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The Hospitalist

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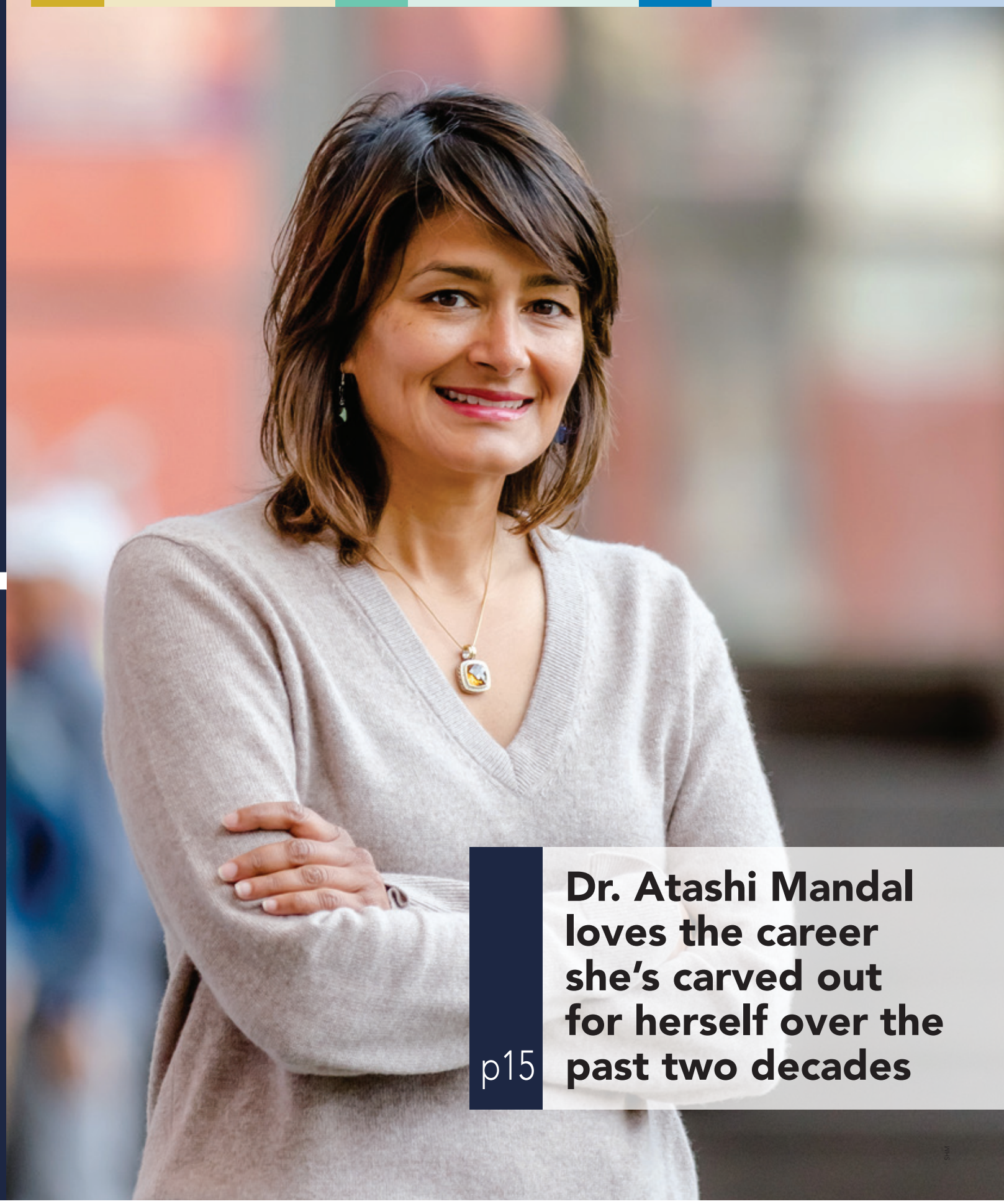

p15
Dr. Atashi Mandal loves the career she's carved out for herself over the past two decades

IN THE LITERATURE
UCSD med-lit reviews

PRACTICE MANAGEMENT
Lessons in redeployment

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IN THE NEXT ISSUE...
LGBTQIA+ challenges and allyship

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THE Hospitalist

The first and only FDA-approved microbiota-based live biotherapeutic to prevent recurrence of *C. difficile* infection starting at first recurrence.[1,2,a]

[a]In the pivotal phase 3 trial, 32.8% of patients were treated at first recurrence of CDI following antibiotic treatment of CDI.[1]

Scan to visit website

INDICATION

REBYOTA (fecal microbiota, live - jslm) is indicated for the prevention of recurrence of *Clostridioides difficile* infection (CDI) in individuals 18 years of age and older, following antibiotic treatment for recurrent CDI.

