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The Hospitalist

the-hospitalist.org

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Insights, recaps, analyses, and more—SHM Converge 2022 at your finger tips.

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SHM NEWS

Andrea Martinez Receives SHM's Inaugural DEI Scholarship

Andrea Martinez, a third-year medical student at the Emory University School of Medicine in Atlanta, received SHM's inaugural Hospital Medicine Diversity, Equity, and Inclusion Scholarship, made possible by keystone sponsor, Vituity. Ms. Martinez will receive a medical education assistance scholarship in the amount of $25,000. The scholarship was presented during SHM Converge in Nashville, Tenn., in April.

"Andrea's commitment to working in underserved communities, coupled with her passion for hospital medicine, perfectly reflects the values we had in mind when developing this scholarship fund," said Jenna Goldstein, chief of strategic partnerships at SHM and staff liaison for SHM's Diversity, Equity, and Inclusion committee.

"Congratulations to Andrea, who truly exemplifies the personal passion needed to transform health care for future generations", said Javay Walton, Vituity's vice president of diversity, equity, and inclusion. "By helping to establish this scholarship fund with SHM, Vituity is proud to take actionable steps to improve representation at all levels of healthcare, so that tomorrow's leaders know they can pursue their dreams without limits".

Throughout her medical school experience, Martinez has found her passion for hospital medicine as well as helping underserved and underrepresented groups. She is the co-founder of the Latino Medical Student Association (LMSA) Pipeline and LMSA Emory's chapter president. In addition to her work with LMSA, she has worked with the COVID-19 Latinx Equity Initiative Vaccination Campaign to enhance vaccination efforts in underserved communities.

Born and raised in Venezuela, Martinez moved to Miami at the age of 15. She earned her biomedical engineering degree with highest honors at the Georgia Institute of Technology. She plans on pursuing a career in internal medicine, where she can use her own experiences and Spanish language to connect with underserved communities, support patients in navigating the health care system, and improve patient outcomes.

"It is an honor to receive this scholarship award, and I am grateful to SHM for recognizing my commitment to diversity, equity, and inclusion," said Martinez. "As someone who comes from an underrepresented community, I know firsthand how important it is to identify new opportunities for medical students like me to join the health care community and advocate for those whose voices are not always heard."

To learn more about the scholarship and selection criteria, visit hospitalmedicine.org/DEIscholarship.

Applications for SHM Fellow Designations Are Open

It's true—2023 is *your* year. Apply to become an SHM Fellow to make an impact in your career and your community next year. SHM offers Fellow designations across a variety of membership categories, including physicians, qualified practice administrators, nurse practitioners, and physician assistants.

Rooted in the *Core Competencies in Hospital Medicine*, those who have achieved a Fellow in Hospital Medicine (FHM), Senior Fellow in Hospital Medicine (SFHM), or Master in Hospital Medicine (MHM) designation have shown their dedication to promoting excellence, innovation, and improving the quality of patient care.

Submissions are open for early decision until September 16. The final deadline to apply is November 18. Apply at hospitalmedicine.org/fellows.

Reunite With Your Pediatric Hospital Medicine Community at PHM 2022

The Pediatric Hospital Medicine (PHM) conference is the premier educational conference for pediatric hospitalists and other clinicians who care for hospitalized patients. Join your pediatric hospitalist community from July 28-31, 2022, at Disney's Yacht & Beach Club Resorts in Lake Buena Vista, Fla.

The course schedule includes:

- Clinical and Procedural Skills
- Community Hospital Medicine
- DEI/Health Equity
- Innovations in PHM
- Women in PHM
- And more!

See the full schedule and register at phmmeeting.org.

JHM Recruiting for National Correspondent

The Hospitalist's sister publication, The *Journal of Hospital Medicine*, is recruiting for a National Correspondent to further develop its Clinical Care Conundrum series. Applications are due June 15.

Movers and Shakers

Eileen Barrett, MD, MPH, MACP, SFHM was recently elected to the Board of Directors of the American Medical Women's Association (AMWA) where she is also chair of the AMWA advocacy committee and a member-at-large on AMWA's governance committee.

She has also been elected as chair-elect-designee of the American College of Physicians Board of Regents.

Dr. Barrett is a district 10 chair of SHM and serves on the SHM Performance Measurement and Reporting and Chapter Support committees. She is a locum tenens hospitalist based in Albuquerque, N.M., as well as an American Medical Association-Satcher Health Leadership Institute Medical Justice in Advocacy Fellow.

She earned her Master of Public Health from the University of North Carolina at Chapel Hill, N.C. and her medical degree from Georgetown University in Washington, D.C. She completed her internal medicine residency at Oregon Health Sciences University Hospital, in Portland, Ore., and a rural faculty development fellowship at the University of Arizona, in Tucson, Ariz.

Justin A. Fu, MD, MBA, FAASM, FHM has been named chief of staff of Dignity Health-St. Bernardine Medical Center (SBMC), San Bernardino, Calif. Dr. Fu, an internal medicine physician, served as the program medical director of the hospitalist program and is a member of the medical executive committee. He has also been the regional medical director at Sound Physicians where he oversees Dignity Health hospitalist programs in Southern California.

Dr. Fu

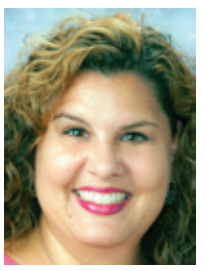
After graduating with a B.A. in molecular and cellular biology from the University of California at Berkeley, Dr. Fu received his medical doctorate from Tufts University School of Medicine, Boston. He completed his internal medicine residency at Veterans Affairs Greater Los Angeles, Cedars Sinai Medical Center UCLA, and a sleep medicine fellowship program at Veterans Affairs Greater Los Angeles, Olive View Medical Center UCLA.

Michael D. Teague, MD, SFHM has been elected chief of staff for 2022 at Our Lady of the Lake Regional Medical Center, Baton Rouge, La. Dr. Teague is a hospitalist with more than 20 years of experience; he's board certified in hospital medicine (HM) as well as hospice and palliative care.

Dr. Teague

He earned his medical degree from the Louisiana State University School of Medicine in Shreveport, La. and performed both his internship and residency at University of Utah Affiliated Hospitals in Salt Lake City. Dr. Teague has previously served as the associate medical director for HM services, from 2013 to 2019, and is currently the medical director of coding and documentation.

Allison S. DeKosky, MD has been named interim medical director of HM at the University of Pittsburgh School of Medicine (UPMC).



Dr. DeKosky

Dr. DeKosky is an assistant professor in the UPMC Division of General Internal Medicine's (DGIM) section of HM. Previously she was the director of quality initiatives and education, and in 2021 moved on to director of HM faculty development for DGIM. She also serves as director of the HM track for the UPMC general medicine academic clinician-educator scholars fellowship, and as associate program director for quality and patient safety for the internal medicine residency program. She will maintain these roles along with her new interim role.

Dr. DeKosky spearheaded the comprehensive faculty development programming for hospitalists at UPMC. She is the hospitalist liaison to the internal medicine residency program on overall medicine service operational and policy issues affecting house staff teams. Her academic efforts are diverse and span quality improvement, medical education, health policy/advocacy, and the cultivation of leadership skills in medical students, residents, and faculty.

She graduated from Penn State with a degree in health policy and administration and worked in the U.S. Senate and the private sector prior to attending the University of Pittsburgh School of Medicine. She did her internal medicine residency at the University of Chicago and fellowship in academic hospital medicine at the University of California, San Francisco. Prior to joining UPMC, she was an academic hospitalist at the University of Pennsylvania.

Ray Ramirez, MD has been appointed interim associate medical director, hospital medicine, for UPMC Presbyterian, Pittsburgh.

Dr. Ramirez

Dr. Ramirez is a clinical assistant professor of medicine who joined the division of general internal medicine at the University of Pittsburgh in 2013. Previously, he earned both his undergraduate and medical degrees at Indiana University, Indianapolis, before completing his internal medicine residency at UPMC.

Dr. Ramirez is a hospitalist supervising second- and third-year residents on the junior hospitalist rotation and providing didactic instruction to the residents on the rotation. Dr. Ramirez also is a core hospitalist at Magee Women's Hospital, Pittsburgh, providing primary hospital care as well as consultative services.

Along with working with residents, interns, and medical students on the house staff teams, Dr. Ramirez presents didactic lectures for the junior hospitalist residents. He is also a facilitator in several medical school courses. i

Marcial A. Santos, MD, a hospitalist at Cape Cod Healthcare, Hyannis, Mass., ran in the 126th Boston Marathon this spring to raise money for the Esplanade Association in honor of medical patients who passed away due to COVID-19. A Cape resident since 2005, Dr. Santos joined the Esplanade Association in Boston, a group dedicated to supporting open space along the Charles River. Through his givengain campaign (www.givengain.com/ap/marcial-santos-raising-funds-for-esplanade-association), he's raised nearly $12,000.

Dr. Santos

Dr. Santos earned his medical degree from the Technological Institute of Santo Domingo, Dominican Republic and completed his residency at Advocate Illinois Masonic Medical Center, Chicago. He is board certified in internal medicine. ■

Getting Your Scholarly Project Ready to Submit for SHM Converge 2023

By Margaret Shyu, MD, Abu Baker Sheikh, MD, and Eileen Barrett, MD, MPH

Today's the day to start thinking about submitting a scholarly project to SHM Converge 2023. Our job is to convince you why it's important and show you how to proceed. Our advice is based on our experience of applying to SHM Converge 2022.

What is SHM Converge?

SHM Converge is an annual meeting that serves as an opportunity to engage in hospital medicine research or workshops, learn about new topics in the field, and network.

Why should you submit your work to SHM Converge?

SHM Converge provides an opportunity to share knowledge during its annual scientific abstract competition through research, innovation, or interesting patient vignettes. For instance, if you have an inpatient research project, this conference is the perfect way to disseminate your findings. The competition has recently received more than 1,700 abstract submissions for its 1,200 poster spots, so being able to include this national poster presentation on your resume is no small feat. Plenary and oral presentation slots are also offered to select authors. Abstracts are published in a *Journal of Hospital Medicine* online supplement.

SHM Converge is also a venue to receive informal feedback. Conference attendees can identify additional ways to interpret results or suggest individuals who would be interested in collaboration; this input can help a poster turn into a publication. Whether you're a medical student or a seasoned attending, it's a safe space to practice presenting information in a formal setting. Finally, attending SHM Converge is a chance to learn from colleagues. Educational sessions are targeted toward a wide variety of learners, ranging from medical students to residents, to attendings. The four-day event offers multiple opportunities to network with others who may share similar interests and to promote future collaborations.

What types of abstracts are accepted?

There are three competition abstract categories: research, innovations, and clinical vignettes. Abstracts can focus on children or adults as long as they have relevance to hospital medicine. Abstracts cannot have been published in a peer-reviewed journal before December 31 leading up to the conference but are still eligible if they were presented at another conference in the past year.

1. Research

This category includes basic science research, clinical research, and systematic reviews of clinical problems. Topics that touch on cost, efficiency, and quality of health care are also within this category. For instance, one of our projects looked at reasons behind delayed discharges for patients discharged on a Monday who could have left earlier.

Some other examples are:

- A study on the prognostic value of labs ordered on patients with COVID-19 to determine which labs correlated with mortality and ICU stay
- An evaluation of residents' attitudes toward patient discharge instructions before and after an educational module
- A quality improvement project looking at the outcomes of an inpatient team dedicated to initiating buprenorphine and facilitating transition to outpatient opioid use treatment

2. Innovation

This category includes any activity that has been piloted or implemented in the health care setting. This includes patient safety, electronic medical records, medical education, communication, and clinical pathways. This category is the most flexible and typically contains a description of the innovation, although preliminary data is welcome. If I had come up with an intervention to reduce delayed discharges but did not have the outcome data yet, I could still submit it here.

