

October 2022  
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Photograph: Walter Ng, MD, MPH

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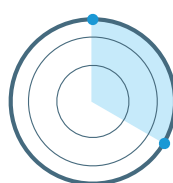
# A VICIOUS CYCLE WITH SIGNIFICANT BURDEN

WHAT COULD BE THE  
CONSEQUENCES OF RECURRENT  
*C. DIFFICILE* INFECTION?

Learn why it requires aggressive action



THE CDC ACKNOWLEDGES  
*C. DIFFICILE* INFECTION AS A  
MAJOR AND URGENT THREAT.<sup>1</sup>



IT RECURS IN UP TO 35%  
OF CASES WITHIN 8 WEEKS  
AFTER INITIAL DIAGNOSIS.<sup>2,3</sup>



THE CONSEQUENCES OF  
RECURRENCE ARE SIGNIFICANT,  
POTENTIALLY DEADLY.<sup>2</sup>

Now is the time to learn how Ferring is shedding light on the link between disease and disruptions in the gut microbiome, exploring the potential for repopulating its diversity and restoring hope to patients.

**References:** **1.** Centers for Disease Control and Prevention. 2019 Antibiotic Resistance Threats Report: *Clostridioides Difficile*. <https://www.cdc.gov/drugresistance/pdf/threats-report/clostridioides-difficile-508.pdf>. Accessed April 8, 2021. **2.** Lessa FC, Mu Y, Bamberg WM, et al. Burden of *Clostridium difficile* infection in the United States. *N Engl J Med*. 2015;372(9):825-834. **3.** Cornely OA, Miller MA, Louie TJ, Crook DW, Gorbach SL. Treatment of first recurrence of *Clostridium difficile* infection: fidaxomicin versus vancomycin. *Clin Infect Dis*. 2012;55(suppl 2):s154-s161.



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Weijen W. Chang, MD, FAAP, SFHM  
Weijen.ChangMD@baystatehealth.org

Pediatric Editor

Anika Kumar, MD, FAAP, FHM  
KumarA4@ccf.org

Editor

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Publishing Director

Lisa Dionne Lento  
ldionnelen@wiley.com

Associate Director, Advertising Sales

Steve Jezzard  
sjezzard@wiley.com

ADVERTISING STAFF

Display Advertising

Senior Account Managers  
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sdonohue@wiley.com  
MJ Drown  
mdrown@wiley.com

Classified Advertising

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Fax: 267-702-2690  
Website: www.hospitalmedicine.org

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Hospitalists are charged with treating individuals at their most vulnerable moments, when being respected as a whole person is crucial to advancing patients' healing and wellness. Within our workforce, diversity is a strength in all its forms, which helps us learn about the human experience, grow as leaders, and ultimately create a respectful environment for all regardless of age, race, religion, national origin, gender identity, sexual orientation, socioeconomic status, appearance, or ability. To this end, the Society of Hospital Medicine will work to eliminate health disparities for our patients and foster inclusive and equitable cultures across our care teams and institutions with the goal of moving medicine and humanity forward.

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# Movers and Shakers

**Christie White, MBA, HCM-CMPE** has been named chief operations officer at Lovelace Health System, Albuquerque, N.M.

Ms. White has more than 26 years of experience in health care, including both inpatient hospital and ambulatory operations management. She most



Christie White

recently served as assistant vice president of hospital operations for Lovelace Medical Group/ Lovelace Medical Center/ Lovelace Cancer Center. In this role, she managed all aspects of the hospital medicine services and ambulatory services, including the hospitalist program, medical oncology, radiation oncology, gamma-knife, infectious disease, and the neuro-hospitalist program.

Under Ms. White's leadership, Lovelace opened the Monoclonal Antibody Therapy Clinic on a short timeline. To date, the clinic has completed more than 900 treatments. In addition to leading the radiation oncology program to achieve ACR accreditation in 2017 and re-accreditation in 2020, Ms. White is preparing the cancer program for its 2023 Commission on Cancer accreditation.

She received a Bachelor of Science degree in business administration and a Master of Business Administration in health care management from the University of Phoenix.

**Alpesh N. Amin, MD, MBA, MACP, SFHM**

has been named the Orange County Physician of the Year by the Orange County Medical Association.



Dr. Amin

Dr. Amin serves as the Thomas and Mary Cesario Endowed Chair of the University of California, Irvine (UCI) School of Medicine's department of medicine. He is a professor of medicine, business, public health, nursing science, and biomedical engineering. As executive director of the School of Medicine's hospitalist program, he is a longtime champion of hospital medicine. Throughout the COVID-19 pandemic, Dr. Amin played a leadership role in expanding therapeutics for UCI Health patients, including opening a monoclonal infusion clinic and clinical trials.

The Orange County Medical Association's Physician of the Year award recognizes Orange County

physicians whose career exemplifies extraordinary professional ability and a commitment to their patients and colleagues.

Dr. Amin is an internationally recognized leader in the field of hospital medicine. He pioneered one of the nation's first hospitalist programs in 1998 at UCI Medical Center and remains its executive director. He is the first hospitalist chair of medicine to lead a department of medicine at an academic medical school and academic medical center worldwide.

Dr. Amin earned his medical degree from the McGaw Medical Center of Northwestern University, Chicago, completed his residency at UCI, and earned an MBA in healthcare from UCI.

The Medical Alumni Association of Wake

Forest University School of Medicine, Winston Salem, N.C. recognized

**John Nelson, MD, MHM** for his achieve-



Dr. Nelson

ments and contributions to WFU School of Medicine recently.

Dr. Nelson received the Achievement Award as one of the principal founders and architects of the specialty of hospital medicine. After completing his internal medicine residency, he became one of the nation's very early hospitalists in 1988 and practiced full-time patient care in Gainesville, Fla., before relocating to Bellevue, Wash.

Dr. Nelson has served terms as chief of medicine and chief of staff at his hospitals, and at Overlake Medical Center in Bellevue, Wash., he worked as hospitalist group leader for 16 years, and started the hospital's palliative care service and other programs. He currently chairs the hospital committee dedicated to provider well-being and burnout prevention.

In 1997, he partnered with Winthrop F. Whitcomb, MD, MHM, to establish the Society of Hospital Medicine. Drs. Nelson and Whitcomb originally managed the Society from their homes, including organizing its first in-person conference and creating its publication, *The Hospitalist*. He served terms as founding co-president and board member and has maintained leadership roles in SHM. In 2010, he was one of the first three hospitalists to be honored with the distinction of Master in Hospital Medicine, SHM's highest honor.

Dr. Nelson has worked on-site as a consultant at more than 300 institutions nationwide to help start new hospitalist programs or improve existing ones.



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**Joshua Lenchus, DO, RPh, FACP, SFHM**, has been named the new president of the Florida Medical Association. Dr. Lenchus is the 146th president of the FMA, but he's the first hospitalist, first pharmacist, and first osteopathic physician to hold the position since the association was incorporated in 1874.



Dr. Lenchus

Dr. Lenchus began his career as a pharmacist before becoming a hospitalist at the University of Miami Miller School of Medicine. In 2018, he was named chief medical officer at Broward Health Medical Center in Fort Lauderdale, Fla., and now serves as CMO for the entire Broward Health system.

He earned his medical degree from the Nova Southeastern University College of Osteopathic Medicine, Davie, Fla. and completed his residency at Jackson Memorial Hospital in Miami.

**Sameer Qazi, MD, FHM** was recently appointed the associate chief medical officer at Gottlieb Memorial Hospital in Melrose Park, Ill. His focus will be inpatient clinical operations, working alongside the quality leadership team.

Dr. Qazi is an associate professor of medicine in the division of hospital medicine at Loyola University Medical Center, Maywood, Ill and he is the president of the SHM Chicago Chapter.



Dr. Qazi

For the past year, he has also been the medical director for the hospitalist surgical co-management program at Loyola University Medical Center.

Dr. Qazi received his medical degree from Windsor University School of Medicine, St. Kitts, West Indies, and completed his internal medicine residency at Advocate Lutheran General Hospital, Park Ridge, Ill.

Englewood Health, Englewood, N.J. has appointed **Peter Shin, MD**, chief of medicine. Dr. Shin has served as section chief of hospital medicine since 2015.



Dr. Shin

He is board certified in

internal medicine, is a faculty member in the internal medicine residency program and works closely with Englewood Health's information technology department as the inpatient physician lead helping establish provider workflows and adapt the Epic electronic medical record system to fit the institution's needs. Dr. Shin is also a clinical assistant professor at Hackensack Meridian School of Medicine and an exam writer for the American Board of Internal Medicine.

Dr. Shin serves on numerous hospital task forces and committees, including the medical staff professional practice evaluation committee, opioid task force, CHF readmission reduction, denial appeals and revenue recovery, and the clinical informatics committee.

Dr. Shin earned his medical degree from Columbia University, New York, and completed his internal medicine residency at New York-Presbyterian Columbia University Medical Center.

**John Derderian, DO, FHM**, has been named senior vice president of inpatient medicine and transition of care services, and associate chief medical officer of Tower Health, West Reading, Penn.



Dr. Derderian

In this role, Dr. Derderian will serve as a liaison between administration and medical staff, and he'll collaborate with the chief medical, nursing, and quality officers to ensure clinical processes align with the organizational goals for care quality and efficiency. He will continue to serve as the physician leader for hospitalist services across Tower Health.

Prior to joining Tower Health in 2021, Dr. Derderian was in private practice in the early days of Hospital Medicine, working at Lancaster General Hospital and Lancaster Regional Medical Center.

Dr. Derderian earned his medical degree from the Philadelphia College of Osteopathic Medicine and completed his residency in internal medicine at Mercy Fitzgerald Hospital, Darby, Penn.

**Farzana Hoque, MD, MRCP, FACP** received the 2022 Clinical Awards—Physician of the Year during SSM Health's annual Clinical Symposium.



Dr. Hoque

Dr. Hoque is the only physician who received this award from the St. Louis region of Missouri. She is an assistant professor of medicine at Saint Louis University School of

Medicine and president of SHM's St. Louis Chapter. She earned her medical degree from the University of Dhaka in Bangladesh, and completed her residency at St. Luke's Hospital in Chesterfield, Mo.

**Kevin Sowti, MD, MBA, MHCI, SFHM**, the medical director of hospital medicine and chief of internal medicine at Penn Medicine, Chester County Hospital (CCH), West Chester, Penn., has assisted in humanitarian efforts through the years on almost every continent and most recently felt compelled to help Ukrainian refugees fleeing Russia's invasion.



Dr. Sowti

With the help of friends and family, Dr. Sowti gathered a list of medical needs (mostly over-the-counter medications and antibiotics) and CCH agreed to donate all. A few months—and lots of logistical planning—later, Dr. Sowti and others delivered groceries to local volunteers on the Ukraine border, just west of Moldova, and then delivered the medications to shelters housing refugees.

Dr. Sowti is raising money to provide food, medication, and trauma kits through a GoFundMe page (<https://gofund.me/a781739a>).

Dr. Sowti earned his medical degree from New York Medical College in Valhalla, N.Y. and completed his residency at Yale, St. Mary's Hospital in Waterbury, Conn.

**Lisa Kinsey Callaway, MD** has been named chief medical officer of Trinity Health Medical Group, West Michigan. In this role, she will lead and implement the clinical and quality direction of the medical group with a focus on improved performance, provider engagement and wellness, patient experience, and safe environments.



Dr. Kinsey Callaway

Dr. Kinsey Callaway most recently served as board chair and medical director for the hospitalist program at Trinity Health St. Mary's in Grand Rapids, Mich., where she has worked for the past 11 years. Her 22-year health care career includes working as an internal medicine physician at Grand Valley Medical Specialists PLC and as a hospitalist at University of Michigan Health-West.

Dr. Kinsey Callaway earned her medical degree from Michigan State University College of Human Medicine and completed her residency at Spectrum Health/ Michigan State University. ■

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# Introducing The Prez Room!

By Kris Rehm, MD, SFHM,  
SHM president-elect

Since I joined the SHM Board of Directors in 2017, the most rewarding part of my experience has been meeting and learning from SHM members across the country and the globe. As president-elect, I want to make sure I'm hearing our members' voices loud and clear as we navigate the road ahead and lead SHM into the future.