Limitation of Use

REBYOTA is not indicated for treatment of CDI.

IMPORTANT SAFETY INFORMATION

Contraindications

Do not administer REBYOTA to individuals with a history of a severe allergic reaction (eg, anaphylaxis) to any of the known product components.

Warnings and Precautions

Transmissible infectious agents

Because REBYOTA is manufactured from human fecal matter, it may carry a risk of transmitting infectious agents. Any infection suspected by a physician possibly to have been transmitted by this product should be reported by the physician or other healthcare provider to Ferring Pharmaceuticals Inc.

Management of acute allergic reactions

Appropriate medical treatment must be immediately available in the event an acute anaphylactic reaction occurs following administration of REBYOTA.

Potential presence of food allergens

REBYOTA is manufactured from human fecal material and may contain food allergens. The potential for REBYOTA to cause adverse reactions due to food allergens is unknown.

Adverse Reactions

The most commonly reported (≥3%) adverse reactions occurring in adults following a single dose of REBYOTA were abdominal pain (8.9%), diarrhea (7.2%), abdominal distention (3.9%), flatulence (3.3%), and nausea (3.3%).

Use in Specific Populations

Pediatric Use

Safety and efficacy of REBYOTA in patients below 18 years of age have not been established.

Geriatric Use

Of the 978 adults who received REBYOTA, 48.8% were 65 years of age and over (n=477), and 25.7% were 75 years of age and over (n=251). Data from clinical studies of REBYOTA are not sufficient to determine if adults 65 years of age and older respond differently than younger adults.

You are encouraged to report negative side effects of prescription drugs to FDA. Visit www.FDA.gov/medwatch, or call 1-800-332-1088.

Please see Brief Summary on next page and full Prescribing Information at www.REBYOTAHCP.com.

References

1. REBYOTA. Prescribing Information. Parsippany, NJ: Ferring Pharmaceuticals; 2022.
2. US Food and Drug Administration. FDA Approves First Fecal Microbiota Product. https://www.fda.gov/news-events/press-announcements/fda-approves-first-fecal-microbiota-product. Accessed December 1, 2022.

FERRING PHARMACEUTICALS
Microbiome Therapeutics Development

REBYOTA™
(fecal microbiota, live-jslm) suspension, for rectal use

RESTORE HOPE

REBYOTA™
(fecal microbiota, live-jslm) suspension, for rectal use

REBYOTA™ (fecal microbiota, live - jslm) suspension, for rectal use

Brief Summary Please consult package insert for full Prescribing Information

INDICATIONS
REBYOTA is indicated for the prevention of recurrence of *Clostridioides difficile* infection (CDI) in individuals 18 years of age and older following antibiotic treatment for recurrent CDI.
Limitation of Use: REBYOTA is not indicated for treatment of CDI.

CONTRAINDICATIONS
Do not administer REBYOTA to individuals with a history of a severe allergic reaction (e.g. anaphylaxis) to any of the known product components.

Each 150mL dose of REBYOTA contains between $1x10^8$ and $5x10^{10}$ colony forming units (CFU) per mL of fecal microbes including $>1x10^5$ CFU/mL of *Bacteroides*, and contains not greater than 5.97 grams of PEG3350 in saline.

WARNINGS AND PRECAUTIONS
Transmissible infectious agents: Because REBYOTA is manufactured from human fecal matter it may carry a risk of transmitting infectious agents. Any infection suspected by a physician possibly to have been transmitted by this product should be reported by the physician or other healthcare provider to Ferring Pharmaceuticals Inc.

Management of acute allergic reactions: Appropriate medical treatment must be immediately available in the event an acute anaphylactic reaction occurs following administration of REBYOTA.

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ADVERSE REACTIONS
The most commonly reported (≥ 3%) adverse reactions occurring in adults following a single dose of REBYOTA were abdominal pain, (8.9%), diarrhea (7.2%), abdominal distention (3.9%), flatulence (3.3%), and nausea (3.3%).