Some examples are:

- Developing programs to disseminate COVID protocols to underserved areas
- Implementing a patient safety simulation program in which residents had to identify errors or near miss events
- Creating a checklist to assist nurses with utilization of non-invasive positive pressure ventilation after a safety event

3. Clinical vignettes

A clinical vignette showcases a patient case relevant to hospital medicine with an interesting clinical feature. The abstract typically highlights the patient history, exam, laboratory data, management, and overall patient outcome with key learning points emphasized. It's more important to have a case relevant to hospitalists than to have an extremely rare case where the hospitalist is only peripherally involved. Vignettes should have input from anyone critical to the case and use patient-centered language that avoids stereotyping.

Some examples are:

- A near misdiagnosis in which a young man with a family history of Crohn's disease presented with bloody diarrhea and was initially planned for a colonoscopy but later found to have E Coli gastroenteritis
- A case of thiamine deficiency presenting with symptoms of wet, dry, and gastrointestinal beriberi
- A patient thought to have COVID-19 pneumonia but ultimately found to have Pneumocystis jirovecii pneumonia in the setting of newly diagnosed HIV

Timeline of SHM Converge Abstract Submissions

September-November 2022
Submission acceptance period

⌄

January 2023
Announcement of acceptance

⌄

Febuary 2023
Poster Date Assignment

⌄

March 26-29, 2023
SHM Converge Austin, Texas

How do I prepare to submit to SHM Converge?

Now that you're excited to apply to SHM Converge, it's time to discuss the next steps. Research projects typically take at least three months to complete; try reaching out to faculty and peers who share common interests to see what projects are available for you to join, or give yourself a longer time period if you're looking to start something from scratch. If you've started a project but it's incomplete, consider submitting an innovation abstract. Clinical vignettes can be more manageable if you're short on time; it helps to keep track of interesting cases as you see them. Authors can submit multiple submissions in different categories.

Once you have a project in mind, share your goal of applying to SHM Converge with any anticipated collaborators. By setting a deadline ahead of time and determining the order of authors, everyone on the team can have a shared goal.

It is important to work on submission materials at least one month before the deadline in case any unforeseen issues arise. This includes looking at the conference website to learn about the abstract submission requirements. No worries if you don't have enough space to write up all the information you discovered; if accepted, the poster will have room to include other data or images. The abstract is where the most important details are written. Authors must be SHM members to present.

It will take time to write up the abstract and have each collaborator review it for grammar and clarity, the relevance of the results to a hospitalist audience, and the overall message. For me, the most time-consuming part was addressing the questions my mentors posed. It was stressful to complete the abstract on time, so try to finish early, if possible!

Finally, it is almost time to submit! You and your team have put a tremendous amount of effort into your final product, so be sure to submit it before the deadline in case something comes up in your life or with the website. Once you are done, you will hear the results of your submission in January 2023. Good luck!

To learn more information or see past abstracts, check out: https://shmconverge.hospitalmedicine.org/ ■


Dr. Shyu


Dr. Sheikh


Dr. Barrett

Dr. Shyu is a hospitalist in the department of internal medicine, Icahn School of Medicine at Mount Sinai, New York. Dr. Sheikh is a hospitalist and associate program director in the department of internal medicine, University of New Mexico, Albuquerque, N.M. Dr. Barrett is a hospitalist (locum tenens) in New Mexico.

LGBTQIA+ Patient Care

Where are we and where are we going?

By Samantha C. Shapiro, MD

The LGBTQIA+ community has doubled since it was first measured in 2012, according to a 2022 Gallup poll—it now includes 7.1% of Americans.[1] As the community expands, so has acceptance and legal protection against discrimination.

The LGBTQIA+ acronym stands for lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and the plus sign represents all members not otherwise included.[2] The evolution of the acronym itself from LGB to LGBT to LGBTQ to LGBTQIA+ is an example of the inclusiveness and diverse spectrum of sexual orientations and gender identities found within the community.

And while diversity, equity, and inclusion (DEI) efforts throughout medical education and health care systems have brought the care of LGBTQIA+ patients into focus, we still have a long way to go.

A 2017 survey conducted by the Harvard T.H. Chan School of Public Health (Boston), National Public Radio (Washington, D.C.), and the Robert Wood Johnson Foundation (Princeton, N.J.), painted a clearer but not brighter picture of discrimination against LGBTQIA+ people in America. A striking 57% of participants reported "significant personal experiences of discrimination across many areas of life" related to their sexual orientation and gender identity. When it comes to health, about one in six (18%) reported avoiding medical care when in need due to the concern of facing discrimination. This number rose to nearly one in four for transgender or gender non-conforming individuals.[3]

Discrimination is not the only issue that affects the health of LGBTQIA+ individuals. Disparities also exist among health outcomes and risk factors. For example, members of the LGBTQIA+ community exhibit higher rates of suicidality, smoking, and depression.[4,5] And LGBTQIA+ seniors are more likely to be single and childless, with more limited caretaker networks.[6]

Intersectionality—an individual's overlapping characteristics such as age, race, gender, and education level—also affect experiences of discrimination and health outcomes.[7]

Current education and training

Despite these known levels of discrimination and disparity, health care professionals still receive minimal training specific to the care of members of the LGBTQIA+ community. This deficiency permeates undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME) alike.

For example, in 2011, the median reported time dedicated to LGBTQIA+ content in American and Canadian UME curriculums was a mere five hours. A third of the programs reported no required clinical hours for LGBTQIA+ content whatsoever.[8] In response, the Association of American Medical Colleges published guidelines for including LGBTQIA+ content in UME, and many medical schools have responded in kind. We don't know how effective or widespread these efforts have been, since data regarding their effects has not yet been published.

Unfortunately, efforts at the GME level lag. Advocates hope that the Accreditation Council for GME will develop and implement LGBTQIA+ health-related residency requirements in the future.[9]

From the CME perspective, most professional societies—including SHM—now offer content focused on LGBTQIA+ topics.


Dr. Khanijow

Keshav Khanijow, MD, instructor of medicine, Johns Hopkins University School of Medicine, and hospitalist, Johns Hopkins Bayview Medical Center, Baltimore, spearheaded the development of the SHM LGBTQIA+ task force in 2018. To guide future educational interventions, the task force undertook the Quantifying Hospitalist Education and Awareness of LGBTQIA+ Topics in Health (Q-HEALTH) project to identify hospitalists' attitudes and knowledge around LGBTQIA+ health.[10]

"We're excited to publish the full results of the Q-HEALTH study when the time comes," said Dr. Khanijow. "We noticed a need for improved clinical competency caring for LGTBQIA+ patients and a better understanding of LGBTQIA+ identity as a social determinant of health. We were pleased to confirm that hospitalists were enthusiastic about learning how to better support this population."

In June 2021, based on knowledge gaps and the desire for future education expressed by hospitalists in the Q-HEALTH initial survey, the task force released the SHM LGBTQIA+ Health Series, a free collection of video lectures.[11] The lectures are bite-sized (10 to 15 minutes long), and CME credit is available. The series includes content on LGBTQIA+-affirming language and documentation, inpatient care of transgender individuals, gender-affirming hormone therapy, HIV pre-exposure prophylaxis (PrEP) for the hospitalist, LGBTQIA+ identity as a social determinant of health, and advocacy for/with LGBTQIA+ persons.

LGBTQ+ youth

Work is also underway to assess and address what's needed to better care for LGBTQIA+ youth. Lauren Titus, MD, a pediatric hospital medicine fellow at Medical College of Wisconsin, Milwaukee, is interviewing LGBTQIA+ youth ages 12 to 20 to understand their perceptions of and experiences with health care professionals, especially as they pertain to rapport and disclosure of LGBTQIA+ status. Her goal is to use both the interviews with LGBTQIA+ youth and responses from pediatric hospitalists to create a patient-centered curriculum on the health care needs of this population.


Dr. Titus

"I think LGBTQIA+ youth will have a lot to say about how health care professionals can do better," Dr. Titus said. "I used to feel I was somehow inconveniencing kids and families by asking them about sexual orientation and gender identity. Now, I see it as a service, not an inconvenience. Feeling like you not only have to "come out" to your clinician, but also explain your sexual orientation and gender identity, is taxing. I hope that the LGBTQIA+ youth in this study help us develop tangible ways to demonstrate we're invested in their care and committed to fighting the heteronormative and transphobic status quo in medicine."

LGBTQIA+ frontline care

Christopher Terndrup, MD, assistant professor of medicine, assistant program director–ambulatory services, division of general internal medicine and geriatrics, Oregon Health Sciences University School of Medicine, Portland, Ore., became an LGBTQIA+ advocate as a medical student. He earned a scholarship to attend the GLMA: Health Professionals Advancing LGBTQ Equality (GLMA) Conference as a second-year medical student and has attended every year since. "With GLMA, I found a sense of community and received a lot of education specific to caring for this population. The training I received in medical school and residency just seemed to focus on gay men and sexually transmitted infections, but there is a lot more to it than that," he said.


Dr. Terndrup

Despite a lack of formal education outside of GLMA conferences, Dr. Terndrup advertised himself as an LGBTQIA+ practitioner in his primary care practice at Oregon Health Sciences University. "About half of my patient panel are members of the LGBTQIA+ community, and one third are people living

Resources

- **SHM Diversity, Equity, and Inclusion Special Interest Group**
  https://www.hospitalmedicine.org/membership/special-interest-groups/
- **SHM LGBTQ+ Health Series**
  https://www.shmlearningportal.org/content/lgbtq-health-series#group-tabs-node-course-default1
- **GLMA Cultural Competence Webinar Series**
  https://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=1025
- **Human Rights Campaign: Resources for Transgender Patients**
  https://www.thehrcfoundation.org/professional-resources/transgender-patient-services-support-resources-for-providers-and-hospital-administrators
- **Human Rights Campaign: Resources for LGBTQIA+ Patients**
  https://www.hrc.org/resources/patient-resources
- **The PRIDE Study**
  https://pridestudy.org/study

with HIV. I have continued to self-educate as I go, learning about gender-affirming care, new antivirals, and PrEP guidelines."

As a clinician educator, Dr. Terndrup enjoys being at the forefront of GME change despite the significant amount of personal legwork required. He said, "The best part is teaching the residents how to care for these patients, and then watching them do it independently. Seeing them leave training with the skill set to care for this community is profoundly gratifying."

Best practices

Best practice guidelines regarding LGBTQIA+ patient care are slowly coming to fruition. GLMA published "Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients".[12] Highlights include tips for creating LGBTQIA+-sensitive intake forms and fostering inclusive patient-provider discussions.

The Human Rights Campaign Foundation published "Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies". This document provides guidance on both legal and regulatory nondiscrimination mandates and best practices for the inpatient care of transgender patients.[13]

GLMA has also published "Recommendations for Enhancing the Climate for LGBT Students and Employees in Health Professional Schools".[14] This document draws attention to oft-overlooked aspects of school and work environments for the LGBTQIA+ community. For example: offering health care policies that apply to same-sex spouses and domestic partners on an equal basis; and policies that don't exclude transgender care.

Dr. Khanijow astutely noted, "We need to remember that there is more to this than just lectures on LGBTQIA+ patient care. To ensure DEI in the workplace, we need to advocate for workplace policies that support this community, too."

The LGBTQIA+ practitioner experience

Drs. Khanijow and Terndrup were kind enough to share their own experiences as health care professionals who identify as part of this community. Dr. Khanijow said, "I wasn't sure if I should list my sexual orientation and gender identification on my medical school application. Fortunately, my school was ahead of the game in that it had already established a network of LGBTQIA+ faculty with whom I could connect."