To facilitate more frequent conversations with our members, current Board president Dr. Rachel Thompson suggested The Prez Room—a series of in-person and virtual events to introduce ourselves and discuss hot topics and issues affecting members at their institutions and the innovation that they have seen—or created!—to help address these topics. Our goal is to learn how SHM fits into the lives of our members and how SHM can be part of the solution to support our members better at the local and national levels.

While attending the pediatric hospital medicine conference (#PHM22) at Disney's Yacht and Beach Club in Lake Buena Vista, Fla. this summer, I was able to sit down with Dr. Thompson and SHM members attending the

*"I hope that through all that SHM has to offer, including our new series of Prez Room opportunities, you, too, will be encouraged to get involved. I think you will be really glad you did!"*

—Dr. Kris Rehm

meeting. We met around a table, enjoying a lunch break in this new format that we are so excited to introduce. In a wonderful dialogue, the members introduced themselves and shared meaningful conversation around important topics, such as:

- The importance of advocacy for our members and patients
- The incredible impact SHM has made in our personal and professional careers
- The importance of being together again at an in-person conference
- Our desire to improve communication among our executive council for SHM's Pediatrics Special Interest Group (SIG)

Often, we take for granted our influence in others' lives. One of the highlights for me in our first Prez Room was to hear a Pediatrics SIG member share her memories from the pediatric hospital medi-

cine meeting that I chaired in the summer of 2017. At that meeting, I was lucky enough to open the first plenary by sharing an experience I had the week prior, when I needed a friend in Minneapolis to help with a family emergency. When I thought of all the possible people who could help, many were connections I had made through my network in SHM. This member shared how impactful that story had been for her and how it encouraged her to get more involved with SHM. I hope that through all that SHM has to offer, including our new series of Prez Room opportunities, you, too, will be encouraged to get involved. I think you will be really glad you did!

Dr. Thompson and I look forward to seeing many of you over the next year. We would love to hear your suggestions for ways SHM can help you both personally and professionally in the years to



Dr. Rehm

*Dr. Rehm is the associate chief medical officer of Children's Services in the department of pediatrics at Vanderbilt University Medical Center in Nashville, Tenn. She is also SHM's president-elect.*

come. We hope to take what we learn from these informal conversations with diverse groups of our members to better inform future programming and directions for SHM. There is no time like the present to really understand how our Society can shape the future for our members and our patients, and we invite you to be a part of the discussion. ■

## In the (Prez) Room —Where it Happens!

By Anika Kumar, MD, FAAP, FHM

Recently several SHM Pediatrics Special Interest Group (SIG) members had the pleasure of participating in Drs. Rachel Thompson and Kris Rehm's inaugural Prez Room at the 2022 Pediatric Hospital Medicine Conference (PHM22) at the Disney Yacht Club in Lake Buena Vista, Fla. Dr. Rehm was present at the conference and helped facilitate the conversation as Dr. Thompson joined virtually.

This informal gathering allowed for the presidents and attendees to share stories of how SHM has affected their professional growth. Drs. Rehm and others shared how their engagement with the Pediatrics SIG (formerly Pediatric Committee) helped them build connections and relationships that have helped influence their professional careers. Drs. Thompson and Rehm also listened as members shared some unique challenges that pediatric hospitalists face in providing care to children. Members discussed the closing of pediatric units at community hospitals, and the state-specific Medicaid model for children, as opportunities for hospital medicine advocacy unique to pediatric hospital medicine. This conversation led to a fruitful discussion on how SHM chapters can help advocate for their members.

Drs. Rehm and Thompson closed the session thanking members for attending and for shar-



ing their feedback. Members enjoyed the session and afterwards shared that they appreciated the opportunity to advocate on behalf of pediatric hospitalists with SHM Board members, and that they welcomed similar discussions in the future. The presidents hope to hold similar Prez Rooms in other settings. ■



Dr. Kumar

*Dr. Kumar is a pediatric hospitalist at Cleveland Clinic Children's and an assistant professor of pediatrics at Cleveland Clinic Children's Lerner College of Medicine of Case Western Reserve University in Cleveland, Ohio. She is a member of SHM's Pediatrics SIG's executive committee and is the pediatrics editor for The Hospitalist.*



# Saint Louis University School of Medicine Research Reviews

By Hiral Choksi, MD, FACP, SFHM, Ryan Freedle, MD, Adam Fritz, MD, MSHA, FACP, Farzana Hoque, MD, MRCP (UK), FACP, Joshua Mayer, DO, and Philip Vaidyan, MD, FACP

Saint Louis University School of Medicine, St. Louis, Mo.

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4. Sodium-containing acetaminophen intake increases the risk of CVD and all-cause mortality
5. CT coronary angiography in stable, intermediate-risk chest pain
6. Antiplatelet medications and the risk of ICH in patients with metastatic brain tumors

By Hiral Choksi, MD, FACP, SFHM

### 1 Prediction of end-stage kidney disease using estimated glomerular filtration rate with and without race

**CLINICAL QUESTION:** Does using old and new chronic kidney disease epidemiology collaboration (CKD-EPI) equations alone have a better predictive value for two-year incidence of end-stage renal disease (ESRD) compared to using the four-variable kidney failure risk equation (KFRE)?



Dr. Choksi

**BACKGROUND:** In response to race-based equations perpetuating racial inequities, CKD-EPI made new estimated glomerular filtration rate (eGFR) equations without race adjustments. The KFRE was developed but there were various barriers to using it.

**STUDY DESIGN:** Observational, prospective cohort study

**SETTING:** Seven U.S. clinical centers

**SYNOPSIS:** More than 3,800 patients were enrolled in the chronic renal insufficiency cohort between 2003 and 2006, with monitoring through May 2020 and follow-up data points every two years. Five CKD-EPI equations were calculated, including those updated in 2021, based on serum creatinine and/or cystatin C, with or without race adjustment. Then each eGFR equation was compared for predictive value with the four-variable KFRE.

During the follow-up period, 856 patients developed ESKD, in which Black participants were more likely than non-Black participants to develop ESKD (6.5% [95% CI, 5.3% to 7.7%] versus 5.5% [CI, 4.6% to 6.5%]). The KFRE score was found to be superior for predicting two-year risk for ESKD compared to eGFR alone among Black participants (AUC ranges, 0.945-0.953 versus 0.908-0.927) and non-Black participants (AUC ranges 0.945-0.954 versus 0.900-0.923). A KFRE score greater than 20% showed high specificity and sensitivity for predicting two-year risk for ESKD.

**BOTTOM LINE:** The KFRE was superior to using eGFR alone for ESKD prediction, regardless of

which eGFR equation was used and irrespective of race.

**CITATION:** Bundy JD, et al. Prediction of end-stage kidney disease using estimated glomerular filtration rate with and without race: A prospective cohort study. *Ann Intern Med.* 2022;175(3):305-313. doi:10.7326/M21-2928.

*Dr. Choksi is an associate professor of internal medicine and associate dean of admissions at Saint Louis University School of Medicine, St. Louis, Mo.*

By Ryan Freedle, MD

### 2 Antiplatelet therapy does not improve outcomes in critically ill patients with COVID-19 and may increase the risk of bleeding

**CLINICAL QUESTION:** Do antiplatelet agents improve organ support-free days among critically ill adults with COVID-19?

**BACKGROUND:** COVID-19 is known to increase the risk for thrombotic events, and patients with COVID-19-associated thrombotic events are more likely to have worse outcomes. Recent findings indicated that therapeutic heparin improved outcomes in noncritically ill patients with COVID-19, but therapeutic heparin was not found to improve outcomes in critically ill patients. The potential benefits of antiplatelet agents in reducing the risk of thrombotic events and subsequent poorer outcomes were unknown.

**STUDY DESIGN:** This study was an adaptive platform trial that utilized an open-label, control design for the intervention in question.

**SETTING:** This study took place at 105 hospital sites in eight countries between October 2020 and June 2021

**SYNOPSIS:** 1,557 critically ill adults with polymerase chain reaction-confirmed COVID-19 were randomly assigned to receive either open-label aspirin, an open-label P2Y12 inhibitor, or no antiplatelet therapy. This was in addition to standard deep venous thrombosis prophylaxis. Patients receiving antiplatelet therapy were treated for 14 days or until hospital discharge, whichever came first. Patients were followed for a total of 90 days after initiation of the study. The primary outcome was respiratory and cardiovascular organ sup-

port-free days up to day 21. A secondary outcome was survival to day 90. The authors found that the median for organ support-free days was seven in all groups (OR 1.02, 95% CI, 0.86-1.23) with a 95.7% posterior probability of futility. Major bleeding events were recorded in 2.1% of patients on antiplatelet agents and 0.4% of those in the control group. This represented an adjusted OR of 2.97 (95% CI 1.23-8.28) representing a 99.4% probability of harm.

Limitations included that the results of four of the antiplatelet agents were pooled together, limiting the ability to draw conclusions regarding any single agent, and the open-label design.

**BOTTOM LINE:** Antiplatelet therapy does not improve outcomes in critically ill adults with COVID-19 and increases the risk of bleeding.

**CITATION:** REMAP-CAP writing committee for the REMAP-CAP investigators. Effect of antiplatelet therapy on survival and organ support-free days in critically ill patients with COVID-19: A randomized clinical trial. *JAMA.* 2022;327(13):1247-1259. doi:10.1001/jama.2022.2910

*Dr. Freedle is an assistant professor of internal medicine at Saint Louis University Hospital, St. Louis, Mo.*

By Adam J. Fritz MD, MSHA, FACP

### 3 International validation of syncope risk assessment score

**CLINICAL QUESTION:** Does the Canadian Syncope Risk Score (CSRS) compare favorably to another scoring system, Osservatorio Epidemiologico della Sincope nel Lazio (OESIL) in predicting 30-day event outcomes in patients presenting to the emergency department (ED) with syncope?



Dr. Fritz

**BACKGROUND:** Risk stratifying syncope patients is fraught with challenges of clinical, social, financial, and legal implications. In the U.S., these factors lead to 80% of patients with syncope being admitted for evaluation with an annual cost of \$2.4 billion. There is a need for widespread adoption of a risk scoring system in clinical practice to better assess the need for admission.

**STUDY DESIGN:** Prospective cohort study

**SETTING:** EDs at 14 hospitals across eight countries (United States, Switzerland, Spain, Germany, Italy, Poland, New Zealand, and Australia)

**SYNOPSIS:** 2,283 patients who presented to the ED within 12 hours of a syncopal event were included. Patients underwent standardized clinical assessment and clinicians provided a clinical classification (vasovagal, cardiogenic,



etc.) of syncope prior to disposition (admission or discharge). Patients were followed at 30 days, and at 6, 12, and 24 months. Analysis was performed on patients according to their disposition status for the primary outcome of serious events (death, myocardial infarction, serious arrhythmia, etc.) occurring that were not evident in the ED. All patients were scored with CSRS and OESIL, and CSRS outperformed OESIL (area under the receiver-operating characteristic curve, 0.85 [95% CI, 0.83 to 0.88] versus 0.74 [CI, 0.71 to 0.78] and 0.80 [CI, 0.75 to 0.84] versus 0.69 [CI, 0.64 to 0.75], respectively). It was found that among patients deemed (very) low risk by CSRS, 0.6% (9/1388) had an event by 30 days, while of those with a moderate or (very) high risk by CSRS, 6.8% (61/895) had an event by 30 days. Limitations included that clinician clinical classification performed similarly to CSRS, but there was no control for provider experience.

**BOTTOM LINE:** The CSRS can help clarify the risk of 30-day significant events in patients presenting with syncope, thus supporting decision making regarding admission.

**CITATION:** Zimmermann T, et al. International validation of the Canadian Syncope Risk Score: A cohort study. *Ann Intern Med.* 2022;175(6):783-794. doi:10.7326/M21-2313.

*Dr. Fritz is an assistant professor of medicine and section chief of hospital medicine at Saint Louis University School of Medicine, St. Louis, Mo.*

**By Farzana Hoque, MD, MRCP (UK), FACP**

## 4 Sodium-containing acetaminophen intake increases the risk of CVD and all-cause mortality

**CLINICAL QUESTION:** Does the use of sodium-containing acetaminophen increase the risk of cardiovascular disease (CVD) and all-cause mortality in patients with and without a history of hypertension when compared to non-sodium-containing acetaminophen?