Clinical Trials Experience: The safety of REBYOTA was evaluated in 2 randomized, double-blind clinical studies (Study 1 and Study 2) and 3 open-label clinical studies conducted in the United States and Canada. A total of 978 adults 18 years of age and older with a history of 1 or more recurrences of *Clostridioides difficile* (CDI) infection and whose symptoms were controlled 24 – 72 hours post-antibiotic treatment were enrolled and received 1 or more doses of REBYOTA; 595 of whom received a single dose of REBYOTA.

Adverse Reactions: Across the 5 clinical studies, participants recorded solicited adverse events in a diary for the first 7 days after each dose of REBYOTA or placebo. Participants were monitored for all other adverse events by queries during scheduled visits, with duration of follow-up ranging from 6 to 24 months after the last dose. In an analysis of solicited and unsolicited adverse events reported in Study 1, the most common adverse reactions (defined as adverse events assessed as definitely, possibly, or probably related to Investigational Product by the investigator) reported by ≥3% of REBYOTA recipients, and at a rate greater than that reported by placebo recipients, were abdominal pain, (8.9%), diarrhea (7.2%), abdominal distention (3.9%), flatulence (3.3%), and nausea (3.3%).Most adverse reactions occurred during the first 2 weeks after treatment. After this, the proportion of patients with adverse reactions declined in subsequent 2-week intervals. Beyond 2 weeks after treatment only a few single adverse reactions were reported. Most adverse drug reactions were mild to moderate in severity. No life-threatening adverse reaction was reported.

Serious Adverse Reactions - In a pooled analysis of the 5 clinical studies, 10.1% (60/595) of REBYOTA recipients (1 dose only) and 7.2% (6/83) of placebo recipients reported a serious adverse event within 6 months post last dose of investigational product. None of these events were considered related to the investigational product.

USE IN SPECIFIC POPULATIONS
Pregnancy: REBYOTA is not absorbed systemically following rectal administration, and maternal use is not expected to result in fetal exposure to the drug.

Lactation: REBYOTA is not absorbed systemically by the mother following rectal administration, and breastfeeding is not expected to result in exposure of the child to REBYOTA.

Pediatric Use: Safety and effectiveness of REBYOTA in individuals younger than 18 years of age have not been established.

Geriatric Use: Of the 978 adults who received REBYOTA, 48.8% were 65 years of age and over (n=477), and 25.7% were 75 years of age and over (n=251). Data from clinical studies of REBYOTA are not sufficient to determine if adults 65 years of age and older respond differently than younger adults

For more information, visit www.REBYOTAHCP.com

You are encouraged to report negative side effects of prescription drugs to FDA. Visit www.FDA.gov/medwatch, or call 1-800-332-1088.

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This brief summary is based on full Rebyota Prescribing Information which can be found at www.RebyotaHCP.com

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Bringing SHM's Vision, Mission, and Goals to Life

By Eric E. Howell, MD, MHM, CEO of SHM

Dr. Howell

Dr. Howell has been SHM's CEO since 2020. Prior to that, he was faculty at the Johns Hopkins University, School of Medicine for 20 years.

The cover article of the April issue of *The Hospitalist* was a message from the SHM president, Dr. Kris Rehm. In her article, she outlined the recently completed vision and mission statements developed by the SHM Board of Directors:

- **Vision:** To be the professional home of hospitalists dedicated to exceptional and equitable care for acutely ill patients
- **Mission:** As the home for hospitalists, SHM activates and engages our community to:
  - Advocate for our specialty, our members, and the diverse patients we serve
  - Promote high-value care and optimal outcomes for acutely ill patients
  - Meet the evolving educational needs of a dynamic specialty
  - Cultivate an inclusive community for hospitalists and support career growth and well-being
  - Advance the research and innovation of health care delivery, quality, safety, and experience across the care continuum

As the CEO of SHM, it is my job to put the Board's vision and mission into action. To that end, the Board and SHM staff collaborated with membership to develop four strategic goal areas:

- Invest in a diverse, equitable, and inclusive culture
- Advocate for members and for the field of hospital medicine
- The SHM community—a place to belong, grow, and partner
- Advance health care delivery, quality, and experience through science and innovation

You can find the vision and mission statements, along with these goals, and the statements of desired achievement for each on our website at hospitalmedicine.org/about/history-mission/.

I want to share with you the concrete and tangible ways SHM is working to realize those four goals.