That said, he has also faced some discrimination from patients. "Although I identify as a cis-male, I do have gender non-conforming mannerisms that people do comment on sometimes. Over time, I've learned to be comfortable with myself, which helps me be the best at work and provide patient-centered care."

Dr. Terndrup, who also identifies as a gay cis-male, was less lucky as a medical student. He said, "I grew up as a queer boy in the south and came out in high school. I didn't have many role models for what it's like to be a gay man in medicine. I observed some very clear discrimination from a family medicine doctor in rural Louisiana as a medical student. I'll never forget that." These experiences inspired him to co-create the first LGBTQIA+ student group at his medical school.

"I do want to note that it's easier for me than others to be an LGBTQIA+ provider due to my privilege as a white cis-gender male," Dr. Terndrup said. "It's important for me to call out that privilege, and realize my experience is not the same as others in our community."

Making progress

Though slow-coming, work continues to be done to identify areas for improvement. The Population Research in Identity and Disparities for Equality (PRIDE) Study, conducted at Stanford University (Stanford, Calif.) and the University of California, San Francisco, is the first large-scale, longitudinal cohort study of people who identify as part of the LGBTQIA+ community.[15] The study aims to understand how being an LGBTQIA+ person influences physical, mental, and social health. Since most health studies do not collect data regarding sexual orientation and gender identification, PRIDE hopes to bridge the information gap. The study continues to enroll patients actively online.

In addition to medical education changes, a growing number of health care institutions are also creating and adopting LGBTQIA+-inclusive policies and practices, as benchmarked by the Human Rights Campaign Foundation's Healthcare Equity Index.[16]

Future directions

So, how do we push forward?

"The health care disparities in the LGBTQIA+ community are driven by a social stigma that is not welcoming to them. If we want to improve health outcomes for these patients, we need to address social determinants of their health care," said Dr. Terndrup.

Regarding medical education, he said, "The key is both integration and dedication. It's not just a lecture about PrEP or pronouns for gender diverse folx (the spelling of which indicates gender diversity). It's also about including an LGBTQIA+ patient in the hypertension lecture when their high blood pressure has nothing to do with their sexual orientation or gender identity." ■

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Treating Hyponatremia?

UREA FOR THE TREATMENT OF HYPONATREMIA

Published CJASN Nov. 2018, Rondon et al.

FINDINGS

- 58 patients received ure-Na for hyponatremia. 14 patients received ure-Na as monotherapy.
- 57 of 58 patients tolerated ure-Na.
- SIADH was the most common cause of hyponatremia.
- Dose of urea ranged from 7.5 to 90 g per day, with a median duration of treatment of 4.5 days.
- Ure-Na therapy was associated with a median increase in plasma sodium from 124 mEq/L to 130.5 mEq/L ($p<0.001$) with no over-correction.
- No adverse effects were reported.
- Overall, treatment with ure-Na was found to be well tolerated, safe and effective for the treatment of inpatient hyponatremia.
- Nephcentric, the developer of ure-Na, did not sponsor or have prior knowledge of this clinical study.

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*The European Clinical Practice Guideline on the management of hyponatremia recommend the use of oral urea as a treatment option in SIADH for moderate to profound hyponatremia. UpToDate also reviews the use of urea as a management option for hyponatremia.

ure-na.com

SHM 2022 Awards of Excellence and Junior Investigator Award

SHM's Awards of Excellence Program honors members who've made exceptional contributions to hospital medicine in a variety of categories.

Clinical Leadership for Physicians

Marisha Burden, MD, FACP, SFHM


Dr. Burden

Dr. Burden is the division head of hospital medicine and an associate professor of medicine at the University of Colorado School of Medicine in Aurora, Colo. She earned her medical degree from the University of Oklahoma School of Medicine in Norman, Okla., graduating with the honor of Alpha Omega Alpha. She completed her residency at the University of Colorado in the hospitalist training track.

Dr. Burden's interests include building a thriving workforce and developing clinical staffing models that support the workforce to do their best work. This in turn drives outstanding patient and institutional outcomes. She's led numerous clinical innovations including building novel clinical service lines and large-scale surge plans for the COVID-19 pandemic. She also devotes considerable time and effort to mentoring, faculty advancement, and educational efforts. Dr. Burden dedicates her time to many diversity, equity, and inclusion efforts and is the co-founder and co-chair of SHM's diversity, equity, and inclusion special interest group (SIG). She uses research methods to develop and understand best practices. She is the co-lead for the Hospital Medicine Reengineering Network's (HOMERuN) research network workforce planning group, principal investigator on an Agency for Health Care Research and Quality study, "Discharge in the AM: A Randomized Control Trial of Physician Rounding Styles to Improve Hospital Flow", and she recently received a Total Worker Health pilot grant to study hospitalist work.

Clinical Leadership for NPs and PAs

Kasey Bowden, MSN, FNP, AGACNP


Bowden

Ms. Bowden is an assistant professor and associate division head in the University of Colorado Hospital division of hospital medicine in Aurora, Colo., where she helps lead strategic planning and clinical operations for a team of more than 100 physicians and advanced practice provider (APP) faculty. Her career focuses on improving the delivery, quality, and experience of health care through the development of innovative care delivery models. Ms. Bowden is a member of the task force for mass critical care, which published a consensus guideline in *CHEST* on contingency strategies for mass critical care surge response and created the conceptual framework which continues to guide the division of hospital medicine's COVID-19 response. She is the medical director of the CARE Clinic at the CU Cancer Center, which aims to reduce unplanned acute care utilization through providing advanced urgent care services to oncology patients, a model which has gained national attention and has been replicated at numerous institutions. In addition, Ms. Bowden serves as the senior clinical lead of strategy for the UCHealth office of advanced practice, where she guides the strategic development of advanced practice provider programs. She has been an SHM member since 2012 and served on the board of directors of the Rocky Mountain chapter since 2015. Ms. Bowden has authored numerous publications and speaks nationally on topics of clinical operations, advanced practice provider utilization and advancement, and value-based care delivery models.

Diversity Equity & Inclusion Leadership Award

Amira del Pino-Jones, MD


Dr. del Pino-Jones

Dr. del Pino-Jones is an associate professor in the department of medicine at the University of Colorado. She is the director of diversity, equity, and inclusion for the division of hospital medicine; the assistant program director for diversity and inclusion in the internal medicine residency program; and one of the assistant deans for student affairs in the school of medicine. Most recently, Dr. del Pino-Jones became the inaugural chair of SHM's diversity, equity, and inclusion committee. Her dedication to diversifying the health care workforce has been exemplified through her work with college students who are underrepresented in medicine. Specifically, she created and directed several pathway programs that focus on mentorship, advising, coaching, quality improvement, and leadership training for pre-health students. Her article, "Advancing Diversity, Equity, and Inclusion in Hospital Medicine," published in the *Journal of Hospital Medicine*, highlights some of the transformational diversity, equity, and inclusion programming and initiatives at the University of Colorado. This work shows how a strong commitment and systematic approach to diversity, equity, and inclusion can change the demographics and culture of our health care workforce, prioritize equity, enrich medical education, sustain research endeavors, and optimize the care we provide for all patients.

Excellence in Humanitarian Services

Ingrid Pinzon, MD, FACP, CHCQM-PHYADV


Dr. Pinzon

Dr. Pinzon graduated from medical school at the National University of Colombia and practiced medicine in her country until 2006 when she moved to the U.S. She completed her training in internal medicine at Morehouse School of Medicine, Atlanta. Dr. Pinzon is currently a hospitalist and the medical director of care coordination at Emory Johns Creek Hospital, Johns Creek, Ga. Throughout her career, she has consistently and meaningfully engaged the community, with a focus on underserved Hispanic communities and those who are hesitant to engage with the health care system. She has partnered with the Atlanta Latin American Association, working directly to provide education about COVID-19 to the Hispanic population, including Facebook Live educational sessions and food-drive education. Her reputation and air of authoritative kindness have resulted in multiple interviews regarding COVID-19 safety and vaccination community education in both English and Spanish media, including Univision, Fox 5 News, and Telemundo. In collaboration with the Gwinnett Public Library system, she has presented and recorded culturally competent Spanish-language diabetes and COVID-19 information presentations that are aired on YouTube. As both a physician and a humanitarian, Dr. Pinzon has used her expertise to improve care and outreach to underserved communities.

Excellence in Research

Derek Williams, MD, MPH


Dr. Williams

Dr. Williams is an associate professor of pediatrics and chief of the division of hospital medicine at Vanderbilt University Medical Center, Nashville, Tenn. Dr. Williams is a clinical and health services researcher with a federally funded research program centered on improving care delivery and outcomes for children with pneumonia and other acute respiratory illnesses. He has contributed substantially to numerous studies that have advanced the field, including the landmark Centers for Disease Control and Prevention Etiology of Pneumonia in the Community (EPIC) study. This study was the largest prospective investigation of pediatric pneumonia hospitalizations ever conducted in the U.S., and fundamentally altered how we think about pneumonia etiology in the era of highly effective pneumococcal vaccines. Currently, his research team is focused on the conduct of two National Institutes of Health-funded pragmatic randomized trials testing the effectiveness of predictive analytics and clinical decision support to optimize antibiotic utilization and inform disease-severity assessments in childhood pneumonia. In total, Dr. Williams has authored more than 100 peer-reviewed publications in top-tier journals. He is an active research mentor, with nine current trainees and junior faculty, including two Research Career Development awardees. He also serves on the executive council for the pediatric research in inpatient settings (PRIS) network, an independent, hospital-based research network that has garnered more than $32 million in federal grants to conduct innovative research.

The B Team at Dell Seton Medical Center and Dell Medical School at the University of Texas at Austin

Excellence in Teaching

Christopher Moriates, MD

Dr. Chris Moriates is a practicing hospitalist and clinician-educator dedicated to improving the safety, quality, and value of care delivered to patients. Over the past 10 years, Dr. Moriates has contributed on many fronts to the recent transformation in medical education from "choosing more to choosing wisely."

Dr. Moriates

He has created impactful programs and resources with an international reach. He co-authored the book "Understanding Value-Based Healthcare" (McGraw-Hill, 2015), which surgeon and writer Atul Gawande called "a masterful primer for all clinicians." He led the creation of the Dell Med Discovering Value-Based Health Care online learning platform (vbhc.dellmed.utexas.edu), currently used by medical professionals and trainees across the U.S. He also created and leads the U.S. Choosing Wisely Students and Trainees Advocating for Resource Stewardship (STARS) program, which has included approximately 500 medical students from more than 50 medical schools over the past five years. The trainee-led STARS model has now emerged in eight countries, and Dr. Moriates serves as co-chair of the medical education strategy for the International Choosing Wisely Consortium.

He is also the executive director at Costs of Care, a global, nonprofit, change-cultivating agent focused on making health care more affordable and equitable.

Excellence in Teamwork

The Buprenorphine Team

The Buprenorphine Team (B-Team) at Dell Seton Medical Center and Dell Medical School at the University of Texas at Austin is a hospitalist-led interprofessional team that has worked over the past four years to transform internal organizational culture and the standard of care for recognizing and managing opioid use disorder (OUD) in the hospital setting.

The team, including hospitalists, psychiatrists, palliative care practitioners, social workers, nurses, pharmacists, chaplains, and people with lived experience was founded in 2017 to identify patients with OUD, start buprenorphine therapy for interested patients, implement hospital-based harm reduction strategies, link patients directly to addiction care after discharge, and provide institutional education to reduce the stigma of patients with substance use disorders. The B-Team was the first program of its kind in Texas and one of few in the country to empower hospitalists to treat OUD as a routine part of acute hospitalization.