Dr. Hoque

**BACKGROUND:** There is a common misconception that excess sodium intake comes primarily from dietary sources. The excipients of common over-the-counter medications such as some formulations of acetaminophen may contain significant amounts of sodium. For example, a 500-mg dose of soluble acetaminophen contains 390 mg of sodium, and a 500-mg dose of effervescent acetaminophen has 440 mg of sodium.

**STUDY DESIGN:** A large population-based study of two cohorts of individuals 60–90 years old.

**SETTING:** The Health Improvement Network (THIN), a UK-based electronic medical record database was analyzed from January 2000 to December 2017. The THIN database identified individuals receiving sodium-containing and non-sodium-containing acetaminophen both with and without a diagnosis of hypertension.

**SYNOPSIS:** A total of 151,398 individuals with hypertension and 147,299 individuals without hypertension were analyzed. The primary outcomes were incident CVD (myocardial infarction, stroke, and heart failure) and all-cause mortality during a one-year follow-up.

Incident CVD risk at one year was higher among sodium-containing acetaminophen initiators compared to non-sodium-containing

acetaminophen initiators in individuals with a history of hypertension (5.6% versus 4.6%; hazard ratio [HR], 1.59; 95% confidence interval [CI], 1.32–1.92) or without (4.4% versus 3.7%; HR, 1.45; 95% CI, 1.18–1.79). In addition, all-cause mortality at one year was higher in sodium-containing acetaminophen initiators compared to non-sodium-containing acetaminophen initiators with a history of hypertension (HR, 2.05; 95% CI, 1.92–2.19) or without (HR, 1.87; 95% CI, 1.74–2).

Limitations included a lack of dietary sodium intake data and no assessment of the association between sodium-containing acetaminophen and cause-specific mortality.

**BOTTOM LINE:** Increased risk of cardiovascular disease and all-cause mortality were associated with intake of sodium-containing acetaminophen compared to non-sodium-containing acetaminophen in individuals with and without hypertension.

**CITATION:** Zeng C, et al. Sodium-containing acetaminophen and cardiovascular outcomes in individuals with and without hypertension. *Eur Heart J.* 2022;7:43(18):1743-1755. doi:10.1093/eurheartj/ehac059.

*Dr. Hoque is an assistant professor of internal medicine and acting internship co-director at Saint Louis University School of Medicine, St. Louis, Mo. She is president of SHM's St. Louis Chapter.*

**By Joshua Mayer, DO**

## 5 CT coronary angiography in stable intermediate-risk chest pain

**CLINICAL QUESTION:** Is it safe to perform computed tomography (CT) coronary angiography to rule out obstructive coronary artery disease (CAD) in patients with stable intermediate-risk chest pain instead of proceeding to invasive coronary angiography (ICA)?



Dr. Mayer

**BACKGROUND:** CT angiography identifies patients who are appropriate candidates for coronary revascularization. It is not clear if CT would safely replace ICA as an initial diagnostic imaging strategy for guiding the treatment of patients with stable chest pain.

**STUDY DESIGN:** Pragmatic, investigator-initiated, assessor-blinded, parallel-group, superiority trial

**SETTING:** 26 certified clinical centers in 16 European countries with a median 3.5-year follow-up.

**SYNOPSIS:** 3,561 patients with intermediate (10–60%) pretest probability of obstructive CAD who were referred to angiography centers were randomly assigned to invasive or CT angiography. Hemodialysis, arrhythmia, and pregnancy were exclusion criteria. Trial centers were given guidelines encouraging patients without obstructive CAD be discharged back to referring providers for further management.

Major adverse cardiac events occurred in 2.1% of the CT group and 3.0% of the ICA group (hazard ratio (HR) 0.7; 95% confidence interval (CI) 0.46–1.07). Major procedure-related complications occurred in 0.5% of patients in the CT group and 1.9% of patients in the ICA group (HR, 0.26; 95% CI, 0.13–0.55). Angina during the final four weeks of follow-up was similar between the groups. 22.3% of patients in the CT group underwent invasive angiography, 72.5% of whom were found to have obstructive CAD.

**BOTTOM LINE:** Using CT angiography to evaluate for obstructive CAD in patients with stable intermediate-risk chest pain is as safe as invasive angiography in preventing major adverse cardiac events over 3.5 years when performed at certified centers with qualified radiologists.

**CITATION:** DISCHARGE trial group. CT or invasive coronary angiography in stable chest pain. *N Engl J Med.* 2022;28:386(17):1591-1602. doi:10.1056/NEJMoa2200963.

*Dr. Mayer is an assistant professor of medicine at Saint Louis University School of Medicine, St. Louis, Mo.*

**By Philip Vaidyan, MD, FACP**

## 6 Antiplatelet medications and the risk of ICH in patients with metastatic brain tumors

**CLINICAL QUESTION:** Do antiplatelet medications increase the risk of intracranial hemorrhage (ICH) in patients with metastatic brain tumors?



Dr. Vaidyan

**BACKGROUND:** Brain metastases increase the risk of intracranial hemorrhage in patients with advanced malignancies. The safety of the use of antiplatelet therapies in patients with brain metastases and cardiovascular disease is unknown.

**STUDY DESIGN:** Single-center, retrospective, matched-cohort study

**SETTING:** 673-bed academic medical center at Beth Israel Deaconess Medical Center, Boston

**SYNOPSIS:** To address the safety of antiplatelet therapies (aspirin and P2Y12 inhibitors) in patients with metastatic brain diseases and comorbid cardiovascular diseases, investigators conducted a single-center, retrospective, matched-cohort study of 392 patients with brain metastases. The primary endpoint of the study was the cumulative incidence of ICH after tumor diagnosis. The most common primary malignancies represented were lung cancer (non-small cell lung cancer, 74.0%). Of the 134 patients who were exposed to antiplatelet therapies, 116 patients (86.6%) were on aspirin alone. There was no statistically significant difference in the cumulative incidence of ICH at one year in patients on antiplatelet therapy compared to those patients who were not on antiplatelet agents (22.5% and 19.3%;  $P=0.22$ ). The severity of the ICH was also statistically similar ( $P=.49$ ). The subgroup who was on both antiplatelet agents along with anticoagulation (23.1%) did not experience a higher risk of major ICH compared with the use of antiplatelet agents alone. There was a slight survival advantage in the cohort of patients receiving antiplatelet agents.

**BOTTOMLINE:** The administration of antiplatelet therapies was not associated with an increase in the incidence, size, or severity of ICH in the setting of brain metastases

**CITATION:** Miller EJ, et al. Antiplatelet medications and risk of intracranial hemorrhage in patients with metastatic brain tumors. *Blood Adv.* 2022;6(5):1559-1565. doi:10.1182/bloodadvances.2021006470.

*Dr. Vaidyan is an associate professor of medicine and division director of general internal medicine at Saint Louis University School of Medicine, St. Louis, Mo.* ■





Ms. Wohlford is director of sustainability for Carilion Clinic. The Roanoke, Va.-based health system has numerous awards and recognitions for its sustainability efforts that include everything from installing solar-power receptors to hiring sheep to keep the lawn.

# Hospitalists Join in Sustainability Efforts

By Larry Beresford

In a world transformed by environmental degradation and the effects of climate change, hospitals can be major generators of greenhouse gases, energy consumption, and waste. But they are also important centers for health and wellness promotion, not just for the patients they serve but also for staff and their communities. That is why a growing number of hospitals and their hospitalists are seeking ways to contribute to the conversation about sustainability and environmental stewardship for their facilities and the larger world.

Health involves more than health care, said Bill Flattery, CEO of Carilion New River Valley Medical Center in Christiansburg, Va. “We realize that health and well-being are affected by the environment in which we live, and we are stewards of that environment in the same way we are stewards of people’s health.”

This awareness has helped drive the 146-bed New River Valley Medical Center’s leadership in sustainability efforts. “It starts with understanding how much unbelievable waste there is in health care. If you acknowledge that fact, you can be invited into a culture that says we can do better,” Mr. Flattery said.

Hospitals can consider what they could do to run more efficiently, with reduced energy costs, enhanced patient experience, and public recognition for their efforts,

he said. “We’ve done a lot at this hospital to demonstrate our green initiatives. This invites people to look at things with a different lens. And our hospitalist group has come up with some neat ideas to participate because of the culture we have established here.” For example, getting involved in conversations about how to reduce unnecessary waste of medical supplies.

## A movement for sustainability

A sustainability movement is growing in U.S. hospitals, focused on ways to reduce waste and energy usage and promote healthier habits for the individual, the institution, and the world. Groups are leading the way, such as: Practice Green-health, a membership and networking organization for the health care community committed to environmentally sustainable practices; Sustainability Roadmap for Hospitals, an online initiative to help hospitals plan a path toward sustainability; and the global organization Health Care Without Harm.

“This is a direction that most, if not all, health care systems are now heading or soon will be,” says Sara Wohlford, MPH, RN, director of sustainability



Ms. Wohlford

for the seven-hospital Carilion Clinic health system, based in Roanoke, Va. “Some health systems have decades-old sustainability

programs. But the trend is growing by leaps and bounds. Meanwhile, we’re following conversations the Centers for Medicare and Medicaid Services, the Joint Commission, and other regulatory bodies are starting to have about sustainability. If new regulations come down, we’ll be ready,” she said.

“Until four years ago, we had a lot of smart people who were working in silos on climate health and sustainability projects and didn’t know about each other,” said Katherine Gundling, MD, FACP, emerita professor of internal medicine and allergy/immunology—and a one-time hospitalist—at the University of California San Francisco (UCSF).

“We were able to bring those people together.”

Now there’s a Center for Climate Health and Equity for all University of California campuses, for which Dr. Gundling is director of patient care innovations. UCSF’s Academic Senate Committee has endorsed two upcoming “theme years” dedicated to health and sustainability for the campus. “We’re really moving forward,” she said.

UCSF has an Office of Sustainability, directed by Gail Lee,



Dr. Gundling



Ms. Lee

REHS, MS, HEM, who also supervises five health-professional graduate fellows in sustainability. The university is putting up a number of buildings in its new Mission Bay Campus, with a goal of powering them as much as possible with clean electricity rather than gas or other fossil fuels.

## What are we talking about?

Sustainable design, which means trying to address how a facility’s practices affect the health and safety of its patients, staff, visitors, and the larger environment, can follow LEED (Leadership in Energy and Environmental Design) standards, introduced in 2000 by the U.S. Green Building Council. It may mean maximizing natural lighting and installing energy-efficient LED (light-emitting diode) light bulbs and motion-sensitive light dimmers.

Energy waste management may target, for example, the operating room and its waste. Are all the supplies set out for a medical procedure truly necessary, especially if they all must be discarded if not used—or even opened? Heating, ventilation, and air conditioning—also called HVAC—are major targets for energy-efficient practices, including scheduled preventive maintenance. Many hospitals have found that increasing energy efficiency makes significant contributions to their bottom line.

Regulating medical waste might aim to divert some that otherwise would end up incinerated or in landfills, focusing on improper



waste labeling and re-educating staff about what needs to go into the red biohazardous waste bin. Questions are being asked about reusing, reprocessing, and recycling medical devices, such as reprocessing cardiac catheters and cleaning and recycling pulse oximeter cords.

How about bringing more local, fresh, and organic foods into the hospital's dietary programs and onsite cafeterias? Some hospitals have hosted farmer's markets on their campus or started in-house composting programs.

Sustainability also refers to the hospital's human resources. Doctors and other clinicians face job stress and burnout. Could natural lighting or other environmental enhancements make them more comfortable in their jobs? What about the ergonomics of the workspace and the need for havens to relax and unwind while on the job? What else can make a hospital facility more tolerable to patients—and to all who use them or work there? Could the hospital offer yoga classes or educational programs for staff or the public on environmental stewardship?

Ms. Wohlford, a former emergency-department nurse who observed opportunities for enhancing sustainability on the job and got a master's degree in public health before starting to build the case for sustainability at Carilion Clinic, said her position involves working with the system's facilities staff to understand and communicate what they're already doing around energy conservation. "We work with other health systems from across the country to get a sense of best practices in reducing energy consumption and greenhouse gases," she said.