Goal: Invest in a diverse, equitable, and inclusive culture

SHM has always prided itself on its inclusive culture, both in terms of professional background and regarding personal background. I believe the composition of our Board of Directors is the ultimate testament to that. Recently we have been even more deliberate about investing in the infrastructure that supports diversity, including a Diversity, Equity, and Inclusion committee. This DEI committee resulted from the recommendations from a Board-appointed DEI Task Force assembled in 2021. The DEI committee has made impressive accomplishments since its inception less than two years ago, including mentoring and sponsoring students from Meharry Medical College as well as students from underrepresented groups in medicine from University of Texas at Austin's Dell Medical School.

Another very impressive accomplishment for SHM has been the launch of a competitive medical-student education-assistance scholarship. Now in its second year, this scholarship awards one third-year medical student $25,000 towards tuition. We launched this scholarship in 2022, with Andrea Martinez, a medical student from Emory Medical School in Atlanta, as the inaugural recipient. This year, Cedric Mutebi from Wayne State University School of Medicine in Detroit was awarded the $25,000 scholarship. Both recipients were chosen for their commitment to their respective communities and for their academic accomplishments. We could not have made these scholarships possible

without the generous support of Vituity, which sponsored both through the Hospital Medicine DEI Scholarship Fund!

Goal: Advocate for members and the field of hospital medicine

The SHM Public Policy committee, partnering with the staff in SHM's advocacy department, are the most powerful advocates hospitalists have. Whether it's your paycheck, or your patients, SHM is there advocating for hospitalists' interests. A partial list of "wins" includes eliminating the X-waiver—you know that pesky rule that required a day of training for you to be able to prescribe buprenorphine? That training requirement no longer exists because SHM was a key leader in getting the X-waiver repealed, an important tool for fighting the opioid epidemic. SHM was a leader in mitigating Medicare payment cuts, extending Medicare incentives for advanced payment models, and keeping telehealth as a reimbursable service. Without SHM, hospitalist paychecks would be a bit lighter. Our advocacy group has also made important progress on wellness by supporting the Dr. Lorna Breen Health Care Act, and we have advocated for our internationally trained colleagues by successfully lobbying for the Conrad State 30 extension, helping J-1 visa holders.

RALF GEITHE - STOCK.ADOBE.COM

Goal: The SHM community—a place to belong, grow, and partner

I know how important meaningful relationships were (and are) to my own professional growth. Collaboration through a supportive community of peers can provide guidance and belonging. That's why events like Converge are so rewarding and important. Yes, we get to learn about medicine, but we also get to connect with more than 3,500 like-minded hospitalists, learn from our peers, and get support when we need it. To continue expanding the SHM community, SHM course directors are retooling our specialty meetings, like the Leadership Academies, the Quality & Safety Educators Academy, and the Academic Hospitalist Academy, to meet the needs of learning and connecting in a post-pandemic world. In addition, SHM is expanding chapters, chapter engagement, and chapter staff to support your SHM community at the local level, so you don't have to travel to stay connected.

Goal: Advance health care delivery, quality, and experience through science and innovation

SHM has a long history of innovation and advancing science. This is especially true in quality improvement (QI) where our Center for QI has been partnering with academicians on dozens of government grants to improve quality and safety in the hospital for more than a decade. This year, the Center for QI will convene hospitalist researchers to explore both the role SHM should play in advancing that research agenda, and also how SHM can positively influence areas that are important to defining the profession. There remain important questions around workload, burnout, and our role in the continuum of patient care, as well as a number of other topics. SHM can, and should, play a leadership role in this assessment through active collaboration with our membership.

The SHM staff and I look forward to implementing these goals and furthering the strategic work of the Board of Directors. I have seen the positive impact on our members. I believe the mission, vision, and goals will advance the profession. These goals are not static, but working, flexible goals that will be continuously reassessed by the Board and SHM leadership, with the best interests of our members and our field in mind. ■

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SHM News

Mark your calendars, celebrate MHM, pre-order Converge On Demand

Next Year's Annual Conference

Save the date for SHM Converge 2024—April 12-15, in San Diego. Register now and get the early-bird rate at SHMConverge.org.

PHM 2023

The Pediatric Hospital Medicine 2023 Conference (PHM 2023) is the premier educational and networking conference for pediatric hospitalists and other professionals specializing in the care of hospitalized children.

The largest meeting of its kind for pediatric hospitalists, the conference is co-sponsored by the American Academy of Pediatrics, its section on hospital medicine, the Academic Pediatric Association, and SHM. Mark your calendars to attend, August 3-6, 2023, in Philadelphia.