The B-Team has systematically engaged team members at five additional hospitals across Texas to work as a collaborative team to expand access to medications for opioid use disorder (MOUD) for hospitalized patients. Moving forward, the team will work on expanding the program to additional substance use disorder diagnoses. The emphasis on teamwork and collaboration allowed our partner hospitals to increase statewide institutional knowledge and comfort with buprenorphine and other MOUD. The B-Team presents a highly effective model that has proven to be transferrable using existing hospital resources.

Outstanding Service in Hospital Medicine

Amith Skandhan, MD, FACP, SFHM

Dr. Skandhan

Dr. Skandhan is an assistant professor and internal medicine hospitalist at Southeast Health in Dothan, Ala. He holds leadership roles in revenue optimization, population health, and graduate medical education. As a co-founder of SHM's Wiregrass chapter, he aimed to improve the quality of medicine practiced in the rural area it served. He frequently visited regional hospitals and clinics to understand their specific concerns and hardships. Using the resources provided by SHM, he led projects which led to improvements in patient flow and throughput, established revenue optimization streams, and boosted population health in these rural institutions. He developed a network of grassroots health care advocates who have met with Alabama state legislature members to present case studies that reflected pressing local patient care issues. When the COVID-19 pandemic hit Alabama, Dr. Skandhan realized the disease would disproportionately affect smaller rural hospitals and hospitalists due to institutional isolation and lack of resources. He formed a weekly statewide meeting for hospital medicine program directors, sharing care pathways, discussing supply chain issues, and addressing leadership challenges. The forum collaborated with the Alabama Public Health Department and Alabama state health policy committee to address the hurdles of frontline providers. Dr. Skandhan also sought to address vaccine hesitancy in Alabama, given statewide low vaccination rates. He organized a discussion forum where physicians, community religious leaders, and government officials discussed COVID-related topics with an evidence-driven but non-judgmental approach. To improve academic outreach during the pandemic, his SHM chapter also created an e-poster competition on Twitter with more than 500,000 digital interactions. Additionally, he led outcome-driven, multi-month collaborative virtual projects with institutions across the country to improve trainee well-being and facilitate faculty development.

Junior Investigator Award

SHM's Junior Investigator Award recognizes junior/early-stage investigators whose research interests focus on the care of hospitalized patients, the organization of hospitals, or the practice of hospitalists.

Micah T. Prochaska, MD, MSc

Dr. Prochaska

Dr. Prochaska is an assistant professor of medicine at the University of Chicago. He is a clinical investigator and hospitalist clinician and is supported by grants from the National Heart, Lung, and Blood Institute to study how red blood cell transfusion for hospitalized patients with anemia affects their fatigue, activity, and fatigability levels after they have been discharged from the hospital. Dr. Prochaska's work has been recognized by the Association for the Advancement of Blood & Biotherapies, who elected him to their patient blood management and clinical transfusion medicine guidelines committees, and by the Society for the Advancement of Patient Blood Management, where he is chair of the scientific committee.

Dr. Prochaska is also the associate director and co-investigator of the University of Chicago Hospitalist Project research infrastructure and is involved in the integration of the Chicago Area Patient Centered Outcomes Research Network into clinical research at the University of Chicago. He is co-investigator of the University of Chicago Translational Medicine Program, and the Cultivating Health & Aging Researchers by Integrating Science, Medicine, & Aging Program, both of which train undergraduate students in clinical and translational research. Dr. Prochaska is an associate director of the MacLean Center for Clinical and Medical Ethics and a Healthcare Delivery Science and Innovation Scholar, both at the University of Chicago. ■

New HHS Guidance for Increasing Number of Buprenorphine Providers Who Can Treat OUD

Does your state allow it?

By Anita Silwal, MS, MA, Robert M. Bohler, MPH, MA, Cindy P. Thomas, PhD, Anna Maria South, MD, Jeffery Talbert, PhD, Laura C. Fanucchi, MD, MPH, FASAM, and Michelle R. Lofwall, MD, DFAPA, DFASAM

The ongoing opioid epidemic

The U.S. hit a grim milestone of more than 100,000 drug overdose deaths,[1] most opioid-involved, in the 12 months ending April 2021. This alarming increase underscores the critical need to expand access to effective medications for opioid use disorder (OUD), including in the hospital setting, as noted by Linker and colleagues in *The Hospitalist* in December, 2021.[2]

A brief history of buprenorphine regulation and policy

Pharmacotherapy with buprenorphine, a schedule III partial opioid agonist, and methadone, a schedule II full opioid agonist, reduces overdose and all-cause mortality by more than 50% but is drastically underutilized.[3] One critical barrier to providing buprenorphine treatment for OUD in the hospital is the requirement for prescribers to have a Drug Enforcement Agency (DEA) waiver (a.k.a. an X-license) to be able to prescribe buprenorphine upon discharge. Until recently, prescribers were required to complete specific training before applying for the waiver. To increase the number of buprenorphine prescribers, the U.S. Department of Health and Human Services (HHS) enacted a federal policy change[4] allowing prescribers to receive the 30-patient waiver without this additional training. Through illustrative examples, we present that there may be policy and/or regulatory barriers at the state level that may hinder hospitalists' use of the new federal pathway.

The Food and Drug Administration (FDA) approved buprenorphine in 2002 for OUD treatment after Congress passed the Drug Addiction Treatment Act in 2000.[5] The Drug Addiction Treatment Act of 2000 (DATA 2000) allows physicians to prescribe narcotic medications for the treatment of OUD if certain criteria are met:

1. Medications prescribed must be schedule III-V and FDA-approved for opioid dependence (as defined in the Diagnostic and Statistical Manual of Mental Disease-IV).
2. Clinicians must have an active medical and DEA license.
3. Clinicians must fulfill specific educational training criteria. Most physicians fulfilled the training requirement by completing a Substance Abuse and Mental Health Services Administration (SAMHSA)-certified eight-hour course.

Physicians initially could prescribe buprenorphine to a maximum of 30 patients in their first year with the DEA waiver, and could increase to a limit of 100 patients after one year and up to 275 patients after two years. In 2016, the Comprehensive Addiction Recovery Act (CARA) was implemented, allowing physician assistants (PAs) and advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners (NPs), and certified nurse-midwives) to obtain waivers. Expanding waiver eligibility to non-physicians significantly increased the size of the workforce,[6] but it remains inadequate, with many choosing not to apply for a waiver, or prescribing far below their patient limit.[7] And, in 2020, more than half of rural U.S. counties lacked a single waivered practitioner, and many counties have only one.[8]

New hope: federal policy change aims to remove barriers

In a further effort to expand the buprenorphine prescribing workforce, HHS issued a new policy guideline[4] on April 28, 2021. It outlined a process where eligible providers with a valid DEA registration and state clinical license can receive the 30-patient-limit waivers without completing the prerequisite 8- or 24-hour waiver training for physicians and non-physicians, respectively, and attesting to the capacity to refer patients to counseling and other ancillary services.

This major policy change aims to decrease gaps in buprenorphine treatment availability at several points of care, such as discharge from inpatient hospital settings and emergency departments (ED). Hospital admissions of people with OUD and serious injection-related infections (e.g., endocarditis and osteomyelitis) are rising.

Treatment of the underlying disease is critical, particularly given the increases in overdose deaths due to the rising potency and prevalence of fentanyl in the country, and in patients being initiated on medications for OUD in both the ED and inpatient settings. Hospitalists and ED clinicians must be waivered to provide a short buprenorphine prescription upon discharge to provide effective care transitions. This change will hopefully help erode the misperception among medical professionals, leaders, and administrators that OUD treatment with buprenorphine is optional and encourage more widespread recognition that providing this mortality-reducing treatment is not more medically or legally complicated or risky than treatment of other chronic diseases. In fact, not providing access to this treatment may violate several laws and put medical professionals, their employers, and health care entities at risk.

The Legal Action Center has explained that hospitals may be violating the Emergency Medical Treatment and Labor Act, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964, when they choose not to provide evidence-based medical treatments for substance use disorders, such as OUD.[9]

Role of the states: friend or foe to the new federal exemptions?

While DATA 2000 increased the role of individual physicians in treating OUD with FDA-approved schedule III-V medications, the Federation of State Medical Boards (FSMB), in collaboration with SAMHSA, developed model guidelines for state medical boards to use in regulating office-based OUD treatment with buprenorphine. This resulted in the Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office,[5] revised in 2013. Although it was designed to encourage state medical boards to adopt consistent standards, some states have codified additional requirements through state legislatures or medical and nursing boards.[10] We've identified two scenarios where the adoption of the new federal guidelines may be delayed at a state level.

First, state laws and regulations may contain language derived from DATA 2000 or the FSMB model policy, to reflect federal requirements in state law or regulation, predating the new HHS guideline, without further restriction. For example, in Maine, a joint rule of the Board of Licensure in Medicine, the State Board of Nursing, and the Board of Osteopathic Licensure required buprenorphine treatment providers to "obtain a DATA 2000 waiver and complete buprenorphine training."[11] Maine is now amending the joint rule to state that the practitioner must "obtain a DATA 2000 waiver and complete buprenorphine training in accordance with applicable state and federal laws, rules, and regulations." Thus, Maine will likely have only a short delay in implementing the new HHS guideline.[11]

Alternatively, state laws and regulations may impose more restrictive rules than DATA 2000 due to perceived diversion and/or safety issues with buprenorphine prescribing and may not align with the new HHS guideline. In Kentucky, for example, the Board of Medical Licensure has additional requirements for buprenorphine prescribers and is not adopting the new HHS guideline. Physicians in Kentucky alerted the medical board of the HHS policy change and the corresponding supportive recommendation from the American Society of Addiction Medicine, while the state's buprenorphine regulations were open for revision. Unfortunately, the revised (July 2021) Kentucky Administrative Regulation on professional standards for prescribing, dispensing, or administering buprenorphine still stipulates that the DEA-licensed prescriber shall have obtained "...buprenorphine certification through a completion of a SAMHSA-certified course." This effectively blocks the implementation of the new federal policy in Kentucky.[12]

Takeaway

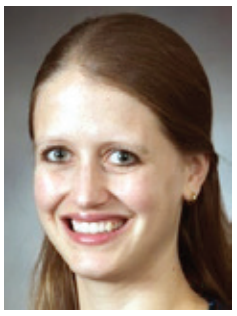
The federal government has decreased provider-level policy barriers to obtaining a DEA waiver, but how this change is realized in the states, and whether practitioners waivered under the new pathway will be able to practice without violating regulations from their nursing, medical, or osteopathic boards, is not yet known. It's not uncommon for state laws and regulations to be more restrictive than federal ones. However, given the ongoing and worsening opioid epidemic, more than two decades of U.S. data demonstrating the overall safety, cost-effectiveness, and mortality reduction associated with buprenorphine treatment, and several medical societies[13] calling for the removal of the waiver requirement entirely, the state example of Kentucky is worrisome.

Patients with OUD frequently visit EDs, hospitals, primary care, general psychiatry practices, and


Silwal


Bohler


Dr. Thomas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long-term care and skilled nursing facilities (e.g., after sequelae of non-fatal overdose or serious injection-related infections). Access to evidence-based medication treatment for OUD is often absent or inconsistent[14,15] at these locations and is direly needed along the entire care continuum for this chronic illness.[16]

Overall, the potential for inconsistencies between federal and state regulations (that vary between states) is important for hospitalists, ED clinicians, and others to be aware of if they obtain the waiver without doing the training. Further, we hope that raising awareness of these state-level barriers to expanding access to life-saving buprenorphine treatment will spark more conversation on the need for hospitalists practicing in every state to utilize the new federal pathway to obtain the X-waiver.