Carilion New River Valley Medical Center has been variously honored for its sustainability work by Practice Greenhealth, the Virginia Society of Healthcare Engineers, and the American Society for Healthcare Engineers, and received a 2019 Governor's Environmental Award. In 2018, as part of its commitment to sustainability, the hospital installed 4,000 articulating solar-power receptors in a field adjacent to the facility. This move is projected to save \$1.5 million in energy costs over the next two decades, or about 17% of the facility's total electric bill.

More recently, it arranged for a flock of sheep from a local farm co-op to spend weeks at a time eating the grass in the solar-panel field, which is not readily accessible to power mowers. A healing garden on the hospital campus offers a meditative walking labyrinth. An apiary was installed in a nearby open field in 2020 by Carilion radiographer Daniel Kolasa, with two hives now located inside an electrical bear fence. The bees offer benefits such as supporting the



Carilion radiographer, Mr. Kolasa, tends to the apiary he installed in a field near the health center.

pollination of local plants, encouraging local bird and insect populations, and producing local honey, which goes to the food services department.

The solar field is visible to everyone who visits the hospital campus, Mr. Flattery said. "Because it's so visible and front of mind, it invites other people to get involved. We celebrate the fact that we did this, and when we celebrate these things, it reinforces our culture of sustainability and our message of taking care of our community," he said.

"There are the big initiatives, but you also start thinking about the little things. Instead of isolation gowns that are plastic and disposable after one use, we now have reusable cloth gowns," Mr. Flattery added. "We also have a facility-wide recycling program. We brought in the infection control team to discuss the best way to roll out our recycling program, and we also educated environmental services staff and brought them on board as partners."

**How are hospitalists involved?**

Hospitalists need to speak up on the job if they want to contribute to their hospital's commitment to sustainability, which means a building that produces less waste, said Moises Auron, MD, FAAP, FACP, SFHM, a hospitalist and member of the Board of



Dr. Auron

Governors at the Cleveland Clinic in Cleveland, Ohio. "Frontline hospitalists typically aren't asked to be part of building-design teams, but we need to be meaningful stakeholders. If we don't speak up, we won't be heard. That means engaging with others in the system. I'd say, don't be afraid to reach out to your leaders with your suggestions for space-use improvement and optimization," he said.

"You could bring the designers in to sit down with the hospitalists and say, 'We're designing a new hospital. We want to brainstorm with you.'" The conversation should also include frontline nurses, he said. "Come to the night shift. Get people from all levels. Go on rounds with the hospitalists. Shadow them. Where do they park? Where are their offices located? Where will they clean their hands prior to entering a patient's room?"

Dr. Auron said he does a lot of networking around issues like these. "I speak for myself. I have met with key stakeholders of the team that is designing a new hospital for our system. They are trying to enhance the new building's sustainability and energy efficiency."

The first step for hospitalists is to talk to their group leaders when they see sustainability issues they think need to be addressed, said Dustin Colegrove,



Dr. Colegrove

DO, MBA, FACP, HMDC, a hospitalist at Legacy Salmon Creek Medical Center in Vancouver, Wash. "We lead the hospital in many ways—we're the glue, the backbone. I'd like to think our voices are heard and our administration is responsive to our ideas in this area, as well."

In recent years, the seven-hospital Legacy system has emphasized accessible green spaces and therapeutic hospital gardens developed with the leadership of horticultural therapists. It also studied the impact of its nature access on job stress and patient outcomes. All Legacy gardens are designed with environmental sustainability in mind, using organic and safe methods of garden maintenance. "The gardens matter more to some patients than others, but when we have sunny days, we know people go out there to enjoy them," Dr. Colegrove said.

**Making your voice heard**

Ms. Wohlford said Carilion's sustainability efforts naturally link back to its hospitalists. "We're trying to figure out how to bring hospitalists and other physicians and staff into the spaces where leaner energy decisions are being made—helping them bring their clinical voice to those decisions. That way, it's more than just a conversation about money and BTUs, it's about helping facilities and maintenance folks really see and feel the links between the work they're doing, patient health, community health, and the health of the environment," she said.

"What are you ordering for your



patients? Do your order sets bring excessive amounts of supplies into patients' rooms, which then must be thrown away unused? Can these order sets be pared down?" Ms. Wohlford said. What else can hospitalists do? She suggested going to the units where they primarily work and connecting with the unit's sustainability champion or director of nursing to better understand the sustainability opportunities in the units.

"As the sustainability professional at Carilion Clinic, what I could use most immediately is to have hospitalists reach out and connect with me. If this is something that resonates with them, and they have a desire to engage—or frankly, even just to be in the room—I need to know their names. I always have opportunities that bubble up, but if I don't know your name, then I can't include you," she said.

"We can connect them with the leaders of the relevant departments and help to facilitate sustainability conversations. If the hospital leaders who need to implement change are not hearing that this is a priority to their physicians, then they may not go as far down this path," Ms. Wohlford said. "But if you have physicians coming in and saying: 'Hey, this is important to me,' it helps to rally and build that groundswell."

The next step in stewardship

Environmental stewardship by hospitalists can extend one step further: to the patients they care for who are confronting the effects of climate change more directly,



for example from California's extreme wildfires in recent years for asthmatic patients or from heat-related illnesses and complications for heart conditions and pregnancy triggered by this past summer's extreme heat waves.

A recent report from the Medical Society Consortium on Climate and Health estimates that health costs, physical and mental, from air pollution and climate change already far exceed \$800 billion per year.<sup>1</sup> Climate change has also been associated with exacerbated risk for several types of cancer.<sup>2</sup>

"We need to be talking with our patients about this and identifying our most vulnerable patients to prevent the impact of climate change," Dr. Gundling said. One of the projects her students at UCSF

worked on was to survey clinicians asking if they are aware of any conversations currently happening with patients in the UCSF health system about the threat of climate change to their personal health. The answer, largely, was no, with no structured process for discussing the risks patients face.

"We've been talking about how to come up with tools to educate our faculty and physicians on the best ways to bring up these topics and to develop a curriculum for it," Ms. Lee said. How will they avoid the wildfire smoke that exacerbated their asthma? Do they have windows that shut properly if they are likely to be exposed? What can they do to cool off on very hot days?

"If they don't have good answers to these questions, do we then need to connect them with public

health resources?" Dr. Gundling said. "We're trying to build up more awareness as we learn more about the impact of climate change on health, and help professionals see their work through that lens." ■

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

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Commitment to the Environment

Resources

A key proponent of sustainability efforts at the Carilion Health System is Jessica Fleming, DO, currently chief resident of internal medicine at Carilion Roanoke Medical Center, where she functions as an academic hospitalist and educator. Her interest in environmental issues dates back to the volunteer work she has done in wildlife restoration and conservation.



Dr. Fleming

Dr. Fleming got a degree in clinical herbal medicine before starting medical training. "I applied for medical school because I enjoyed working with people and being a healer. And I have been doing sustainability and botany work ever since." Away from the hospital, she is president of the Blue Ridge Wildflower Society, a regional non-profit organization that educates the public on native landscaping and restoration. She also volunteered at a wildlife rehabilitation center where people bring injured or orphaned wild animals to be rehabilitated and released.

These commitments have given her a greater

- **Practice Greenhealth** <https://practicegreenhealth.org/>
- **Sustainability Roadmap for Hospitals** <http://www.sustainabilityroadmap.org/>
- **Health Care Without Harm** <https://noharm.org/>
- **U.S. Green Building Council** <https://www.usgbc.org/leed>
- **Virginia Clinicians for Climate Action** <https://www.virginiaclinicians.org/>
- **Medical Society Consortium on Climate and Health** <https://edsocietiesforclimatehealth.org/>

appreciation for native flora and fauna and the benefits of using native plants in landscaping design—whether on hospital grounds or in residential backyards. Dr. Fleming also helped to spearhead a native-species planting day held at the hospital.

"Hospitals in this country can greatly impact ecosystem restoration by how they choose to landscape," she said. "Hospital campuses comprise many acres of land, opening opportunities to restore habitat and healing gardens that

attract native migratory birds and butterflies." She also recommended green roofing as a way to save money on energy expenditures.

Dr. Fleming sits on the Carilion Clinic's system-wide Sustainability Committee and is part of a current grant application to support teaching in the community. "I often lose sleep over nature conservation issues. I wish I didn't care quite so much, but it's wired into the framework of my being. I will always be working on nature conservation in some shape or form," she said.

"For hospitalists, there is a wide spectrum of ways to get involved. People trust physicians, and most hospitalists have considerable training in biology. Hospitalists interested in nature conservation can volunteer to help plan new hospital structures and landscaping. Advocate for the benefits of spending more time in nature, both for your patients and for yourself," she said.

Find groups like Virginia Clinicians for Climate Action or the Medical Society Consortium on Climate and Health. "Participate in recycling and refill events. Know where your hospital recycles, and if it doesn't already, help to start it. See if it has a sustainability committee. If it doesn't, start one." ■



# Vaught Verdict Shines Spotlight on the Need to Report Errors Without Fear

Hospitalists and other frontline health workers concerned about retribution; need for support from hospital, health care system is critical

By Vanessa Caceres

The outcome of the RaDon-da Vaught case could have a chilling effect on the reporting of medical errors by hospitalists and other front-line caregivers.

Earlier this year, RaDonda Vaught, a registered nurse, was charged with criminally negligent homicide and gross neglect of an impaired adult because of a 2017 medical error that killed a 75-year-old female patient at Vanderbilt University Medical Center in Nashville, Tenn. Ms. Vaught was convicted and received a sentence of three years of supervised probation.

## Medical groups weigh in

In response to the trial outcome, SHM issued a statement that proclaimed SHM's solidarity with health care team members and other professional societies in opposition to medical errors being criminally prosecuted. "This case affirms the need for health care institutions to recommit to the principles of just culture and to support all members of the care team."

SHM's response also points out the importance of handling medical errors as a group effort: "Medical errors are the result of systemic failure rather than a single individual in isolation. The criminalization of medical errors and prosecution of an individual for an error will not result in a safer healthcare system. Instead, it will discourage timely reporting of medical errors and have a chilling effect on the culture of safety and openness."

SHM was not the only medical society with concerns about the Vaught verdict.

"The criminal conviction and sentencing of a nurse for a medication error is a backward step for patient safety ... This case has placed patient safety at risk and has further demoralized an already exhausted and overworked nursing workforce in the face of existing nurse staffing shortages," according to a May 13 statement from the American Association of Critical-Care Nurses.

Robyn Begley, DNP, RN, chief nursing officer for the American Hospital Association (AHA) and chief executive officer of the American Organization for Nursing Leadership said, "Criminal pros-

ecutions will discourage health caregivers from coming forward," in the AHA's statement of the same day.

Other medical societies made similar statements. The American Bar Association weighed in: "A robust culture of safety relies on self-reporting and transparency to drive process improvement, and criminalizing errors instead foments blame and creates fear," according to the organization.

"It was encouraging to see the near-unanimous response from medical and nursing societies in opposition to the criminalization of unintentional medical errors," said Rick J. Hilger, MD, SFHM, system utilization-management medical director and hospitalist in the department of hospital medicine at HealthPartners in Minneapolis. Dr. Hilger is chair of SHM's Public Policy Committee, which helped draft SHM's statement on the Vaught case.



Dr. Hilger

## The effect on hospital medicine

Hospital medicine physicians, and all health care workers, should be concerned about the Vaught outcome.

"To have a frontline worker convicted of a felony for an unintentional mistake is groundbreaking, and threatens the substantial progress made over the past two decades in advancing just culture within hospital walls," Dr. Hilger said.

"The concept of just culture introduced in the early 2000s has allowed us to make huge strides in patient safety in the last two decades," said Kunjam Modha, MD, FACP, SFHM, a hospitalist and assistant professor of medicine with the Cleveland Clinic Foundation in Cleveland. This work has focused on consistent error reporting, transparency, and shared accountability without individual blame and shame, Dr. Modha explained.



Dr. Modha

## What hospitals can do

- Provide support from the top down
- Foster open communication
- Create and share policies
- Emphasize accountability
- Make policies known during onboarding
- Educate and improve culture
- Examine errors in real time

One major concern from hospitalists is that the case verdict will lead to lowered quality of care within hospitals as clinicians and nurses may be less likely to report errors or near-misses, Dr. Hilger said.