SHM Leadership Academy

Take advantage of the only leadership program created and designed specifically for hospitalists. SHM Leadership Academy offers four leadership courses—Strategic Essentials, Influential Management, Mastering Teamwork, and Leadership Capstone—curated to enhance your leadership skills will networking with like-minded professionals to advance your career.

This year's academy is Oct. 23-26, 2023, at the JW Marriott Camelback in Scottsdale, Ariz. The faculty includes Kierstin Cates Kennedy, MD, MSHA, FACP, SFHM, Kheyandra D. Lewis, MD, MeD, Eric E. Howell, MD, MHM, Mark V. Williams, MD, FACP, MHM, Brian Harte, MD, MHM, Amit Prachand, M.Eng, Leonard Marcus, PhD, Jeffrey J. Glasheen, MD, MHM, and Russell L. Holman, MD, MHM.


Dr. Amin


Dr. Fang


Dr. Scheurer


Dr. Hunt

2023 Masters in Hospital Medicine

Four hospitalists joined an elite group in March when SHM outgoing president Rachel Thompson, MD, MPH, SFHM, kicked off SHM Converge 2023 by honoring the SHM's 2023 class of Masters in Hospital Medicine.

They are Alpesh N. Amin, MD, MBA, MACP, MHM, Margaret C. Fang, MD, MPH, MHM, Daniel Payson Hunt MD, MHM, and Danielle B. Scheurer, MD, MSCR, MHM.

These leaders join 39 other Masters in Hospital Medicine. Learn more about each of them online here.

Pre-Order SHM Converge 2023 On Demand

If you weren't able to attend SHM Converge 2023 in Austin, Texas or missed some of the sessions you can pre-order Converge On Demand. It will provide access to recordings of most didactic sessions and enable you to earn up to 89 AMA PRA Category 1 Credit(s)™ and up to 44.5 American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) points.

SHM members can log in to the SHM Learning Portal at shmlearningportal.org to pre-order.

Accreditation Statement—SHM is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Credit Statement—SHM designates this live activity for a maximum of 89 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

MOC Statement—Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 44.5 MOC points in the ABIM's MOC program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

Publishing Opportunities

If you're an SHM member interested in contributing to *The Hospitalist*, there are lots of opportunities.

Scan the QR code for more information about clinical options (In the Literature, Key Clinical Questions, Interpreting Diagnostic Tests), and HM Voices.

Movers and Shakers

Are you an SHM member with good news to share? If you or someone on your team has recently been promoted, changed jobs, or has other good news to share, we'd like to hear from you. Send your information and headshot to us at lcasinger@wiley.com. We hope to see you in an upcoming issue! ■

Improving Sepsis Outcomes

WITH LTACH REFERRALS

Recent data demonstrates that transitioning sepsis patients to long-term acute care hospitals (LTACHs) can improve outcomes and reduce readmissions.