Acknowledgment

The National Institutes of Health Helping to End Addiction Long-term Initiative, a large-scale community intervention trial in four states (Kentucky, Massachusetts, New York, and Ohio) aims to reduce opioid overdose deaths by expanding access to evidence-based practices, including buprenorphine treatment in the hospital and other clinical care venues.[17] Examination of policies surrounding buprenorphine treatment is one part of the initiative. This work is supported by the initiative with the following awards: UM1DA049406 (KY) and UM1DA049412 (MA). The content is solely the responsibility of the authors and does not necessarily represent the official views of the Initiative. ■

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Onboarding Changes in the Wake of the Pandemic

The switch from in-person to virtual takes away a personal touch, but also offers some convenience hospitals may continue to use

By Vanessa Caceres

The COVID-19 pandemic forced everyone to work a little differently, including hospitalists involved with onboarding.

From virtual sessions to new ways to connect in person, the two-plus years of pandemic-style onboarding have left behind some permanent changes, as well as some plans to return to onboarding as it was done before.

Here's how the pandemic shifted onboarding at three hospitals across the U.S. and what they learned along the way.

Baystate Health, Springfield, Mass.

Dr. Medarametla

Before the pandemic, new hospitalists at Baystate Health usually all started on the same day in June or July and attended a two-day, in-person orientation, said Venkatrao Medarametla, MD, associate professor of medicine at the University of Massachusetts Chan Medical School, Baystate, and hospitalist at Baystate Health. The in-person orientation allowed them to learn about the hospital's culture and meet other new employees, some of whom were non-hospitalists.

In addition to department-specific training and electronic health record training that took place after the first two days, new hospitalists received a senior hospitalist "buddy" who would serve as a resource. During their first four weeks, new hospitalists gradually received more patients until they reached their full patient load. After that, there were one- and three-month check-ins with new hospitalists.

Now, start dates are more random because of internal personnel changes, COVID-19 statuses, and short staffing, Dr. Medarametla said. Because of short staffing, the gradual introduction of new hires to their full patient load currently takes two instead of four weeks. The more formal presentations associated with onboarding are virtual and sometimes pre-recorded. Baystate still uses the buddy system, which he said is a crucial part of onboarding.

The virtual format and the decrease in in-person group activities due to COVID-19 have changed the tone of onboarding, Dr. Medarametla said. He would like to see more face-to-face interactions, and while he anticipates some will return, some training will remain virtual.

One bright spot in the current onboarding plan, he said, is an in-person, two-day session held about three to four months after hiring, when leaders give more in-depth explanations of metrics and other information. This is invaluable because there's often information overload during the first few weeks of any job. The session, held in a space large enough to allow social distancing, has been so successful that some senior hospitalists said they want to attend. "They can always join if they are free. They can retrain and realign their goals with the organizational goals," Dr. Medarametla said.

Northwestern Medicine, Chicago

Pre-pandemic, a new hospitalist hired at Northwestern Medicine attended a six-hour onboarding session that included meals, a hospital tour, and other helpful information, said Maya Defoe, MD, recruitment director for the division of hospital medicine at Northwestern Medicine. In the afternoon, daytime hospitalists and nocturnists would branch into their respective groups for shift-specific information. The session also included a light icebreaker with activities like singing a random song together.

Dr. Defoe

Administrators matched new hires with a clinical coach who could help answer questions, be a support system, and even guide new hires with some information about Chicago living.

Now, onboarding is done virtually in a three-hour session, and there's no plan (yet) to resume it in person, Dr. Defoe said.

Dr. Defoe isn't a huge fan of virtual onboarding. "It's more draining for me because I can't see reactions," she said. Although attendees are encouraged to turn on their video, not everyone does, which removes the personal aspect. Virtual onboarding also prevents formal hospital tours and the ability to meet and interact with fellow new hires even though there is a virtual icebreaker. To help connect staff members, a wellness committee schedules informal get-togethers. But of course, participation in these takes more initiative from everyone, including both new hires and more experienced hospitalists.

That said, Dr. Defoe thinks one perk of virtual orientation is that it's more accessible to those who've not yet moved to the Chicago area.

The new format has led to more reliance on the clinical coaches to guide new hires, said Rachel Cyrus, MD, clinical practice director for

Dr. Cyrus

the hospitalist program at Northwestern Medicine. Dr. Cyrus is also the chair of SHM's practice management committee.

Carilion Clinic, Roanoke, Va.

The recruiting process at Carilion Clinic, where Shyam Odeti, MD, is the section chief of hospital medicine for its seven hospitals, used to be in-person interviews that enabled candidates to get to know potential fellow staff members and tour the hospital. This was true for both physicians and advanced practitioners, even though their interview processes were slightly different.


Dr. Odeti

For onboarding itself, the presentations for hospitalists given by various staff members, once in person, are now virtual. "Virtual is great, but it's not the same. It's not only the learning. It's also meeting people, which is the most important part," Dr. Odeti said. He likens the role of a hospitalist to that of a quarterback, who would naturally want to know who his offensive-line team members are, not to mention other players.

"Developing relationships and learning the culture and processes outside the hospitalist section is taking longer and taking extra efforts," he said.

Both before the pandemic and now, new hospitalists shadow a seasoned hospitalist physician and will see fewer patients for a couple of weeks until they become more familiar with their hospital.

Despite the drawbacks of going virtual, the pandemic has forced Carilion's seven hospitals to standardize onboarding more, Dr. Odeti said. He sees this as a positive result of the pandemic changes.

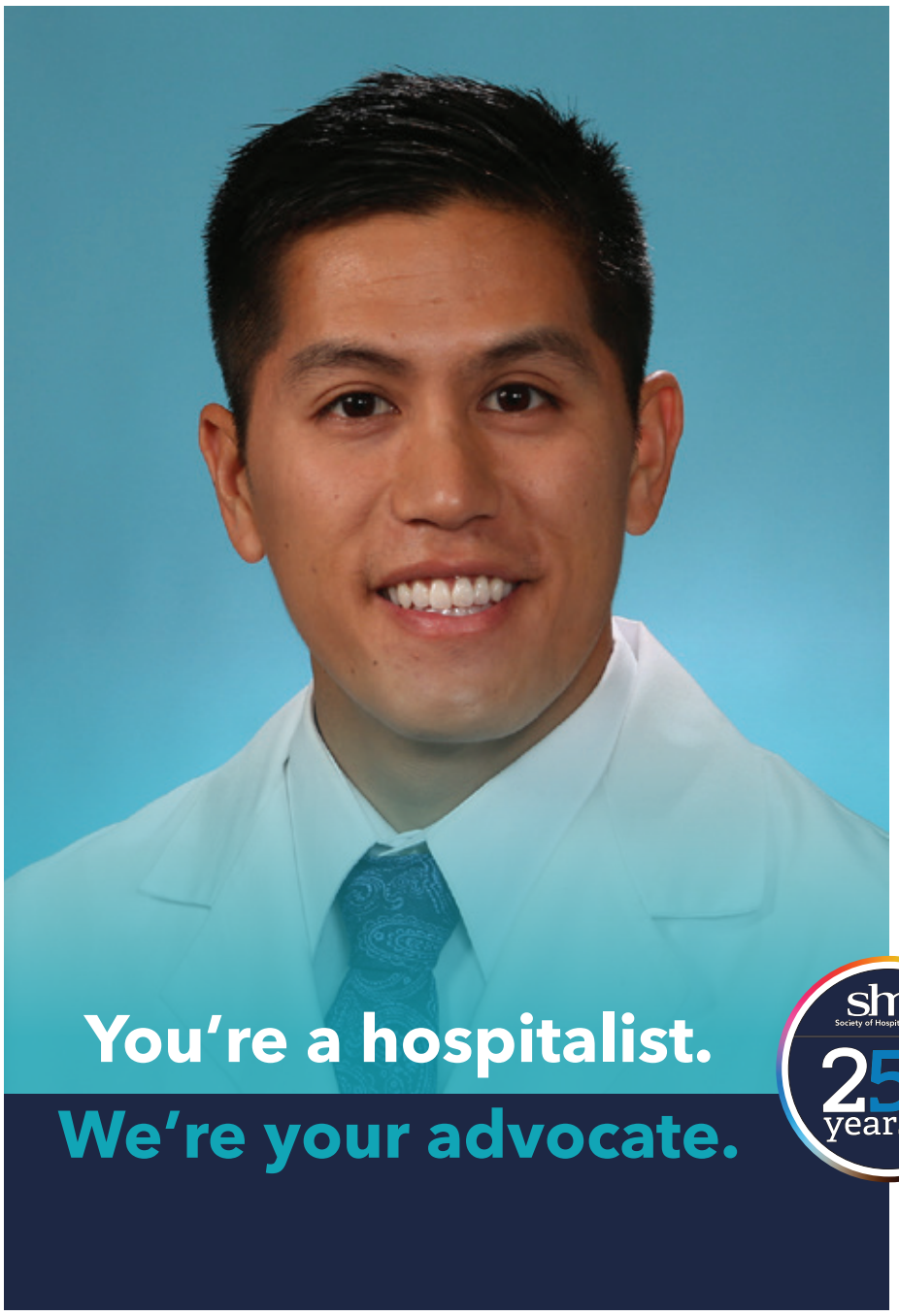
Lessons learned

Hospitalists have faced innumerable challenges these last few years, not the least of which is how to onboard new clinicians. But they've taken it in stride much like everything else. They've adapted, innovated, and created new ways of doing things. Here are just a few of the ideas hospitalists shared about onboarding during a pandemic.

- Think of the recruiting process as part of onboarding. Ask potential hospitalists about their goals. If their goals aren't aligned with your hospital's goals, then it may not be the right time for them to start with your organization, Dr. Medarametla said. "Recruiting right is crucial," he said.
- Have hospital leaders seek out new hires in person during the first week. Drs. Cyrus and Defoe always find new hospitalists in their units in the first week to say hello. It helps them feel valued and like an important member of the hospital staff. "These in-person touches become even more important," Dr. Cyrus said.
- Remind new hires to have self-compassion, Dr. Cyrus said. No matter what new job you start, there's always a lot of information to process. Let new hires know they should be patient with themselves, even if they can't remember where the bathroom is for the first day or two.
- Think of onboarding as a marathon, not a sprint, Dr. Odeti said. Because of pandemic-related changes, you may need to take longer to orient new hospitalists, and that's okay. What's more important is to make a thoughtful investment of time and effort to help them succeed as hospitalists and enable their long-term retention. Hospitalist leaders should initially do frequent check-ins.
- Continually check-in and retrain. Have standard time points at one month, three months, or as you see fit to check in with new hires, Dr. Medarametla advised. Use this time to hear their concerns or questions and retrain as needed. You could do this individually, or you could hold a structured event to present information that may have been too overwhelming to share during the first week or two. "Intervene and re-evaluate until they are completely on board," he suggested.
- Find ways for new hospitalists to meet with non-hospitalists. Hospital medicine is a team sport. Because hospitalists must be in contact with a range of people, virtual sessions where they can put a name to a face with subspecialists, nursing, or other hospital units can be helpful, Dr. Odeti said. Even quarterly sessions like this can be useful.

Whether your institution reverts to all in-person onboarding, switches to all virtual, or implements a hybrid of both, onboarding comes down to communicating, listening, supporting, and connecting. ■

Vanessa Caceres is a medical writer in Bradenton, Fla.



"As sexual and gender minorities (SGM) continue to face healthcare disparities, it is vital that we build trust within the SGM community by supporting the growth of a diverse workforce to decrease biases and stigma. Listening to the community's needs, while advocating for increased access to care for SGMs and education for the healthcare practitioners caring for them can positively impact patient care."