"When health care professionals are deterred from self-reporting errors due to punitive risk, patient safety is impaired," Dr. Modha said.

## What hospitals can do

Although it is too early to assess what effect the Vaught case will have on hospital medicine, Dr. Modha hopes that hospitals will use this case as an opportunity to revisit patient-safety policies.

While hospitals and health systems typically have processes in place to assess medical errors, there are comprehensive steps they can consider or review to encourage an open discussion of errors with hospitalists and other health care workers:

**Start at the top.** Within a day or so of the Vaught ruling, the chief executive officer of Ballad Health, a 22-hospital system based in Johnson City, Tenn., sent out a message reassuring all 15,000 frontline caregivers that the system would support them, said Amit Vashist, MD, SFHM, senior vice president and chief clinical officer of Ballad Health. Dr. Vashist is also a member of SHM's Public Policy Committee.



Dr. Vashist

**Prioritize open communication.** "Physicians, advance practice providers, and nurses should feel safe to speak up about adverse events without fear of retaliation," Dr. Modha said.

**Have systematic and written policies in place for events where errors may occur.** "When a systematic process around testing and

medication administration is in place, it acts as a safety net, which prevents errors and reduces harm in the event they do occur," Dr. Modha said.

**Emphasize shared accountability.** "Shared accountability permits us to dive deep and identify areas of actionable change without holding a particular individual responsible for it," Dr. Modha said. "This creates a much-needed safe environment in which errors can be reported and studied."

**Make error-reporting policies crystal clear during onboarding.** In the current age of fast-growing hospitals and traveling nurses, reviewing how to report an error should be part of onboarding and not something an employee struggles to figure out after an event has occurred, Dr. Modha cautioned.

**Assess how to improve hospital culture to encourage error reporting.** In August, Ballad Health launched plans to become a high-reliability organization that emphasizes safety above all else, as well as a just culture, Dr. Vashist said. This launch included educational sessions, classes, and town-hall meetings with a more scientific approach to looking at errors and helping employees feel safe reporting errors. "We need to provide a psychologically safe environment for hospitalists and other frontline caregivers, so people aren't hiding errors," Dr. Vashist said.

**Look at errors in real time.** Dr. Vashist's hospital system has successfully used tiered safety huddles for more than three years. The huddles move the discussion of errors along four tiers, from the unit to hospital leaders to market region leaders and, finally, to senior executives. This error review has helped Ballad Health attack and reduce systemic problems in real time. "The whole focus is on collaboration, learning and process improvement," he said. ■

*Vanessa Caceres is a medical writer in Bradenton, Fla.*





# Nonclinical Medical Teams Role Gives Clinical Staff More Time for Patient Care

By taking on important clinical duties, this position eases transitions, improves patient care and flow, and improves clinical staff morale

By Sue Coons

**A**s patient numbers rise, so do clerical duties, and studies are showing that many highly trained clinical staff are getting bogged down. Two hospital administrators recognized the issue and created a new nonclinical role on the medical team that focuses on clerical tasks, leaving more time for the licensed staff to spend on patient care.

“With the health systems getting more complex and patient acuity rising, we can make a case for a medical assistant to medical teams to perform duties that typically don’t need a licensed provider,” said Venkat P. Gundareddy, MD, MBBS, MPH, associate director of the division of hospital medicine and assistant professor of medicine at Johns Hopkins Bayview Medical Center in Baltimore.

“We realized that a lot of those tasks were not fitting with working at the top of one’s license,” said

Anand Sekaran, MD, division head of hospital medicine and medical director of inpatient services at Connecticut Children’s in Hartford, Conn. The Accreditation Council for Graduate Medical Education recently called for purely nonclinical tasks for residents to be limited so they can focus on actual patient care, he said.



Dr. Sekaran

## Establishing duties

The role of a medical team assistant (MTA) can be varied based on the needs of the group, Dr. Gundareddy said. “An analogy would be that of a medical office coordinator or a medical assistant in primary care/specialty clinic settings in the outpatient world.”

This role would offset the medical team’s nonclinical workload and at the same time enhance patient safety around care transitions, he said. “Things that are not top of the license for the providers could be diverted to the assistants so the providers can focus on

medical care. For example, communications with the primary care offices/specialty offices to plan a safe transition often takes time and effort.” Other tasks could include obtaining records, obtaining medication history, filling out forms for patients and facilities, obtaining prior authorizations, doing assessments such as cognitive screening, screening for safety, following up on imaging/consult requests, and arranging family meetings.

The MTA at Connecticut Children’s has several significant roles, Dr. Sekaran said. One is to optimize team-rounds functioning. Each morning, the medical team, the appropriate nurse, the MTA, and the family gather at the bedside to discuss the plan of care. The MTA pages the patient’s nurse ahead of time to alert them that the team is approaching.

The MTA is then responsible for tracking metrics during the rounds, such as the percent of time the nurse is present, the percent of time spent on read-back of orders, and time spent teaching.

The MTA is also responsible for purely clerical, but crucially important, tasks. First, the MTA schedules follow-up appointments. About two-thirds of the hospital’s services now involve complex care,

Dr. Sekaran said, resulting in patients needing multiple subspecialty appointments to be arranged before discharge. Handing already-scheduled appointments to the family has been shown in the literature to increase the compliance of keeping the appointment, as opposed to saying, “Here’s the phone number to call a doctor to get your follow-up,” he said.

The MTA also works to resolve discharge barriers, which have worsened during the pandemic. For example, if the patient needs formula or a medication that is difficult to find at a pharmacy, the MTA can call different pharmacies to find what is needed so the patient can go home in a timelier way.

The MTA position ensures patients have available home nursing care, too, Dr. Sekaran said. Staffing shortages, particularly in the home nursing component, have caused difficulty since the pandemic. “We take care of such complicated kids at Connecticut Children’s that many of them require ongoing home nursing care just for daily maintenance.”

Dr. Gundareddy said his medical center had the opportunity to pilot and develop a robust care-transitions coordinator program to



support its hospitalists and house staff teams. “This was born out of necessity,” he said. “Not being able to function at the top of their license was driving down the morale of hospitalists in our group.”

They hired the first medical office coordinator more than four years ago through initial funding from the quality improvement program. Since that time, the role matured into its current form as a care-transitions coordinator. “Initial years were focused on streamlining workflows for medical documents/information flow, helping with prior authorizations, filling of forms, barrier-busting for procedures/imaging, and obtaining outside records,” Dr. Gundareddy said.

“Over the years this evolved into a safety net around transitions as we realized this is where more effort was being spent by providers,” he said. “Early identification of primary care teams, medication history gathering, effective communication between inpatient and outpatient teams, prior

authorizations, lining up discharge needs, aiding in consenting and disseminating information for patients around specific things like COVID-19 vaccinations, and receiving communications from discharged patients all helped us improve our transitions of care while decreasing burden of non-clinical work on providers.”

MTAs are essential at Connecticut Children’s since pediatric hospitals, in general, have been swamped post-pandemic with mental health and non-COVID-19 respiratory issues, Dr. Sekaran said. “By having them on rounds, when things are busier, they just help with overall efficiency and flow as we manage increasingly high patient volumes.”

### Creating the position

Drs. Sekaran and Gundareddy also advised on how to advocate for creating this position. The accreditation piece was a primary reason Dr. Sekaran was able to get its MTA position funded. “We framed it in the context of, ‘this

is essential to maintaining adequate accreditation of our training programs,” he said. “Secondly, we made the case successfully that it would optimize team functioning, and third, we are so busy that we needed help in patient flow and facilitating earlier discharges and optimizing the beds that we do have.”

Connecticut Children’s hired three MTAs, but the pandemic put the position on hold in 2019. Connecticut Children’s now has one MTA and is in the process of adding the other two back. “We have three main pediatric floors,” Dr. Sekaran said. “We’ve learned you need one per unit, so each unit is 28 beds. Our goal is to get back to where we were, which is one MTA medical team assistant per 28-bed unit.”

“Success in creating such a program is directly related to the institutional value it brings,” Dr. Gundareddy said. “First, we need to understand hospitalists’ workload and how much of it is not at the top of their license. Based

on this needs assessment, we can build a medical assistant program to support the provider teams.”

The value of the program can be shown at various levels, he explained. At the individual level, the value translates to less burnout and more satisfaction in work. At the group/division level, the value translates to decreased turnover, better clinician engagement, and improved standardization of work delegated to the assistants. At the institution level, this role can be aligned to deliver some of the key institutional goals, such as decreased readmissions, increased communication with outpatient providers, early signing of documents, and better compliance with standards of care around transitions, Dr. Gundareddy said. “Overall, if we can show that the value far exceeds the cost of the program, institutions would be willing to support it.” ■

*Sue Coons is a medical writer in Chapel Hill, N.C. She also has worked in the hospital patient-access area for 10 years.*

## Career

# Make the Most of Media Opportunities

By Karen Appold

It’s the sign of the times—24-hour news cycles, information at your fingertips, and “experts” everywhere willing to share their voices. During the last two years especially, health care professionals have been subjects of news stories and sources for reports on the pandemic and health care.

Providing clarity, expertise, and timely information in a professional manner helps society build trust in physicians, medicine, and health care systems—particularly when there’s so much miscommunication and misinformation. That’s why it’s important now more than ever to become comfortable with the media—be it as a guest on a podcast or local news station, a source in a magazine or newspaper, or even just being yourself (professionally) on Twitter or YouTube.

We spoke with a few physicians who know a thing or two about being in the spotlight to glean some tips and tricks for the best way to represent yourself in the media.

### You’re the expert

Having a journalist ask to interview you can be both exciting and a bit nerve-racking. This is an opportunity to discuss what you’re passionate about, and to present yourself as a subject matter expert. At the same time, you don’t want to say or do anything you might regret.

When a reporter requests an interview, be honest about whether you’re the right person to discuss the topic. “It’s flattering to be asked, but if the subject matter is outside of your expertise, it’s best to refer a colleague,” said Kimberly D. Manning, MD, FACP, FAAP, professor of medicine and associate vice chair of diversity, equity, and inclusion in the department of medicine at Emory University School of Medicine in Atlanta.

Dr. Manning is also a nationally recognized public speaker, the co-creator of “The Human Doctor” podcast, which explores the human side of medicine, and an award-winning blogger.

If you’re the right expert, you will want to respond quickly to the journalist because most of them work on tight deadlines and will ask other physicians if you delay, said Samir S. Shah, MD, MSCE, MHM, editor-in-chief of the *Journal of Hospital Medicine*, director of the division of hospital medicine at Cincinnati Children’s Hospital Medical Center, and a professor in the department of pediatrics at University of Cincinnati College of Medicine in Ohio.

Just as when preparing for a job interview or speech at a medical conference, you should prepare for a media interview. If you’re

giving an interview in which your organization’s name might be used, be sure to get clearance through its public relations (PR) office.

And if you’re interested in doing more media interviews, tell them to reach out to you in the future, said Mark Shapiro, MD, a hospitalist at Providence Medical Group-Northern California in Santa Rosa and the founder, and host of “Explore The Space” podcast, which examines the interface between health care and society.

Your institution’s PR office may offer a media press session to teach you how to interact with reporters. A PR person may also be willing to join you for an interview, provide feedback, and manage any challenges, Dr. Shah said. National trade meetings might also have formal media training sessions.

### Print interviews

Before beginning an interview, Dr. Shah asks reporters if he can review the article (or at least his specific quotes) prior to publication to ensure accuracy. “Most reporters are willing to do that, however the tighter their deadline the less likely you’ll have that opportunity,” he said. Larger forums may also be less likely to grant reviews.



Dr. Shapiro



Dr. Shah



Dr. Arora

If a journalist won’t allow her to review her comments, Dr. Manning may or may not proceed with the interview. “My comments not only reflect me and can potentially hurt me if I’m misquoted, but also my patients, co-workers, and others,” she said. “I need to be my own brand manager.”

Vineet Arora, MD, MAPP, MHM, dean for medical education at The Pritzker School of Medicine at the University of Chicago asks when she can expect a piece to be published, and whether there is a fact checker—especially for anything controversial. “When applicable, I’ll say that I’m uncomfortable discussing a matter or that I will follow up with a written statement to avoid saying anything I wouldn’t want to,” she said.