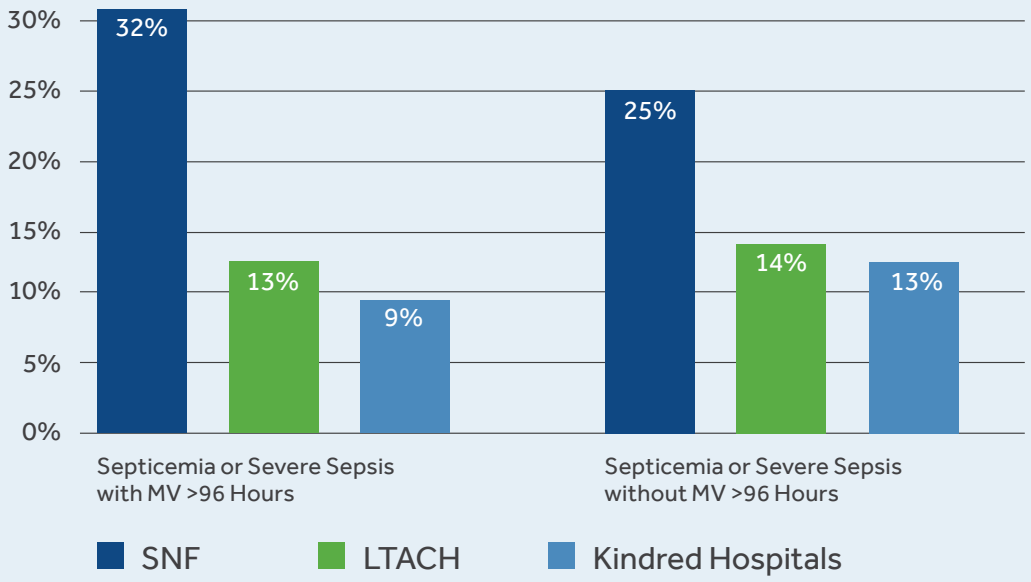
Understanding the Sepsis Challenge

Sepsis is the costliest inpatient condition, resulting in $41.5 billion in total costs in 2018, and has the highest number of 30-day readmissions.[1,2] The average length of stay (LOS) for sepsis is also 75% greater than for other conditions.[3]

Improving Outcomes with LTACH Referrals

These challenges may have to do with recovery pathway selections, which have historically favored skilled nursing facilities (SNFs).[4] When comparing post-acute LOS, sepsis patients discharged to LTACHs have shorter stays than those discharged to SNFs. Additionally, data shows that LTACHs have lower sepsis readmission rates than SNFs, with Kindred Hospitals' network of long-term acute care hospitals achieving even lower readmission rates than LTACHs nationally.[5]

Average 30-Day Readmission Rates, Q2 2021-Q1 2022



At LTACHs, physician-led care teams specialize in treating critically ill patients with complex conditions. LTACH care includes IV antibiotic therapy, onsite labs and pharmacies, and CMS-compliant infection prevention standards, all of which improve sepsis outcomes. Ensuring sepsis patients have timely access to this specialized acute care can help reduce length of stay and readmissions.

How Kindred Can Help

Kindred Hospitals, the nation's largest LTACH provider, offers specialized care to medically complex patients.

With Disease-Specific Care Certifications in Sepsis from The Joint Commission and an established treatment protocol, Kindred can play a key role in improving outcomes.

To learn more, visit refertokindred.com.

Kindred Hospitals
Empowered by ScionHealth

Sources:

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The University of California, San Diego Medical Research Reviews

By Maryann T. Ally, MD, MPH, FACP, CHCQM-PhysAdv, FHM; Diana Childers, MD, CHCQM-PHYADV; William J. Frederick, III, MD, PhD, CHCQM-PhyAdv; Constance Chace, MD, MPH; Nhan Vuong, MD; Charles Hammond, MD; and Bryan Huang, MD, CHCQM-PhyAdv, FHM

The University of California, San Diego

IN THIS ISSUE

By Maryann T. Ally, MD, MPH, FACP, CHCQM-PhysAdv, FHM

1 Procalcitonin to predict severity of acute cholangitis and need for urgent biliary decompression: systematic scoping review

CLINICAL QUESTION: What impact does procalcitonin have on the management of acute cholangitis?

Dr. Ally

BACKGROUND: Procalcitonin has been used to predict disease severity that may lead to septic shock, though this remains a debatable topic. Acute cholangitis portended high morbidity and mortality prior to biliary decompression and enhanced critical care. Severe acute cholangitis is defined by one of these characteristics: cardiovascular dysfunction (such as hypotension requiring dopamine or norepinephrine infusion); neurologic dysfunction (disturbance of consciousness); respiratory dysfunction (PaO_2/FiO_2 ratio < 300); renal dysfunction (with oliguria or serum creatinine >2 mg/dL); hepatic dysfunction (INR >1.5); or hematological dysfunction (platelet count <100,000/mm3). The Tokyo Guidelines 2018 address acute cholangitis severity by using procalcitonin as a prognostic lab. However, the guidelines highlight the low quality of existing evidence and the need for more research on this topic.

STUDY DESIGN: Systematic scoping review article

SETTING: National and international peer-reviewed articles, randomized controlled trials, case-control studies, cohort studies, cross-sectional studies, and case series in adult patients