– Tony Dao, MD

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hospitalmedicine.org/join

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SIG Spotlight: Quality Improvement

By Richard Quinn

More than 25 years ago, hospital medicine was born out of the now obvious-seeming conceit that medical care for hospitalized patients could be qualitatively improved.

So it's no surprise that today one of the most popular SHM Special Interest Groups (SIGs) born of that movement focuses on quality improvement (QI)—the veritable raison d'être for the specialty.

"It's really that commitment to continuous quality improvement and patient safety that puts it together," said group chair Anneliese Schleyer, MD, MHA, SFHM, associate chief medical officer at the University of Washington School of Medicine and hospitalist at UW Medicine's Harborview Medical Center in Seattle. "Having a shared passion and shared commitment to doing that has been an opportunity for us to build and strengthen a community under the SHM umbrella. Having the opportunity to learn from each other and share best practices has been incredibly valuable."


Dr. Schleyer

SHM has 27 SIGs whose purpose is to "create communities of hospitalists around topics of interest, practice areas and/or care models." The QI SIG is an important voice for the specialty and to members across the career spectrum.

"As our community has continued to grow, we have seen the value of learning from everyone. Whether it's a hospitalist who may be starting on the journey in quality improvement, to those who have been doing it for many years. We always have the opportunity to learn from each other regardless of where we are," Dr. Schleyer said. "During the pandemic, there was an opportunity to connect, which is one of the many valuable offerings that SHM has. And at that time, probably more than any other, the shared connectedness and shared approaches were really valuable."

In the heart of the pandemic, SIG vice-chair Sarah Baron, director of inpatient quality improvement at the Albert Einstein College of Medicine's Montefiore Medical Center in New York, saw scores of new members flock to the group.


Dr. Baron

In fact, according to SHM figures, the group saw increases in membership every month from June 2020 through January 2022, the latest data available. The group had 1,370 members in January, up from 224 in January 2018.

Members new and old come for community support, in addition to clinical pearls.

Sometimes, "it was less about sharing particulars," Dr. Baron said. "That happened in other forums for many of us. It was significantly more about having a safe space outside the realm of the institution where we knew people and we were welcoming new people to participate about shared fears, shared experiences, in some ways shared backgrounds, and in other ways varied backgrounds. But we created this supportive environment in the middle of a time where we needed all of the support we could get."

Dr. Baron is particularly proud of the idea that hospitalists feel empowered by the SIG to share concerns and issues that they might feel less comfortable sharing in other professional settings.

"We have all done projects, big or small, that have run up against administrative challenges," she said. "And often, those challenges are best met and understood and deciphered by fresh eyes, by someone outside of your own institution. Those of us in this group call on each other constantly to examine our issues with a new perspective.

"And I do think a lot of the discussions we have are painted in broad terms. But every once in a while, we get down to teaching some very basic quality improvement tools. We like to post them on HMX (SHM's members-only online community) afterward so they can do double duty and start some conversations. We are making changes within our group, which is the work that we do within our hospital, also. We are doing the QI that we are talking about to our group."

Dr. Schleyer says keeping that momentum going post-COVID-19 is now key to adding even more value. That was part of the motivation for last year's appearance by SHM CEO Eric Howell, MD, MHM, who was a quality expert himself before taking on the Society's leadership post.

Another facet of engagement: monthly meetings of the SIG's resources sub-group where anyone from residents to department heads can make presentations.

"We call them medical moments," she said. "But we asked people who were interested in sharing projects that they were working on, no matter where they were in the project. Whether it was something they were just starting to think about, to get insights from others, or if it was something they were invested in and were working on for a long time...because you can always learn something from someone else, regardless of how much experience they have. That is something very magical to watch." ■

Richard Quinn is a freelance writer in New Jersey.

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Chapter Spotlight: Los Angeles

By Richard Quinn

In early March 2020, the Los Angeles chapter of SHM was hosting former society president and local chapter member Nasim Afsar, MD, MBA, MHM, (chief health officer of Cerner, Los Angeles) for an in-person event. The event was particularly exciting for hospitalist Stephanie Zia, MD, MACM, FAAP, FACP, FHM, who was about to take over as chapter president.

Dr. Zia

Then the world changed.

That was the last in-person event Dr. Zia attended for the chapter she now runs—but it surely wasn't the last get-together.

"Even though we haven't met as a full chapter in person since 2020, we've hosted more events than we ever have," said Dr. Zia, who works at Keck School of Medicine at the University of Southern California in Los Angeles. "Before the pandemic, one of our initiatives was to try to host more virtual meetings because we hadn't really tapped into that resource and the pandemic thrust us into this meeting platform. We always aimed to have in-person meetings. Ironically, during the pandemic, we've put on more events virtually and more consistently than we previously had when we were still meeting in person."

The Los Angeles chapter launched in 2007 and has 321 members. And while SHM has nearly 70 chapters nationwide, perhaps none approaches diversity the way the City of Angels outpost does.

The chapter caters to all corners of the geographic diaspora that is Los Angeles, and Dr. Zia takes equal care to make the group home to physicians, students, trainees, and advanced-practice professionals. Last year, the chapter launched its "Crucial Conversation" seminar series.

"We talked about difficult topics that pertain to hospitalists with regards to racism in medicine," Dr. Zia said. "We also talked about allyship, and LGBTQIA+ in medicine, whether it was as an LGBTQIA+-identifying provider or while caring for patients who identify as LGBTQIA+, and how to be the most inclusive that we could."

Dr. Zia was awestruck by the response.

"It was amazing," she said. "I can't get over the sense of pride in knowing that we were able to have people who came and attended the meeting, and also, in elevating the colleagues we featured as panelists as they shared their most vulnerable experiences, from the perspective of being the provider, or part of a marginalized group. The dialogue that occurred between the panelists was rich, as our facilitators really engaged them in conversation. I think it was a wonderful moment to witness how, as physicians, our work doesn't end at the of our workdays, but rather, extends beyond the hospital walls."

The focus on diversity doesn't just apply to racism and orientation. To the chapter leadership panel, career diversity is just as important.

"We created a new hospitalist career development series, where we hoped to try to arm our rising or new hospitalists with the tips and tools that we could as they were preparing to embark on a career in hospital medicine.

"The series aimed to have new hospitalists learn more about what it would take to be a good candidate as a hospitalist, how to actually look at their contracts and identify what could be negotiated versus what could not, and finally, to identify how to be good at your job, even before day one on the job."

While this year's plan is to continue both of those series, Dr. Zia and her team are also looking to introduce a leadership-development series.

All of the series are an extension of what Dr. Zia sees as the mission of serving members: A mission crystalized by COVID-19.

Shortly after the pandemic, "we started a group chat, and we did have one group virtual meeting where hospitalists from around the region were invited to connect just so we could check in on each other and see what was going on at each of our respective institutions and hospitals," Dr. Zia said. "Everyone was walking into the unknown. To have even that brief exchange where people were texting each other and saying, 'Oh, what are the latest guidelines you have been learning?' 'What are people at your institution or hospital been saying about these methods of management?' It was really helpful to be able to connect."

Perhaps the best word to describe the chapter is diversity, in every sense of the word. Whether it's a veteran hospitalist at a leading institution or a first-year at a community hospital working with underserved patients, Dr. Zia wants them included.

"No matter your practice setting, no matter your training, no matter what you do, the Los Angeles chapter of SHM can be a home to you," Dr. Zia said. "We're going to delve into topics that are both clinical and societal. And we very much want to be able to support all of our members, as well as think about how we can maximize our networking amongst colleagues in the region as we also bring in and, hopefully, train up the colleagues who join us as they finish up their training." ■

Richard Quinn is a freelance writer in New Jersey.

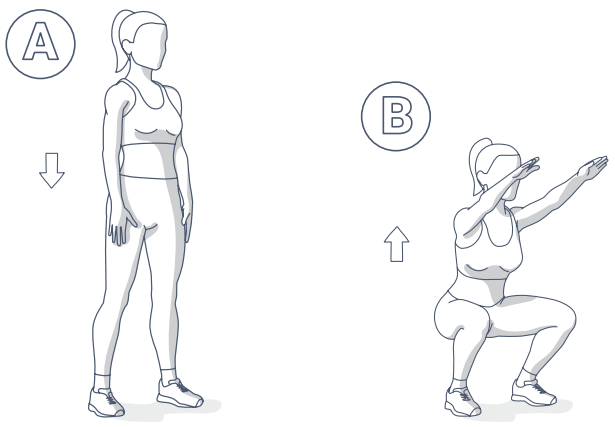
HIIT Your Goals!

How principles of High-Intensity Interval Training can boost your career productivity

Example 8-minute HIIT workout

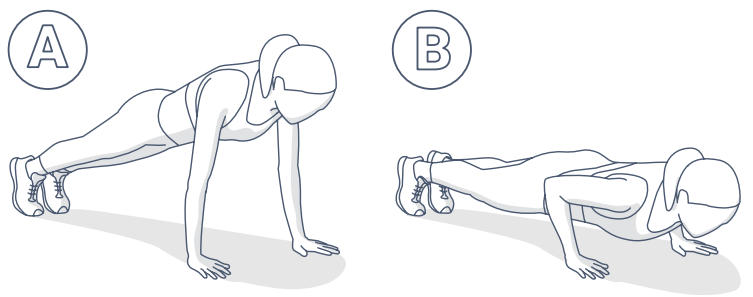
Work interval: 20 seconds • **Rest interval:** 10 seconds

Squats
20 seconds



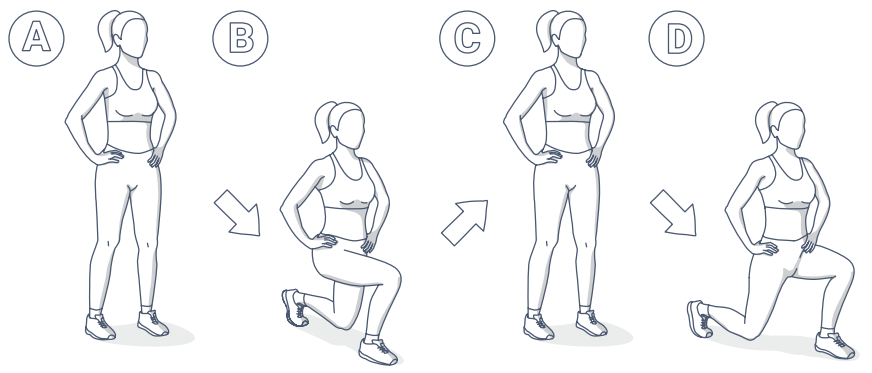
Rest
10 seconds

Push-ups
20 seconds



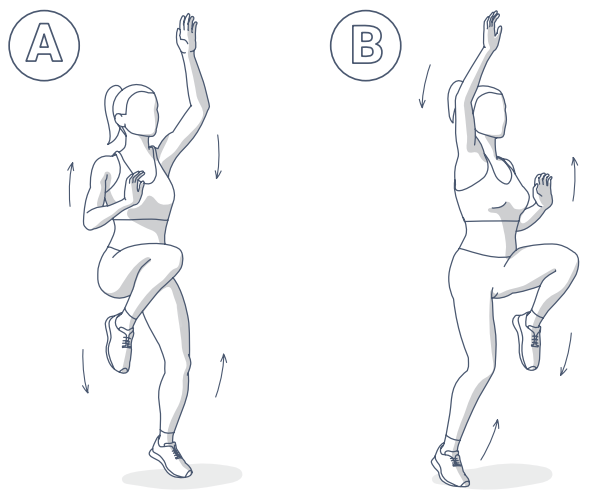
Rest
10 seconds

Lunges
20 seconds



Rest
10 seconds

Mountain Climbers
20 seconds



Rest
10 seconds

Repeat the above four times
for a total of 8 minutes

By Nila S. Radhakrishnan, MD, Dan Griffin BS, CSCS

Everyone manages never-ending career and personal demands, and hospitalists are no different. We're treating and caring for patients and dealing with urgent issues that need our focused attention. We're juggling multiple inboxes—email, patient messages, staff messages, and communications. On top of all that, many of us have further career goals, whether it's stepping into leadership roles, pursuing academic scholarly publication, or even writing a book. Most people are also juggling family needs, raising children, running households, and having a social life. And then of course there's self-care (sleep, health, nutrition, exercise), which the pandemic taught us is more important than ever. There are only 24 hours in a day, so how do we make time for all that?