Dr. Arora is an internationally recognized expert on patient hand-offs in health care and has extensive experience using social media and videos as educational tools. Her videos have been featured on National Public Radio and in *The New York Times*.

### On-screen interviews

If you’ve never done an on-screen interview (be it live, recorded, or virtual), Dr. Manning recommends watching a few online. Find them





on a local or national news channel’s website and search for video clips under the medical news or health section.

During the interview, keep in mind that you’ll be on the record. “Assume that your conversation is being recorded, and ask if this is the case,” said Dr. Shapiro.

Dr. Arora recommends having two to three talking points that you want to drive home. “Stick to your message,” she said. “Even if you’re asked to go off-script or are thrown a curve ball, find a way to pivot back to the answer you want to give or your area of expertise.”

Along these lines, Dr. Shah advised getting to the point quickly. “When a reporter is quoting you, they don’t want to quote 12 sentences, they want a sentence or two,” he said. “Practice delivering your points so it’s second nature during an interview.”

When speaking on camera, make sure you’re comfortable with how you look, or it could throw you off. “Be yourself; if English isn’t your first language and you have an accent, that’s fine,” Dr. Manning said.

Your rhythm, tone, and pace of how you speak are important when having an audio or video interview. “Practice speaking at a volume and pace that feels natural, but also not too slow or fast,” Dr. Shapiro said. “Listen to see if you unconsciously make lots of adventurous sounds like ‘um’ and ‘uh,’ or if you click your tongue, clear your throat excessively, and so forth. Practice speaking while minimizing these sounds. Too many will make an audio interview difficult to listen to.”

Key Points

- Stick to topics in your area of expertise
- Respond to interview requests quickly
- If you’re representing your institution, work with your PR team
- Take advantage of media training sessions
- Know the ground rules—are you being recorded? Can you review the article or your quotes?
- On camera—be comfortable with yourself, practice, don’t talk too fast, and keep it simple
- Know your audience—lay people may not understand medical jargon
- Virtual interview—be mindful of your background; use a quality microphone and good lighting
- Social—consider your goals and find your voice for each platform

And be sure to practice. “Physicians aren’t [always] used to speaking about complex medical topics with a general audience, but they’re very comfortable doing so with colleagues,” Dr. Shapiro said. “So reset how to communicate.”

Dr. Manning warns to watch out for words disguised as jargon. For example, a physician might use the word “appreciate” to talk about something they see on a physical exam. But most lay people aren’t familiar with that word in that context.

Try explaining key points with loved ones who don’t work in medicine. “If they can understand what you’re talking about, then most likely others will too,” Dr. Manning said.

Dr. Arora suggests keeping your answers crisp and having a back-and-forth rapport so you don’t use all your energy answering the first question. “A lot of times a sound bite is used, so be sure to think about your mental script ahead

of time and what your sound bite might be,” she said.

Many interviews on camera now occur via video conferencing because of the pandemic. When doing these types of interviews, have a clear and clutter-free background, make sure your camera lens is clean, keep your camera at eye level, and have good lighting, Dr. Shah said.

Sound quality is also important, so be sure to have a quality microphone that connects to your computer. Due to their visual appearance, avoid wearing headphones or earbuds, if possible, Dr. Shah said.

Using social media

Another way to relay information is to use social media platforms. Dr. Arora recommends finding your voice and considering your goals for each platform. For example, maybe you engage on social media personally more on

Facebook or Instagram and professionally more on Twitter, Dr. Arora said.

Dr. Shah advised having a mission statement and thinking about what you want to be known for. “Have a defined set of interests and expertise,” he said. “Not exclusively, but predominantly tweeting about those things can help people understand why they chose to follow you.”

Dr. Manning advises having a social media profile designated for professional use. “Before you say or do anything, decide how you wish to brand yourself,” she said. “Make sure what you post on social media aligns with your mission.”

“If you’re going to share medical information, you’ll want to be known as a trusted resource,” Dr. Manning said. “Readers will look through your page to see what else you’re talking about and who you’re interacting with to determine if you’re indeed a trusted resource.”

While not every hospitalist wants to be in the spotlight, every hospitalist does have a wealth of experience and knowledge their communities and colleagues can benefit from. If one of your professional goals is to share that information publicly, using these tips can help you feel more comfortable doing so. ■

*Karen Appold is an award-winning journalist based in Lehigh Valley, Pa. She has more than 25 years of editorial experience, including as a newspaper reporter and newspaper and magazine editor.*



# How Do You Address Ongoing In-hospital Substance Use Among Adults with SUD?

By Sarah J. Flynn, MD, MPhil, Soraya Azari, MD, Armond M. Esmaili, MD, and Katie E. Raffel, MD

## Case

A 28-year-old man with a past medical history notable for severe opioid use disorder and aortic valve endocarditis requiring valve replacement was admitted with recurrent bacteremia, prosthetic valve endocarditis, and acute kidney injury. His hospital course was complicated by poor control of his substance use disorder (SUD) and delayed engagement with the addiction medicine team. He had multiple episodes of suspected injection drug use during his hospitalization that were ultimately confirmed with urine toxicology and mass spectrometry analysis. A lack of a clear hospital policy for addressing in-hospital substance use contributed to variable responses from health care team members and the enactment of primarily punitive measures which severely eroded the patient-physician relationship. Ultimately, the patient developed worsening bacteremia and fungemia complicated by septic emboli. He was deemed not to be a candidate for repeat valve replacement, and he died after a prolonged hospitalization..

## Overview of the issue

Hospitalizations related to SUD are rising, and evidence suggests that patients with SUD may commonly use substances during hospitalizations.<sup>1,2</sup> Prospective cohort studies of patients with SUD in Canada found that 43.9% of participants had used substances during a hospital stay.<sup>3</sup> The most common reasons cited for ongoing drug use included “wanting to use” and “being in withdrawal.” A smaller prospective cohort study including hospitalized patients with a history of injection drug use found continued in-hospital drug use in 40.5% of participants.<sup>4</sup> A separate ethnographic study highlighted patients may take measures to conceal substance use from clinicians while hospitalized, such as injecting alone in locked bathrooms.<sup>5</sup>

In addition to a lack of formal

## Key Points

- In addition to better characterizing the frequency and implications of episodes of in-hospital substance use, health systems need to implement response measures that maintain the patient-provider therapeutic alliance, minimize patient trauma, and do not propagate bias.
- Though best practices remain underdeveloped, we recommend a multidisciplinary team response that is based on objective concerns, focuses on eliciting and addressing patients' psychosocial and medical triggers, and prioritizes harm reduction.

prevalence studies on in-hospital substance use, there are associated adverse outcomes such as bloodstream infections, increased length of stay, or unintentional deaths, which are also not well quantified. Although there may be ad-hoc processes for documenting episodes, such as completing an anonymous safety report at the unit level, standardized systems that systematically track these metrics are rare and do not exist within our hospital systems.

While patients with opioid use disorder should be counseled on harm reduction, offered medication-assisted therapy, and connected with outpatient behavioral health and addiction medicine resources, there is often little discussion about what health care professionals or hospital systems should do in response to in-hospital substance use by hospitalized patients.<sup>6-8</sup>

Published guidelines or comprehensive best practices are lacking. Here we describe some of the challenges associated with addressing in-hospital substance use and propose recommendations for the development and implementation of hospital policies to respond to this complex issue.

## Challenges of addressing Issue

Applying an ethical lens, there is a tension between valuing beneficence and patient autonomy: “I must do good by my patient” and yet “this person makes their own decisions.” Ensuring patient safety is an important component of providing high-quality health care, with adverse outcomes of in-hospital substance use including the real possibility of overdose and death. Not only is this distressing for the medical team, but it also carries a



Dr. Flynn



Dr. Azari



Dr. Esmaili



Dr. Raffel

*Dr. Flynn is a hospitalist in the division of hospital medicine at the University of California San Francisco. Dr. Azari is a hospitalist in the division of general internal medicine at San Francisco General Hospital, University of California San Francisco. Dr. Esmaili is a hospitalist in the division of hospital medicine at the University of California San Francisco. Dr. Raffel is a hospitalist in the division of hospital medicine at Denver Health, Denver.*

theoretical risk of liability for both the clinician and the hospital, because patients are considered dependents while hospitalized in some states. However, to our knowledge, there is no legal precedent of hospital or clinician culpability for a hospitalized patient's overdose death from their own substance use. While beneficence is often prioritized, there is the competing issue of respect for patient autonomy. Patients may make decisions that don't always prioritize their own health, including ongoing substance use. We recognize their disease yet accept their decision to use drugs. Non-judgmental acceptance of patients with SUD is an important facilitator of a patient pursuing treatment.

In our current state, systems may often use authoritarian responses to ongoing in-hospital substance use including room and belongings searches, visitor restrictions, privilege limitations, and the placement of cameras and safety attendants. These punitive responses, especially without objective confirmation of in-hospital substance use, may negatively impact physicians' therapeutic alliances with their patients and may further marginalize an already vulnerable patient population. Without clear institutional guidelines there may also be tensions between transdisciplinary clinicians who may share different viewpoints on how to respond to episodes of in-hospital substance use. There is increasing recognition that structural factors, such as organizational policies, bias, and mutual mistrust between patients and clinicians contribute to adverse outcomes among patients with SUD.<sup>3,5,9,10</sup> Pervasive stigmatization by health care workers against patients with SUD, especially racial/ethnic minorities and those of lower socioeconomic status, may be

compounding these factors.<sup>5,11,12</sup>

Recommendations for the development of hospital responses: We believe that policies to address the ongoing use of opioids by hospitalized patients should be locally developed and implemented in a manner that balances the tension between patient safety and maintaining alliance with this vulnerable population. In developing health system approaches, it is necessary to involve relevant stakeholders including not only members of the health care team but also patients, patient advocates, and representatives from legal, ethics, security, and hospital administration. Collaboration during the development of response reduces the risk of interdisciplinary misalignment.

We recommend universal screening of all patients for SUD at the time of admission. Early recognition of SUD may allow hospitalists to take proactive measures to decrease a patient's desire to use substances in the hospital, particularly by ensuring adequate pain management, addressing withdrawal symptoms, initiating clinical treatment for SUD, and engaging addiction medicine service if available.<sup>3,6,10</sup> Adequately treating an individual's SUD will decrease the risk of ongoing substance use by hospitalized patients, though it may not prevent it entirely, as in our patient's case.

Punitive or restrictive measures should not be implemented solely because a patient has a history of SUD. If there are objective concerns for active substance use, such as witnessed possession of an illicit substance or confirmed in-hospital use, health systems should have a standardized strategy for addressing these episodes.

We advocate the involvement of



a multidisciplinary team including members from medicine, addiction medicine, social work, psychology, pharmacy, and bedside nursing to implement a response that includes: 1) identification and mitigation of hospitalization-associated psychosocial stressors<sup>9</sup>; 2) medication titration to address cravings (i.e. increase the dose of as-needed medication, or change from an as-needed to a standing-dose schedule); 3) education to dissuade the patient from using a medication in a way other than prescribed (i.e. injecting oral medications); 4) provision of naloxone to be kept at bedside; and 5) if illicit substances are found, they should be in a personal belongings locker not accessible to the patient until the time of discharge.

Clinicians need to be deliberate about the language used to openly communicate these policies to their patients.<sup>13</sup> Ideally, this language should capitalize on the therapeutic alliance and highlight the need to ensure patient safety without perpetuating bias. Given the illegality of substance use, medical providers may be tempted to engage law enforcement in the response to in-hospital substance use. The presence of security may be traumatizing for vulnerable populations, and we recommend that these approaches minimize the direct engagement of



hospital security.

Once developed, these policies should be publicized and easily locatable. All staff members should be educated on these workflows and the frontline health care team should work collaboratively to ensure appropriate and consistent execution of these responses. Health systems should study the implementation of these measures

over time—both to understand efficacy and to ensure policies do not disproportionately affect specific populations who experience provider bias and structural racism.

