A commitment to training physicians and SHM: a perfect match

5

By Richard Quinn

hen Daniel Ricotta, MD, SFHM, matriculated to residency in 2011, he didn't know what hospital medicine was.

Now, as chair of SHM's Physicians in Training committee, it's his mission to make sure people know what hospital medicine is worth.

"Our goal is to really address the needs of

trainees that are interested in hospital medicine," said Dr. Ricotta, a hospitalist at Beth Israel Deaconess Medical Center in Boston and an assistant professor at Harvard Medical School. "Our charge is to promote hospital medicine among trainees, students, and



Dr. Ricotta

residents, and to make sure the Society of Hospital Medicine is meeting their needs."

The Physicians in Training (PIT) committee is one of 15 that advises the board of SHM. But as the panel tasked in large part with constantly recruiting future hospitalists, it is unique in its purpose and pressure.

Committee member Teela Dawn Crecelius, MD,

an assistant professor at Indiana University School of Medicine in Indianapolis, said it's crucial for a field that has grown as much as hospital medicine to replenish its staffing pipeline with incoming students.



Dr. Crecelius

"It's vital to our specialty to continue to recruit people who are interested and to support them on their pathway into the specialty," she said. "I know when I was a trainee, I didn't have a lot of support, and I would have appreciated a lot of what the PIT committee is trying to provide."

The committee's role is more than just marketing, of course.

The group is working to expand a mentorship program for trainees and is researching the utility of a gap year between residency and fellow-

The Match

While the Physicians in Training committee doesn't work directly on Match Day activities, it is perhaps the SHM panel most focused on ensuring those residents with a future eye to hospital medicine are successful.

A quick look at Match Day:

- » WHEN: March 18 (always the third Friday of March)
- » WHAT: Annual rite of pairing medical students with residency programs
- » WHO: The National Resident Matching Program (NRMP), which began in 1952
- » WHY: Students interested in exploring a career in hospital medicine can join SHM during residency training and access programs.

For more information about SHM's Residents and Fellows membership opportunity, visit hospitalmedicine.org/residents.

ship. In June 2021, it launched a monthly series of webinars to "provide information to trainees on topics that aren't necessarily touched on in residency," Dr. Crecelius said.

Topics so far have included: "From Billing Fear to Billing Fierce: Understanding How the Dollars Flow"; "7 Tips for Creating an Effective Mini Lecture"; and "Make it Count: How to Leverage Your Scholarly Work".

The sessions offer residents an introduction to all the non-clinical duties and responsibilities that can be part of personal and professional satisfaction as a hospitalist. That point is key to Dr. Ricotta, who too often sees budding physicians who "default into hospital medicine as a career as opposed to making a really deliberate choice about it."

To wit, he sees the PIT committee's role as giving those trainees a reason to want to be a hospitalist, to "change the narrative...and make people really dedicated to the field."

Despite the specialty's meteoric rise in the past 25 years, it still lacks some of the allure of dents and residents make proactive decisions to enter a specialty that is highly competitive, in part because they have to as part of the fellowship process."

more established fields, to some extent, "stu-

But Dr. Ricotta knows now what he didn't know 10 years ago as a resident—and the committee's task is to share that knowledge.

"Hospital medicine, as a field, our value is what we bring to hospitals in terms of quality improvement initiatives, value-based care, communication with nursing staff, our skill as frontline teachers, and our commitment," Dr. Ricotta said. "Not hospital medicine the noun, as a field, but the community that works within a hospital."

"I think if we have more people dedicated to that mission, it's going to add value to our field. Whereas the people going into it just kind of willy-nilly but aren't dedicated to the other things that we do, we risk, it's a risk to our identity."

Dr. Ricotta also sees the PIT committee as a chance to introduce fledgling physicians and even early-career hospitalists to SHM as a whole. There are certainly other groups that support the field, including the Society of General Internal Medicine or the American College of Physicians.

But none are so laser-focused on career development for hospitalists as SHM. By providing interactive tools and opportunities before trainees have chosen the field—and in the early years of practice-the PIT committee is showing potential recruits and future leaders how inclusive the field is.

For Dr. Crecelius, that experience has taken on a personal bent.