Where, oh where is the time?

If we invest time in things that will help us meet long-term personal and professional goals, the payoffs can be significant in terms of progression and satisfaction. The problem is long-term goals typically get put on the back burner and we respond to the urgent tasks first. How can we make time to move the tasks forward that will help us reach those long-term personal and professional goals while still fulfilling the everyday demands? Fortunately, hospitalists are typically very good at working intensely on what is in front of them.

Make time for HIIT

High-Intensity Interval Training (HIIT) as the name suggests, is a training modality that involves short periods or intervals of intense work followed by intervals of rest/recovery (see sidebar for an example of a typical HIIT workout).

HIIT has become very popular in exercise and training environments because it allows you to accomplish a lot of work in a short amount of time. Shorter time frames make tasks seem more manageable and less overwhelming. It's much easier to schedule 20-minute intervals in your day than to block off three straight hours. And, once you get going and create positive momentum, your progress builds and compounds and your results are amazing!

The most important aspect of HIIT is the intensity—that's what makes it effective. To get the most out of a HIIT session you must be dialed in and focused on your goal and not allow distractions to sidetrack you. Intensity is relative to the individual—an advanced athlete's intervals are going to look a lot different than a beginner's intervals, but that's the beauty of HIIT. You can customize the intervals to your own ability level, skill set, and schedule or goal/task. It's important to remember when developing a HIIT workout or applying HIIT principles to other tasks in your life that your intervals are realistic and sustainable, otherwise, you won't stick to them.

Dr. Radhakrishnan

Dr. Radhakrishnan is an associate professor and chief of hospital medicine at the University of Florida, Gainesville, Fla. Mr. Griffin is a certified strength and conditioning specialist and owner of Sweat Life Fitness in Gainesville.

Career Productivity intervals

TASK	INTERVAL WORK:REST	COMMENTS
Academic article	25 minutes:5 minutes	Break down the various parts of the writing into aliquots and work on an aliquot in each interval
Inpatient progress note	5 minutes:3 minutes (to answer pages or urgent calls)	During the 5 minutes focus on the task
Online CME course or board practice questions	30 minutes:5 minutes	Break down a 2-hour course to complete over 4 blocks
Writing a book	20 minutes:5 minutes with a longer break every 3 rounds	Scheduled daily or every other day
Reading a book on leadership	15 minutes:3 minutes	Read a little each day

Intervals of focus

Hospitalists naturally thrive in an intense work period followed by a rest period. This same rhythm can be used to achieve productivity, as Francesco Cirillo showed when he developed the Pomodoro Technique in the 1980s.[1] *Pomodoro* is the Italian word for tomato, and Cirillo named his time-management technique after a tomato-shaped kitchen timer he used as a student. He described intervals of focused work time for 25 minutes followed by five minutes of dedicated rest. During the 25-minute work interval, the focus must be on the task and nothing else. That means no checking email, scrolling social media, or responding to calls. During the structured rest time, it's encouraged to do something refreshing like walking around, deep breathing, or anything else. Then it's back to 25 minutes of work. The advantage of the Pomodoro Technique is that it allows for focused work time in small aliquots which helps you make progress and overcome procrastination. You can achieve more in 25 minutes of intense, focused work than in one hour of interrupted work.

Using principles of interval training can seem overwhelming initially. Without a strict deadline it's easy to procrastinate or get sidetracked by something seemingly more urgent that hijacks your attention. We're all busy and have short attention spans. We think we must wait until all conditions are perfect to start a project. When will the day come when we have hours blocked, we have the perfect quiet environment, we have all our ideas assembled, we are caught up on everything, and we can complete our project? The problem is for most people, this day never comes, and the task is never started, much less finished. How many of us have a task on which we've been procrastinating? How many of us have a task that we've procrastinated on for over a year because we never find that "perfect day" to complete it? Principles of interval training can help us here.

Ready, fire, aim. For exercise, as for most things in life, getting started is the key. Rarely is there a perfect time, when all the stars align, and a message is sent from the heavens indicating that now is the ideal time. You simply must make up your mind and take the first step. Even if everything isn't perfect. Even if you aren't ready. Even if it's uncomfortable. Throughout my 20 years as a strength and conditioning coach I've had the pleasure of working with thousands of clients—professional athletes, doctors, teachers, kids, and everyone in between—and I've noticed two factors that determine success more than any others: making the commitment to get started and then remaining consistent. It's that simple.

By employing short, small, achievable intervals, the principles of HIIT make getting started easier and consistency more likely. You'll see greater results from working out consistently for 30 minutes four days per week than you will from working out one day per week for two hours, and you're more likely to stick with it.

The same can be said for using HIIT principles to overcome procrastination and increase productivity for professional goals. By focusing on a short, intense interval, we can block out a reasonable amount of time, like 20-30 minutes, to intensely move a task forward without having the fear and pressure to complete it. This can help overcome the inertia and unconscious procrastination that can come with tackling a big, important task. Many small intervals, done regularly and with focus, will lead to the completion of the task. It's surprising how much can be achieved just by starting. Often the 25 minutes of dedicated work will lead to another 25 minutes and then another. Just as a runner may struggle for the first 10 minutes of a run but then gets into a pace and feels good enough to keep going, just the act of starting to take forward action can help to overcome the mental inertia to take on a lofty goal.

How to pick the intervals

In exercise training, we consider a few things, namely: the task/goal of the individual, their ability level, and their schedule/outside demands. All these factors play a role in choosing the appropriate intervals. For example, an untrained and sedentary 50-year-old may begin with a work-to-rest ratio of 1:3, meaning their rest/recovery interval will be three times that of their work interval. Whereas a more advanced exerciser may have a work to rest ratio of 3:1, meaning their rest/recovery interval will only be one-third of their work time. Likewise, the activity plays a role in determining the intervals. Maximal strength-based movements require more rest time to allow for appropriate muscle recovery and cardiovascular-based movements typically do not require as much recovery time. So, look at your task and determine what the best approach is, and, most importantly, choose intervals that are realistic and sustainable and will lead to long-term consistency. Be sure to reassess your goals and adjust your action plan regularly. Now get out there and attack your goals with purpose and passion!

For productivity, different types of tasks can require different types of work intervals. In our current environment of sound bites and multi-tasking, focused work takes practice to get into shape. For career productivity, after some practice with intervals, you'll get a sense of which tasks require each type of interval.

Let's take the example of documentation. We know there has been much observation about how much time is spent on documentation in the electronic medical record. Focused interval work can help to tackle charting and help physicians finish this task at work rather than spending nights and weekends completing charts. For a follow-up inpatient progress note, setting a timer for five minutes of productive, focused time without distraction can lead to the note being completed with fewer interruptions. It's also likely to be a much more accurate note. Most inputs, including calls, can wait five minutes. A complex note may take more than five minutes and by setting intervals, a physician can add intervals if needed.

The payoffs from increased professional productivity and career development are significant.

As motivational speaker and author Brian Tracy says, "Rule: It is the quality of time at work that counts and the quantity of time at home that matters."[2] Certainly, we have all regularly put in additional hours when absolutely needed for patient care. However, when long, unproductive hours are the norm, this can lead to burnout and unhappiness. When we aren't able to move forward with our strategic priorities, we can feel stuck and not move toward our purpose. What if instead, we saw that day by day, we were moving closer to our goals? Using intervals to move forward with strategic priorities can help us move toward our purpose. Using intervals to help us with our daily mundane tasks can free time for our loved ones and hobbies.

Bonus tips for success

Removing decision fatigue is a key to helping overcome procrastination and anxiety over a task. This is why morning exercisers lay out their exercise clothes, water bottle, and shoes the night before. Similarly, before a productivity interval to take advantage of the work time it's helpful to have all your tools set up—laptop, phone, files, etc.—and keep a timer. It's equally important to turn off as many inputs as possible, such as notifications and emails. The key is not to allow the preparation to take on a life of its own and to avoid delaying the task if the perfect preparation is not completed. Whether for physical fitness or career productivity Nike's slogan of "Just Do It" applies. ■

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Key Clinical Question

Alcohol Withdrawal: Looking Beyond Benzodiazepines

University of New Mexico School of Medicine

By Craig McFarland, MD, Rahul Shekhar, MD, Suman Pal, MD

Case

Mr. Smith is a 48-year-old man with alcohol use disorder (AUD) and compensated cirrhosis who presented to the emergency department with alcohol withdrawal. He had been consuming one pint of vodka daily for the past three months but tried to quit. The next morning, he felt unwell and came to the hospital. On presentation, he was hemodynamically stable but was disoriented to time and complained of nausea, headache, and tremors. He appeared diaphoretic and had visible tremors in outstretched hands. Initial laboratory investigations showed stage 1 acute kidney injury, but were otherwise unremarkable, with normal transaminases. He received IV hydration and was started on symptom-based benzodiazepine protocol based on Clinical Institute Withdrawal Assessment of Alcohol (CIWA) scores.

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Brief overview of the issue

AUD is prevalent in the U.S. with approximately one-fifth of persons aged 12 or older reporting binge alcohol use in the past month.[1] Alcohol is also the most common cause of substance-related emergency department (ED) visits.[2] Alcohol acts as a central nervous system depressant by increased release of gamma-aminobutyric acid (GABA) with its action on GABA$_A$ receptors and its antagonism at N-methyl-D-aspartate (NMDA) receptors.[3] Withdrawal symptoms after discontinuation of alcohol use result from a decrease in GABA and an increase in NMDA pathway neurotransmission. Benzodiazepines are the first-line treatment for alcohol withdrawal syndrome (AWS) and are efficacious in reducing the severity of symptoms, delirium tremens, and seizures.[4] However, commonly used benzodiazepine-only regimens require close monitoring and frequent redosing. Large cumulative total doses may be required to achieve sufficient symptom control, which increases the risk of adverse effects such as sedation or respiratory depression. Concurrent medical conditions, such as chronic liver disease which may coexist with AUD, may also limit the use of benzodiazepines in certain patients. Additionally, benzodiazepines alone may not adequately treat all symptoms in some episodes of AWS. Therefore, familiarity with other medications as alternative or adjunct therapy for AWS is beneficial for hospitalists.

Key Summary

Benzodiazepines are the first-line treatment for AWS.

- For providers experienced with its use, phenobarbital is an effective adjunctive or alternative treatment for AWS.
- Phenobarbital, dexmedetomidine, and propofol are adjunctive treatment options for severe or resistant AWS in the ICU setting.
- Gabapentin, carbamazepine, valproic acid, antipsychotics, beta-blockers, and clonidine can be used as adjunctive treatments to benzodiazepines for AWS. Gabapentin and carbamazepine may be used as monotherapy for mild or moderate cases of AWS when benzodiazepines are contraindicated.