Back to the case

Although our patient was appropriately started on methadone on the day of admission, the available addiction medicine team was not formally involved in our patient's care until over a month into his hospitalization, after the patient had injected oral prescribed medications into his central line. Punitive measures were enacted throughout his hospitalization even before his in-hospital substance use was confirmed. Involvement of hospital security, visitor restrictions, and the creation of informal care agreements contributed to patient stigmatization and led to significant mistrust between our patient and clinicians. The lack of clear institutional protocols for responding to in-hospital substance use created confusion, and at times tension, among the health care team, as well as mixed messages for our patient. Reflecting on our patient's case, we acknowledge that more could have been done within our health system to address psychosocial stressors during his prolonged hospitalization, limit his interactions with hospital security, and reduce the significant stigma he experienced.

Bottom line

Health systems need to develop and implement measures to respond to episodes of in-hospital substance use with strategies that balance the tension between ensuring patient safety and caring for a vulnerable population. ■

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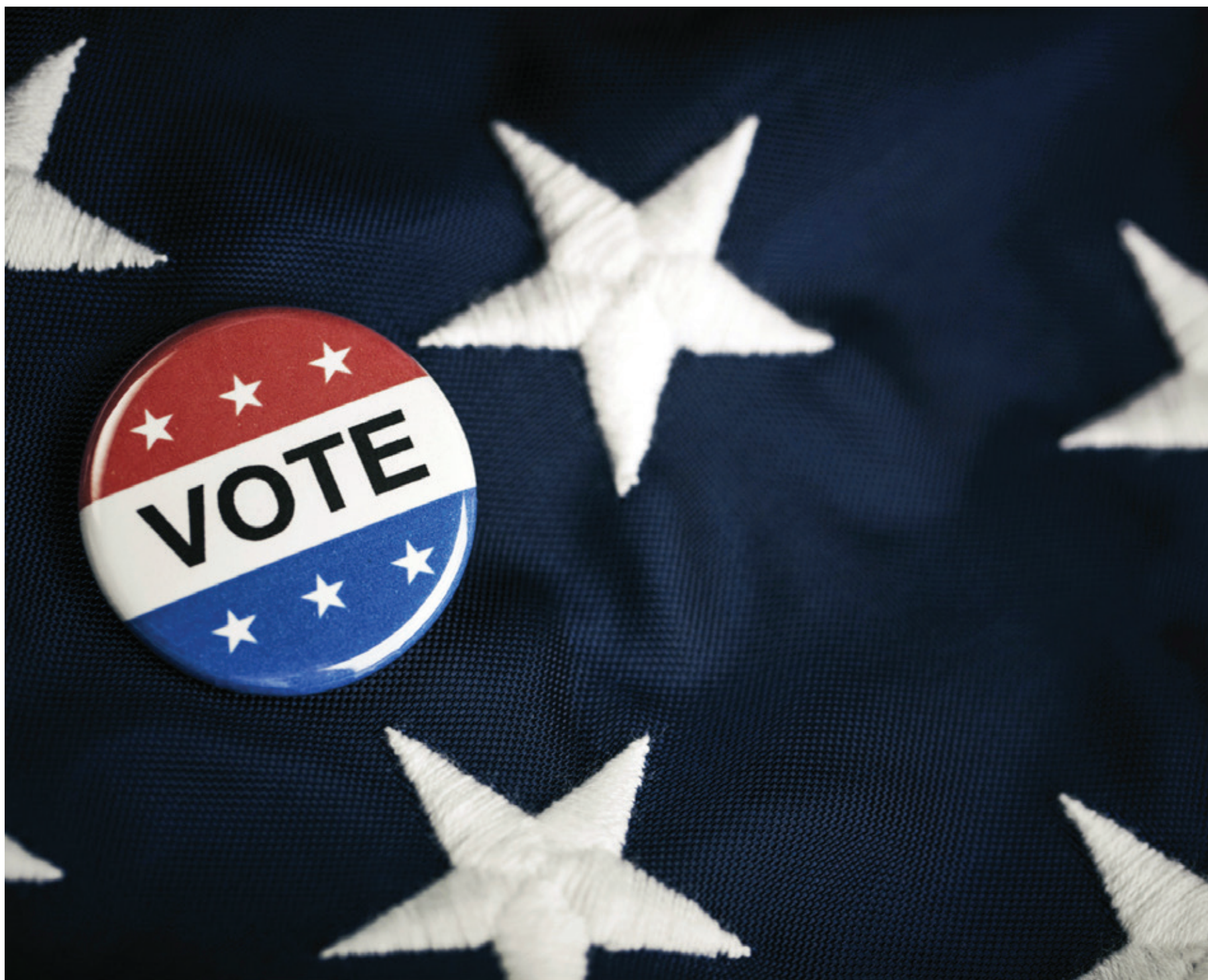
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# Hospitalists' Voices and Votes Make a Difference

By **Alain D. Folefack MD, FHM**, and **Marta B. Almli, MD, JD**

It's that time of the year again: inboxes full of unsolicited requests for donations, people with clipboards approaching as you try to squeeze in a grocery run between work and your child's soccer game, strangers knocking on your door to discuss an issue or a candidate. Election time is here and yes, hospitalists, we must be ready to vote.

Besides being any citizen's duty, voting is an important way to get involved and have a say in public affairs. Individuals may feel their vote will not change an election's outcome. However, there have been several instances in our recent history where a surprisingly small number of votes—537 votes in Florida in 2000, less than 1% of the vote in Wisconsin, Michigan, and Pennsylvania in 2016, and in Wisconsin, Michigan, Arizona, and Georgia in 2020—changed the course of an election.

In state and local elections,

sometimes even a single vote can make all the difference.<sup>1</sup> Although these campaigns typically don't get the same exhaustive coverage as federal elections, they usually have the greatest effect on us, our families, and our patients. Public health, reproductive health, licensing, insurance, business organization, employers', and employees' relations, non-compete clauses, malpractice, taxes, education curriculum, zoning, drilling, and mining are all governed in whole or part by state and local laws and regulations.

These considerations are even more applicable with midterm elections, where turnout is expected to be lower. Therefore, each individual vote may play an even bigger role.

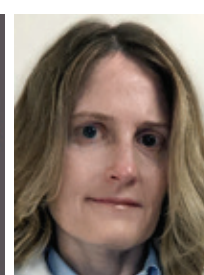
As hospitalists, our particular voice and especially our vote is important. The COVID-19 pandemic and its effects on our patients and practices, and the ongoing debates over health care, health insurance, and public health have all highlighted the importance of our voices. We are an integral part

of a sector that makes up over 17% of the U.S. gross domestic product and therefore has a significant political impact.<sup>2</sup> We are also central to the single most expensive part of health care spending, hospital care.<sup>3</sup>

Hospitalists are perfectly positioned to shape policies and rulemaking with a direct impact on this critical component of the U.S. economy. Failure to do so will result in hospitalists succumbing to rules made by special interest groups, which may not necessarily serve or benefit us or our patients. Indeed, some rules already put in place with little to no physician input have led to lower job satisfaction and increased burnout. It's up to us to push our voices to the forefront. Organizations like SHM have placed a focus on advocacy for hospitalists through the Public Policy Committee and have helped aggregate and amplify our voices, especially at the national level. For that influence to continue and grow we must, as individuals, remain active participants in the discourse, including at the



Dr. Folefack



Dr. Almli

*Dr. Folefack is a hospitalist and regional medical director with Envision Healthcare in Dallas and an adjunct assistant professor of medicine at the University of North Texas Health Science Center in Fort Worth, Texas. Dr. Almli is a nocturnist hospitalist in Los Angeles, California. Both are members of SHM's Public Policy Committee.*

state and local levels.

There are more than one million licensed physicians in the United States. Historically physicians voted at a lower rate than other groups.<sup>4</sup> While that research is decades old, and newer data indicates physicians voted near or above the levels of the general



population in the most recent elections, hundreds of thousands of us are still not voting.<sup>5,6</sup> It is perplexing that a group used to devising and implementing measures to avoid even a single sepsis fallout or hospital-acquired infection would be content with a less than perfect record on election participation.

Getting from wanting to vote to actually voting requires registering to vote, education on the issues, and effectively casting that ballot. Physicians have cited time as a major barrier preventing them from voting or even registering to vote.<sup>7</sup> Hospitalists work long hours, and we are often so focused on trying to balance our patient-care responsibilities with other life responsibilities that we may fail to complete essential tasks like voting. Fortunately, there are tools and strategies to help us accomplish these steps despite our busy schedules.

**Register to vote.** The deadline to register to vote varies by state and is usually at least a few weeks to a month prior to election day. In most states registration can be done online and takes just minutes. Some states even allow same-day registration on election day. In other states, additional procedures such as notariza-

tion of the registration form or “in-person only” registration may be required. Check [www.usa.gov/voting](http://www.usa.gov/voting) or your state’s secretary of state’s website for your specific state’s process.

**Educate yourself.** The number of issues and the plethora of candidates on the usual ballot may seem overwhelming. How are we supposed to know which person to choose for judge of the municipal court, justice of the peace, or transportation-district board member? Fortunately, there are reliable resources that process such information in a more user-friendly format. Start with your state’s voter information guide and secretary of state’s website or go to [www.usa.gov/voter-research](http://www.usa.gov/voter-research) which aggregates this information. Then look to organizations you trust that can help you understand and distinguish the issues and candidates, such as local political parties, civic or professional organizations, media organizations, faith groups, or interest groups.

**Make a plan to vote.** Do it before election day if possible. As hospitalists, our workday often starts before the polls open, and an unexpected event can keep us at the hospital long after the polls close. Fortunately, all but four

states have an option for early voting, such as early in-person voting or voting by mail. Three of the remaining states allow those required to work during polling hours on election day to register as absentee voters. Connecticut has no early voting and does not allow absentee voting based on work requirements. Those voting in Connecticut may want to get to the polls when they open at 6 a.m., ahead of their workday.

**Get involved.** The more you are involved in the political process, the more you can influence the issues that matter to you and your family, to hospital medicine, and our patients. Sure, financial contributions to candidates or organizations supporting issues that matter to you are easier for a busy hospitalist to do. More importantly, volunteer your time, especially at the state and local levels. Get involved in an organization that advocates for issues that matter to you, write postcards to voters, canvass for a candidate or ballot measure, talk to your local and/or state representatives, attend a town hall, or even run for office.

Elections have consequences, and hospitalists’ voices and votes are important. Moreover, we need to be heard. We have a unique understanding of the intricacies

of our health care system and the impact of laws, rulemaking, and regulations on us, our families, our patients, and our communities. Get involved and create positive change. Let’s go vote! ■

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# SIG Spotlight: Hospital Medicine Disaster Preparedness and Management

By Richard Quinn

**T**alk about the right group for the right moment!

SHM's Special Interest Group (SIG) for Hospital Medicine Disaster Preparedness and Management has been working for years to be in a position to better handle acute-care surges, as there is an established years-long national shortfall in both health care staffing and available bed space in hospitals. With surges being defined as roughly 25% more patients immediately, the so-called SIG had long planned how to help hospitalists deal with bombings, natural disasters, or major motor vehicle accidents, among other things.

And then COVID-19 hit.

"The reality is, most hospital systems were already straining their capacity prior to COVID-19," said SIG vice chair Jason Persoff, MD, a hospitalist and assistant director of emergency preparedness at the University of Colorado Hospital in Denver. "Early in the pandemic, things weren't as bad, in part because we were able to shut down elective surgeries and increase the capacity of the hospital to take more patients in."

"But now, post that first year, we are looking at record numbers of hospitalizations for people who

had either delayed care, or who are suffering from COVID-19, and that is in the backdrop of still maintaining full surgical schedules, etc. And 25% of the hospital workforce disappeared during COVID-19. People stopped working in hospitals and all health care settings. It has been an ongoing, significant disaster, finding stuff, staff, and space, which are the three main tenants of emergency preparedness."

SHM has 27 SIGs that are sponsored by SHM to "create communities of hospitalists around topics of interest, practice areas and/or care models."

The SIG for HM Disaster Preparedness and Management has 306 members and was established in 2019.

SIG chair Gaby Frank, MD, FACP, SFHM, says that plans for the group include recorded webinars that hospitalists can view in times of crisis. As medical director of the Biocontainment Unit at Denver Health Hospital Authority, she views those sessions as real education delivered at just the right time.

"How can I get quick access to resources that can make me ready in like, an hour to respond to this event that is happening in my institution/city/town right now," she said. "That's why I think making these resources available on the Society of Hospital Medi-

cine website is important for the SIG...and tailored for hospitalists, as most current resources focus on emergency medicine or trauma specialties."