It "has been one of my favorite things I've been involved in as a hospitalist," she said. "I'm surrounded by people across the nation who are phenomenal at their jobs and are really, truly interested in helping students and trainees succeed in their career path to being a hospitalist. It's a very encouraging and supportive environment, and it's a great place for trainees to turn for support whenever they have any questions about the field."

Richard Quinn is a freelance writer in New Jersey.



Chapter spotlight: Rhode Island

By Richard Quinn

or years, there'd been talk of starting a Rhode Island chapter of SHM.

Sure, hospitalists in the smallest state in the country could have hopped state lines to join a chapter in Boston or Hartford, Conn.

But that's not who Rhode Islanders are.

"We really feel a strong sense of community and that our state is

important," said Brad Collins, MD, SFHM, an associate professor of medicine at the Warren Alpert Medical



Dr. Collins

School of Brown University in Providence, R.I. "Sometimes it might be easier to merge with the Boston chapter or the Massachusetts or Connecticut chapters, but there's a strong sense of self in Rhode Island. Of wanting to have our own independent chapter."

And that's how SHM's newest chapter got started in the summer of 2021.

It has 66 members and already has enough gravitas that Dr. Collins and colleagues were able to dine with Governor Dan McKee. In September, the group hosted hospitalist pioneer Win Whitcomb, MD, MHM, to discuss the future of the field. In November, direc tor-at-large Hussain Khawaja, MD,

helped organize a New England-area poster competition where Rhode Islanders won the categories

research, Dr. Khawaja

innovations and clinical vignettes. All will attend and participate in the national Scientific Abstract Competition taking place during SHM's Converge 2022.

"It was fun to see that," said Dr. Khawaja, who practices at two Providence hospitals staffed by Lifespan. "People were so excited to be a part of the organization."

Being part of something was one of the motivations to start the chapter last year, Dr. Collins said.

"Given the stress hospitals are under with capacity due to COVID, but also in general, having shared experiences matters," he said. "Trying to come up with good plans that involved hospitalists, to make sure we have a united voice at the state level, and making sure we have advocacy for the needs we have as a subspecialty—all of that was extremely important to us.

"Being a small state, Rhode Island is very parochial, but it also gives us an opportunity to make some large changes from an advocacy standpoint. By having a local chapter, we can effect change in that way."

Sometimes the value of a local

chapter is just knowing that another hospitalist is enduring the same struggles, Dr. Khawaja said.

"In a lot of ways, it's very settling to see we're not the only ones going through it," he said. "Physicians everywhere are feeling the same things, the same pressures, the same burdens, and the same degree and type of burnout because we're all going through the same thing at the same time. Having local, regional, and national platforms to discuss these things has been very helpful."

And discussing those struggles with folks who understand local nuances—Ocean State mask and vaccine mandates, for example makes those conversations even more valuable, Dr. Collins said.

"Landscapes are just different across the country. We share the experience of a sustained pandemic nationally, but to be someone who also knows the ins and outs of the landscape of Rhode Island in health care, just means a little bit more. So, while I may connect with someone in California via Twitter or Facebook, we can meet in outdoor spaces here and really actually have that personal, human connection, outside where it is safe, or masking when we have met in person."

One of the challenges of a new chapter is keeping up activities to keep members engaged.

Dr. Collins said the chapter already has three meetings on the books for 2022. The first, this spring, will be a physician town hall of sorts where advocacy concerns will be discussed. The second will be a social event—a wine tasting at a local winery, complete with a jazz band—during the summer. In September, they'll hold the chapter's second annual meeting, with a local poster competition.

There's more, too.

"We're partnering with the Rhode Island Medical Society and the American Academy of Family Physicians to help host an advocacy day," Dr. Collins said. "We'll have speakers from Rhode Island's General Assembly. We've had people from our federal congressional delegation at these past events. I don't know who will be featured, but it's sort of how the sausage is made and how to advocate to get your bills on the floor. I think that will be really important for us as we shape our agenda politically to make the changes we need to make. We can really effectively do those things at a state level. Again, it's much easier because we are a small state."

Put another way? Small, but mighty.

"That seems to be Rhode Island in general," Dr. Collins said. "Hopefully, by having the opportunities to have these meetings people will know their voice is heard and that change can come from this for the better. I think we'll continue to attract new members and our chapter will be something people are excited to be a part of."

Richard Quinn is a freelance writer in New Jersey.

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