SYNOPSIS: The researchers searched MEDLINE, EMBASE, and Google Scholar for articles discussing procalcitonin and its relationship to the management of acute cholangitis. They reviewed articles from the origin of these medical databases to July 2021. The inclusion criteria were articles that discussed the effect of procalcitonin on either the severity of acute cholangitis or the indication to perform biliary decompression in adult patients. The exclusion criteria were qualitative studies, review articles, case reports, commentaries, conference abstracts, and studies with pediatric or obstetric patients. With the inclusion and exclusion criteria in mind, the number of records reviewed was filtered down from 1,987 articles to six studies. These were single-center studies in Asia (four from Japan, one from South Korea, and one from China) with five being retrospective case-control and one being prospective case-control. These studies had small sample sizes (n=28 to n=213). All six studies showed that patients with severe acute cholangitis had higher procalcitonin levels (with cut-off values ranging from 1.76 ng/mL to 3.1 ng/mL) but the median procalcitonin level was variable. Only three studies mentioned when biliary decompression was performed, but did not indicate which procalcitonin levels were used to determine the need for urgent biliary decompression. There was variability in the timing of urgent or emergent biliary decompression. Four studies had blood cultures as an endpoint as well. The etiologies of acute cholangitis included choledocholithiasis (most common), cholangiocarcinoma, chronic pancreatitis, pancreatic head cancer, and gall bladder cancer with bile duct invasion. Hospitalists should continue their usual approach when managing patients with acute cholangitis. Serum procalcitonin may be useful to differentiate an infection, such as acute cholangitis, from malignancy, but its use for prognostication of disease severity for patients with acute cholangitis and as a tool to determine when biliary decompression takes place requires more research on this topic.

BOTTOM LINE: The use of serum procalcitonin to predict the severity of acute cholangitis and to triage which patients would benefit from urgent biliary decompression requires additional studies to validate it as a prognostic tool.

CITATION: Silangcruz K, et al. Procalcitonin to predict severity of acute cholangitis and need for urgent biliary decompression: systematic scoping review. *J Clin Med*. 2022;11(5):1155. doi: 10.3390/jcm11051155.

Dr. Ally is an associate clinical professor of medicine in the division of hospital medicine and a physician advisor at the University of California, San Diego.

By Diana Childers, MD, CHCQM-PHYADV

2 The association of hallway boarding on readmission and mortality rates: a comparative, retrospective analysis, following a policy change

CLINICAL QUESTION: Does inpatient hallway boarding increase in-hospital mortality, 30-day mortality, or 30-day readmission rates?

Dr. Childers

BACKGROUND: Prior studies have reported that the boarding of patients in emergency department (ED) hallways when no inpatient beds are available is a major cause of ED crowding and leads to decreased patient satisfaction and adverse clinical outcomes. One way to alleviate ED overcrowding is to enable hallway boarding in the inpatient setting.

STUDY DESIGN: Linear-regression analysis based on administrative data from January 2013 to September 2019 to compare in-hospital mortality, 30-day readmission, and 30-day mortality rates of patients hospitalized before and after a 2016 policy change was enacted to allow for inpatient hallway beds.

SETTING: Single medical center

SYNOPSIS: The study took place at Shaare Zedek Medical Center, one of the largest hospitals in Jerusalem that averages 7,500 admissions per year. In 2016, due to an increasing number of admissions and subsequent frequent and prolonged periods of ED overcrowding, a new medical center policy to employ inpatient hallway boarding was implemented. Administrative data were collected on 8,583 inpatients before and 11,962 inpatients after this policy change. To minimize differences in the care and treatment of patients, the study focused on two departments with the same leadership over the time of the study. On most days, hallway boarding patients were assigned to an inpatient bed by the end of

the same day. After the policy change, there was a notable increase in admissions. The adjusted in-hospital mortality was lower (odds ratio, 0.76; CI, 0.65 to 0.90), 30-day readmission was mildly higher (odds ratio, 1.18; CI, 1.00 to 1.40), and there was no change in 30-day mortality (odds ratio, 1.16; CI, 0.88 to 1.53).

In 2019, a committee for the improvement of treatment in internal medicine departments in Israel published a recommendation that "the practice of inpatient hallway boarding violates patients' rights for privacy and hampers human dignity." The committee recommended that such practices be prohibited.

BOTTOM LINE: The creation of inpatient hallway beds effectively increased bed capacity, accommodating an increase in patient volume. This was associated with lower in-hospital mortality, increased 30-day readmission, and no change in 30-day mortality.

CITATION: Ben Shoham A, Munter G. The association between hallway boarding in internal wards, readmission, and mortality rates: a comparative, retrospective analysis, following a policy change. *Isr J Health Policy Res*. 2021;10(1):8. doi:10.1186/s13584-021-00443-3.

Dr. Childers is an associate clinical professor at the University of California, San Diego.

By William J. Frederick, III, MD, PhD, CHCQM-PHYADV

3 Implementation of a comprehensive hospitalist-led initiative to improve care for patients with OUD

CLINICAL QUESTION: Can a multidisciplinary, hospitalist-led program improve care for hospitalized patients with opioid use disorder (OUD)?