Dr. Frank is also interested in doing in-person training that can then effectively deputize hospitalists to lead preparedness sessions within their own institutions.

"If we can get more people interested in doing the in-person training, then they can bring it to their institution, and they can have participation in an emergency preparedness committee, and each institution will have a little more experience and skills than if they just went to a webinar," she said. "There is room for both, and there's value in all kinds of training."

Dr. Persoff notes that the need for hospitalist training in emergency preparedness can't be overstated.

"At most institutions, hospitalists care for at least 25-40% of all patients in the hospital," he said. "That can be as a consultative role or as a primary role. So, the footprint of hospitalists is quite large, and when an acute surge occurs—be that by a multi-trauma accident, burns, or chemical exposures—the tendency is for people to think this is a critical care or surgical issue. But the reality is if the whole hospital is affected by a surge, then 25 to 40% of that hospital is run by hospitalists."

Dr. Persoff says that in an area of medicine as high-pressure as emergency and crisis management, having a group of like-minded hospitalists to share pearls and

pitfalls with is valuable.

"At the very personal and intimate level, there's the need to talk about our narrative, our story, with other colleagues," he said. "A lot of people had a lot of pent-up stress that they were internalizing. The need for having peer support, we found, was extraordinarily important. More globally, how do we as institutions deal with that? And how can we figure out best practices in this situation?"

Dr. Frank says that working with the Task Force for Mass Critical Care—a group of emergency-minded physicians that first emerged in the mid-2000s and publishes articles in *CHEST Journal*—is one way to help build institutional resiliency. Ideas include not charting less critical information during surges or taking away some regulations during crisis moments and creating schedules—even during emergencies—that give hospitalists and other practitioners more work-life balance.

"In the past, resiliency has generally been referred to the person themselves trying to find resiliency," Dr. Persoff said. "What we learned in the COVID-19 pandemic is the idea of systems to build personal resiliency are insufficient to deal with the high quantity of demands placed on providers. What we found is, based on work Gaby and I have done with the Task Force for Mass Critical Care, is that resiliency has to come from the institutional level down." ■

Richard Quinn is a freelance writer in New Jersey.



Dr. Persoff



Dr. Frank





## Chapter Spotlight: Michigan

By Richard Quinn

A little baseball can go a long way for the soul, if you ask Matthew George, MD, FACP, FHM, an assistant professor at Michigan State University in East Lansing, Mich., and chief medical informatics officer and hospitalist at the Henry Ford West Bloomfield Hospital, Bloomfield Hills, Mich.

As president of the SHM Michigan Chapter, Dr. George arranged an in-person networking night in May 2022 that he dubbed “Day at the Diamond.” But as the leader of a statewide group, he didn’t just drag everyone to Comerica Park, the home of Major League Baseball’s Detroit Tigers. He also held events at the home fields of the Lansing Lugnuts and the West Michigan Whitecaps, some 90 and 160 miles away, respectively.

The idea was simple: after two years of the COVID-19 pandemic, it was time for a night out for the nine-year-old group’s nearly 500 members.

“Through the pandemic, it’s been tough, what we’ve had to go through in our line of work,” Dr. George said. “I think having the support of people around you who

do the same thing, know what you’ve had to go through, and know what you’ve seen, is helpful. Having that kind of support as a big network, knowing you aren’t alone in the things that you go through, and knowing people are going through the same thing and dealing with it, in the same way, is important.”

It was also a way to give something back to the group.

“That’s why I wanted to do the ‘Day at the Diamond,’” he said. More than 200 people attended events across the state in three locations. “We wanted to make it as open and inviting to as many people as possible. Members attended with their families and just had a good time not working, and getting back together.”

Dr. George, who is in his first year as chapter president, isn’t stopping at peanuts and Cracker Jacks. In addition to in-person events that are now increasingly feasible, the chapter has held a number of virtual meetings over the past few years to keep members coming back.

The virtual meetings held earlier this year included “Hospital Medicine Learning in Post-COVID: Embracing Change. Seizing Opportunity” and “Human Trafficking for Medical Providers.”

Dr. George says events that tackle particularly newsworthy topics or topics that aren’t well addressed in medical school or common liter-

ature are a good tool for increasing engagement.

“If you just give another lecture on pneumonia, well, not much has changed with it,” he said. “It’s not very interesting. You see it every day. It’s hard to make those kinds of lectures interesting and stick with people. The most interesting topics were kind of off the cuff and caught people’s attention. We had a lecture on the medical effects of marijuana when marijuana was becoming legalized in the state of Michigan. We had a subject matter expert come in and shared a lot of things you don’t learn in medical school.”

Human trafficking was another timely subject. “It’s a very taboo subject, but something that’s real life and the real world, and we encounter victims of human trafficking all the time and sometimes we don’t even realize it,” Dr. George said. “Being able to recognize how to intervene, when to intervene, and what to look for in patients who may be victims of human trafficking so we can do our part to help them with that is very important.”

As a statewide chapter leader, Dr. George is also cognizant of trying to appeal to members from different demographic areas. While Detroit and much of Southern Michigan are more urban, the state also has rural hospitals in its northern reaches, as well as summer tourist hubs that see population surges. And it’s key for

practitioners in different locations to give each other practical tips.

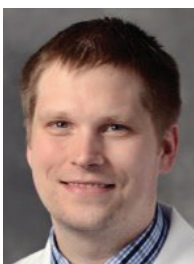
Sharing information and advice was especially important during the past few years when hospital medicine practitioners had to weigh real-time anecdotal advice versus emerging clinical evidence.

“Having a grasp of open communication is always helpful, while still understanding that evidence-based medicine is the ultimate: being able to look at studies that say, this is what works, this is what doesn’t work, and this is the evidence behind it,” Dr. George said.

Dr. George also sees the chapter’s role as helping hospitalists work with other specialties. To that end, the group is co-hosting a three-day meeting with the Michigan chapter of the American College of Physicians (ACP) this fall.

“ACP encompasses many aspects of internal medicine including specifically the outpatient setting of primary care,” Dr. George said. “We have a lot of our hospitalist SHM members who are also ACP members, so it only made sense to partner with them. We share our expertise on inpatient management, and they can share their expertise in outpatient management, and we try to come together to find a way to collaborate and care for the patient between the two.” ■

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



Dr. George



# Curbing *C. difficile* Infection in a Hospital

A hospitalist weighs in

By Dennis Deruelle, MD,  
FHM

This article discusses the prevalence of *Clostridioides difficile* (*C. difficile*) infection in hospitals, the progress that's been made in recent years in reducing hospital-acquired infections, and what's being done to mitigate the spread of this highly contagious disease in hospital settings. It also discusses an increase in community-acquired *C. difficile* infections and why this is important to hospitalists. The article provides some best practices that can help combat the spread of *C. difficile* infection in hospitals.

According to the Centers for Disease Control and Prevention (CDC),<sup>1</sup> *C. difficile* infection is a leading cause of health care-associated infections, with significant morbidity and mortality; it is associated with 15,000-30,000 deaths annually in the U.S.

*C. difficile* infections are extremely contagious, can spread in communal settings, and are one of the most common health care-associated infections in U.S. hospitals.<sup>2,3</sup> As a hospitalist, I have firsthand experience with the challenges of *C. difficile* infections, including severe outbreaks in the hospital setting and recurrence among those with *C. difficile* infection.

The burden of recurrent *C. difficile* infection is significant<sup>4</sup>: one-third of infected people are likely to get the infection again, and among people with recurrent *C. difficile* infection, up to 84% are hospitalized within one year, with an average of about two separate hospitalizations per patient, according to a single-center study.<sup>5</sup>

## Progress in reducing hospital-acquired infections

While hospital-acquired infections like *C. difficile* infection continue to be a major concern for hospitalists, health systems have made significant progress in recent years at reducing hospital-acquired infections overall.

One of the drivers of this progress is the Hospital-Acquired Condition Reduction Program which involves the Centers for Medicare and Medicaid Services (CMS) and links Medicare payments to health care quality in the inpatient hospital setting by incentivizing health care systems to keep hospital-acquired infections down.<sup>6,7</sup> Other possible reasons for the decline in hospital-acquired *C. difficile* infections are less ribotype 027 and the reduced use of fluoroquinolone antibiotics.<sup>1</sup>



The processes and protocols health systems have put in place to reduce hospital-acquired conditions help mitigate the spread of *C. difficile* infection within the hospital. However, we're starting to see a troubling trend outside of our hospitals—an increase in community-acquired *C. difficile* infections.

## Increase in community-acquired *C. difficile*

This is important to hospitalists because an increase in community-acquired infections could lead to more cases in the hospital given the highly infectious nature of *C. difficile*.

Patients who have symptom onset of *C. difficile* infection within 48 hours after hospital admission indicate a community-acquired *C. difficile* infection. If the infection with *C. difficile* occurs 72 hours after admission, it is deemed by CMS criteria to be hospital-acquired.<sup>3,8,9,10</sup> It's important to practice diagnostic-testing prudence, to identify only true *C. difficile* infection and not mere colonization. Patients should have three diarrheal stools within 24 hours that cannot be explained by other causes.

Why are *C. difficile* infections in the community increasing? In my opinion, there are several different reasons, including an aging population, more people living in nursing homes or skilled-nursing facilities where *C. difficile* is easily

spread, and the fact that antibiotics are the go-to treatment for fighting many infections.

While antibiotics can help wipe out disease-causing bacteria, including *C. difficile*, they can also wipe out some of the good microbes, disrupting the delicate balance of the gut microbiome, and allowing a *C. difficile* infection to take hold. Taking antibiotics for an extended period or using more than one antibiotic for treating an illness can raise the risk of *C. difficile* infection and lead to a cycle of recurring infections.<sup>11,12,13,14,15</sup>

## Steps to reduce the spread

The good news is that we have a clear roadmap to how we can reduce the spread of *C. difficile* infection in hospitals. If strictly adhered to, the steps below can help combat the spread of *C. difficile* infection:

- **Handwashing with soap:** Vigorously scrubbing hands with soap and water in between patients is one of the most important actions. While alcohol-based gels are convenient, they are not as effective as soap and water.
- **Cleaning surfaces:** Frequent and thorough cleaning of surfaces with U.S. Environmental Protection Agency-approved agents is extremely important in killing *C. difficile* spores and keeping the room environment as germ-free as possible.
- **Consistent changing of PPE:**



Dr. Deruelle

Dr. Deruelle is executive director of hospital medicine with American Physician Partners, Nashville, Tenn. He's a recognized expert on the Affordable Care Act and has been featured on television and radio talk shows, in newspapers and medical journals, and at national health care conferences. Dr. Deruelle recently published his second book, *Your Healthcare Playbook: Winning the Game of Modern Medicine*.

Disclosure: Dr. Deruelle is a speaker and consultant for Ferring Pharmaceuticals, Inc. He was not compensated for this article.

Changing medical apparel between every patient encounter is critical in reducing *C. difficile* spore transmission. In recent years, personal protective equip-



ment shortages have impacted the ability of health care workers to adhere to this crucial step, which can potentially result in increased spread within the hospital.

- **Isolating patients:** It is essential to isolate patients diagnosed with hospital-acquired infections, or even suspected of carrying such infections. This does not always happen due to a lack of private rooms and appropriate ventilation. The good news is that increasingly, hospitals are being designed and changes are being made to address these specific needs.
- **Antibiotic stewardship:** Key policies often encourage the reduction of antibiotic use and leverage a narrow spectrum of antibiotics. Physicians should have an accurate list of current and previous medications their patient has been prescribed so they can properly assess their need for antibiotic treatment. As part of this, health care professionals should also have an antibiotic history of the patient as far back as three months, given antibiotics are the most important risk factor for *C. difficile*. Consistent education of patients is also critical, including the potential impact of antibiotic overuse that may result in an imbalance of your microbiome which can potentially lead to *C. difficile* growth.

While *C. difficile* infection continues to be an urgent health threat, I believe that as health care professionals we need to take the necessary steps to mitigate exposure and transference of this potentially deadly disease in our hospitals.

The steps and processes listed help identify some of the ways we can all work together to better help contain this infection, and its impact on patients, caregivers, and the entire hospital community. ■

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





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