Overview of the data

Phenobarbital. Phenobarbital, a barbiturate, acts on GABA$_A$ receptors and has been used for the treatment of AWS. Phenobarbital also inhibits NMDA receptors, which may provide additional benefit in AWS. Several studies have reported that phenobarbital is an effective alternative to benzodiazepines in AWS.[5-8] In an uncontrolled prospective study of ED patients with AWS, phenobarbital used alone was effective in improving symptoms.[5] A prospective, randomized, double-blind trial found no difference in ED length of stay or symptom control with the use of phenobarbital versus benzodiazepines.[6] Two studies among hospitalized patients also reported phenobarbital to be an effective alternative to benzodiazepines.[7,8]

Phenobarbital has also been used as an adjunct to benzodiazepines in AWS. It has been postulated that phenobarbital and benzodiazepines have additive effects on AWS due to differential action on GABA$_A$ receptors. While phenobarbital prolongs the duration of chloride channel opening, benzodiazepines increase the frequency of opening. This is borne out by clinical findings in published literature. In a retrospective study of ED patients, single-dose phenobarbital in addition to symptom-triggered benzodiazepines was associated with a shorter length of stay and no significant difference in number of adverse events.[9] A prospective, randomized, double-blind, placebo-controlled study in ED patients reported that the use of single-dose phenobarbital in addition to symptom-guided benzodiazepines was associated with decreased total benzodiazepine dose and fewer ICU admissions with no significant difference in number of adverse events.[10]

A systematic review concluded that barbiturates were safe and effective in the treatment of AWS.[11] Combination of phenobarbital and benzodiazepines could be used to decrease ICU admissions and mechanical ventilation. A beneficial role of phenobarbital was also suggested in severe AWS and benzodiazepine-refractory AWS. It is recommended that phenobarbital be used only by providers who have experience with this medication.[4]

Gabapentin. Limited small-scale studies suggest that gabapentin may be efficacious in the management of mild AWS in ambulatory settings. Gabapentin may have benefits in terms of decreased daytime sedation and decreased alcohol craving.[12] However, alcohol withdrawal seizures in patients treated with gabapentin have been reported in several studies.[13,14] Therefore, gabapentin monotherapy should not be used in severe AWS or in those with a history of AWS seizures or who are at risk for progression to severe AWS. The use of gabapentin as an adjunct to symptom-triggered lorazepam was also not shown to improve outcomes in one open-label retrospective study.[15]

Carbamazepine. Studies have demonstrated some efficacy of carbamazepine in the treatment of AWS, with one meta-analysis showing that carbamazepine was superior to benzodiazepine for alcohol withdrawal symptoms.[16] Compared to benzodiazepines, carbamazepine presents less risk of sedation and misuse, and is an option for monotherapy in the ambulatory setting for mild AWS when there is a low risk for the development of severe withdrawal.[4] In the inpatient setting, carbamazepine is an option for monotherapy for mild or moderate alcohol withdrawal if benzodiazepines are contraindicated. It can also be used as an adjunctive treatment for persistent symptoms in patients treated with benzodiazepines.[4]

Dexmedetomidine. Dexmedetomidine is an intravenous central-acting alpha2-adrenergic

agonist which has been suggested as an adjunct to benzodiazepines in AWS in critical care settings. Besides producing light sedation without respiratory depression, dexmedetomidine has anxiolytic and sympatholytic properties that reduce autonomic hyperactivity, qualities that support its use in AWS. In patients with AWS and delirium, the addition of dexmedetomidine to benzodiazepine has been shown to decrease delirium severity.[17] It may also reduce total benzodiazepine dose requirements in the short term, though the difference seems to be lost when analyzed over the total duration of hospital stay.[18] Dexmedetomidine may also decrease the need for mechanical ventilation and associated complications such as nosocomial infections.[19] The effect on length of stay is debatable with some studies reporting shorter ICU and hospital stays, whereas others noted longer hospital stays.[19,20] An important consideration would be cost and resource utilization, since it can only be used in a critical care setting. With current evidence, the use of dexmedetomidine seems beneficial in a select group of patients in a critical care setting with severe AWS, or in those with delirium, to decrease the need for mechanical ventilation due to high benzodiazepine requirements.

Propofol. Propofol is a dose-dependent sedative-hypnotic with agonism of GABA receptors through a site different from that of benzodiazepines, and inhibition of NMDA subtype of glutamate receptor. Due to its mechanism of action, propofol has been used in AWS in critical care settings as an adjunct to benzodiazepines. In patients with refractory AWS, the addition of propofol is associated with decreased benzodiazepine dose requirement. Studies have reported similar or increased duration of mechanical ventilation, time to resolution of symptoms, and ICU stays with propofol adjunct.[21] Thus, propofol may be beneficial as an adjunct in a select group of patients with AWS refractory to benzodiazepines who are in a critical care setting and requiring mechanical ventilation, or if other adjuvant medications are contraindicated. Hypotension, hypertriglyceridemia, and propofol-related infusion syndrome are possible adverse effects of propofol use.

Beta-blockers and clonidine. Beta-blockers and the alpha2 agonist clonidine may be a reasonable adjunctive treatment for the management of persistent tachycardia and hypertension for patients who are adequately treated with benzodiazepines and who have received adequate fluid and electrolyte replacement.[4] These medications may improve anxiety as well. Neither of these medication classes is adequate as monotherapy.

Antipsychotics. Antipsychotics are not recommended as a stand-alone therapy for alcohol withdrawal. Antipsychotics may be reasonable as an adjunctive treatment to benzodiazepines for alcohol withdrawal delirium with uncontrolled hallucinations and agitation.[3] Antipsychotics reduce the seizure threshold and thus must be used with caution and close monitoring in the setting of alcohol withdrawal.

Valproic acid. Valproic acid is not recommended as a monotherapy for alcohol withdrawal due to insufficient evidence.[22] It can be used as an adjunctive treatment to benzodiazepines.[4] Its use is contraindicated in the setting of liver disease, hematologic disease, and pregnancy.

Baclofen. Baclofen is not recommended for the treatment of AWS.[4] A systematic review of randomized controlled trials yielded no conclusions regarding the use of baclofen for AWS.[23]

Ethanol. The efficacy of ethanol for treating AWS is unknown, and it has recognized adverse effects. Ethanol is not recommended for the treatment of AWS.[4]

Table 1: Medications recommended as possible adjuncts to benzodiazepines for AWS4

Medication	Indication for adjunctive therapy	Remarks
Phenobarbital	Severe or resistant alcohol withdrawal	Recommended only for providers experienced with its use
Dexmedetomidine	Resistant alcohol withdrawal in ICU	
Propofol	Resistant alcohol withdrawal for intubated patients in ICU	
Gabapentin	Persistent symptoms on adequate benzodiazepine regimen	
Carbamazepine	Persistent symptoms on adequate benzodiazepine regimen	
Valproic acid	Persistent symptoms on adequate benzodiazepine regimen	Contraindicated in liver disease, hematologic disease, and pregnancy
Beta-blockers	Persistent tachycardia, HTN, anxiety	
Clonidine	Persistent tachycardia, HTN, anxiety	
Antipsychotics	Uncontrolled hallucinations in alcohol withdrawal delirium	Risks include lowered seizure threshold and QTc prolongation

Table 2: Options for monotherapy for inpatient treatment of alcohol withdrawal when benzodiazepines are contraindicated[4]

Medication	Indication for monotherapy	Remarks
Phenobarbital	Mild, moderate, or severe withdrawal	Recommended only for providers experienced with its use
Gabapentin	Mild or moderate withdrawal	May be transitioned to maintenance AUD therapy
Carbamazepine	Mild or moderate withdrawal	

Application of the data to the original case

Based on his CIWA scores, Mr. Smith received 75 mg oral chlordiazepoxide, and subsequently also received 1 mg intravenous (IV) lorazepam. He became somnolent but arousable, though he seemed to be oriented only to self. Due to his cirrhosis and concern for poor clearance of benzodiazepine, the CIWA-based benzodiazepine protocol was discontinued, and he received IV phenobarbital 260 mg followed by IV phenobarbital 130 mg at re-evaluation in one hour. On subsequent evaluations, Mr. Smith's symptoms improved. The next day he noted the resolution of all symptoms but started to have alcohol cravings and requested medications for craving control to assist with alcohol abstinence. He was provided with a prescription for gabapentin and was discharged with a planned follow-up with a primary care provider. Of note, on his previous admissions for alcohol withdrawal, he had been treated with the CIWA-based benzodiazepine protocol and had a longer length of stay in hospital (three to seven days).

Bottom line

The use of alternative and adjuvant drugs to benzodiazepines may be considered in select patients with alcohol withdrawal syndrome. ■

Additional Reading

The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. *J Addict Med.* 2020;14(3S Suppl 1):1-72.

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Quiz:

1. **A 43-year-old female with a past medical history of alcohol use disorder presents to the emergency department with tremor and malaise after discontinuing her usual alcohol intake of 8 beers daily. She is diagnosed with alcohol withdrawal syndrome and treated with a symptom-triggered benzodiazepine regimen, thiamine, and intravenous fluids. She develops alcohol withdrawal delirium with significant agitation. What is the best next step in management?**

   a. Switch to phenobarbital monotherapy
   b. Add haloperidol
   c. Increase benzodiazepine dosing
   d. Add propofol

Answer: C. Increase benzodiazepine dosing. Benzodiazepines are the first-line treatment of alcohol withdrawal delirium. Large doses may be required, and the initial step in management should be to titrate dosing to control symptoms and agitation while closely monitoring for adverse effects such as oversedation. Phenobarbital monotherapy is an alternative to benzodiazepines, but benzodiazepines are the preferred first-line option; in this case, there is no apparent contraindication to continuing benzodiazepine therapy. Phenobarbital could be used as an adjunctive agent if control of symptoms with benzodiazepines is inadequate. Haloperidol is not an option as monotherapy for alcohol withdrawal delirium, but its addition as an adjunctive treatment can be considered for agitation or hallucinations inadequately controlled with benzodiazepines. In this case, ensuring adequate dosing of benzodiazepines would be prudent before adding haloperidol. Haloperidol and other antipsychotics also can lower the seizure threshold and prolong the QTc. Propofol may be required for resistant alcohol withdrawal but would generally require intubation. If this patient were to experience resistant withdrawal on benzodiazepines, propofol might be considered; ensuring adequate benzodiazepine dosing should be done first.

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Photo was taken before March 2020 when COVID-19 precautionary measures were not in place.

Promoting Patient Recovery through **Care Coordination**

Medically complex patients who receive care in a hospital often experience longer recovery times than other patients do and are more likely to readmit to the ICU.[1] For these patients especially, implementing care coordination strategies can help mitigate recovery setbacks and improve outcomes.

Recent findings indicate three types of patient setbacks

1. **Adverse events:** An average of 10% of patients in a hospital will experience at least one adverse event, 50% of which are deemed avoidable. [2]
2. **Discharge delays:** Unnecessary discharge delays are associated with negative outcomes such as mortality, infections, depression and reduced patient independence. [3]
3. **Avoidable readmissions:** Approximately 27% of 30-day post-discharge hospital readmissions are considered avoidable. [4]

Internal coordination can reduce patient setbacks

Medically complex patients often require a team of specialists. As the number of caregivers involved increases, so does the risk of miscommunication, which is a primary cause of adverse events. [5] When physicians, respiratory therapists, bedside nurses and others collaborate as an interdisciplinary care team to develop a comprehensive treatment plan, they are able to more effectively treat their patients and reduce the risk of adverse events.

External coordination can improve access to appropriate level of care

Additionally, care coordination between providers, including at the post-acute care (PAC) level, and payers can minimize discharge delays and readmissions.

In some cases, patients may clinically be ready to discharge to a lower level of care, but are unable to do so because of logistical barriers. When providers from different levels of care and payers work together, they can remove these obstacles.

xMedically complex patients, however, may benefit from remaining in a more specialized care setting. Clear communication between all entities leads to a more comprehensive understanding of the patients' clinical needs and ensures that patients have access to the care they require.

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