BACKGROUND: Despite rising opioid-related hospitalizations and deaths, hospitalists often fail to address substance use disorders or prescribe medications for opioid use disorder (MOUD). Lack of prescriber knowledge, provider beliefs about patients with substance use disorders, and additional training and waiver requirements have traditionally reduced provider engagement in prescribing MOUDs.

STUDY DESIGN: A single-arm, pre-post, interventional study

SETTING: A single U.S. academic medical center

SYNOPSIS: The multidisciplinary Project Caring for patients with Opioid Misuse through Evidence-based Treatment (COMET) was a comprehensive, two-year intervention launched in 2019 to address substance-use disorders in hospitalized patients with goals of increasing MOUD prescriptions and improving post-discharge care coordination. Project COMET was funded by the health system and engaged stakeholders including pharmacy, nursing, infectious disease, psychiatry, pain management, and community-based providers. Templates for documenting opioid use and withdrawal and an order set for prescribing buprenorphine and initiating methadone were implemented in the electronic health record. Fourteen hospitalists who completed X-waiver training and orientation were partnered with a social worker to guide patients during hospitalization and coordinate post-discharge care. 512 patients (median age 40, 57% male, 60% white, 31% Black, <1% Hispanic) were evaluated during the two-year study period. 88% of evaluated patients had an opioid-use–disorder diagnosis within 12 months prior to admission. High rates of comorbid pain, psychiatric illness, and infection were present in this cohort. 71% of patients received medications to manage opioid use disorder during admission. Comparing pre- and post-COMET prescribing habits showed that MOUD prescriptions rose from 36% to 57%, and prescriptions for buprenorphine and naloxone at discharge rose from 2% each to 20% and 26%, respectively. 64% of patients prescribed buprenorphine during admission were continued on this medication after discharge, and 83% of patients treated with methadone during hospitalization were referred to a methadone clinic.

BOTTOM LINE: This study successfully demonstrated the implementation of a multidisciplinary approach to changing hospitalist prescribing patterns and improving post-discharge care coordination when caring for patients with OUD.

CITATION: Clifton D, et al. Implementation of a comprehensive hospitalist-led initiative to improve care for patients with opioid use disorder. *J Hosp Med*. 2022;17(6):427-36.

Dr. Frederick is an associate clinical professor of medicine in the division of hospital medicine and a physician advisor at the University of California, San Diego.

By Constance Chace, MD, MPH

4 Early treatment with thiamine and mortality among patients with AUD who are hospitalized for pneumonia

CLINICAL QUESTION: Does early thiamine administration improve mortality outcomes for patients with alcohol use disorder who are hospitalized for pneumonia?

Dr.Chace

BACKGROUND: Wernicke's Encephalopathy (WE) is a devastating neurological condition that affects patients with alcohol use disorder (AUD). It can be precipitated by acute illness and is fatal in up to 20% of patients. Thiamine deficiency has been thought to cause WE and, although it has long been considered the standard of care for the treatment and prevention of WE, thiamine is not universally administered to hospitalized patients with AUD.

STUDY DESIGN: Retrospective cohort study

SETTING: Data was collected from 670 geographically diverse, nonprofit, nongovernmental, community, and teaching hospitals in rural and urban areas that participated in the Premier Healthcare Database between 2010 and 2015. Combined, these hospitals account for 25% of all U.S. inpatient admissions.

SYNOPSIS: Patients with both a principal or secondary International Classification of Diseases (ICD-9) diagnosis of pneumonia and an alcohol-related ICD-9 diagnosis who also received benzodiazepines in the first two days of hospitalization were included (totaling 36,732 patients). Patients were considered to have been treated with thiamine if they received any thiamine at all by hospital day two. Patients receiving thiamine were more likely to be male and/or to have liver disease, coagulopathy, or fluid or electrolyte disorders, and were less likely to have Medicare insurance. There was substantial variability in thiamine administration across hospitals and, notably, 28% of patients received no thiamine at all.

Thiamine treatment was associated with a significantly lower 14-day mortality (20% lower odds, P <0.001). The likelihood of ICU admission did not vary by thiamine treatment status, but those who received thiamine were less likely to require invasive mechanical ventilation (20.9% versus 25.5%) or vasopressors (8.8% versus 12.8%). There was no significant difference in outcomes for those who received low- versus high-dose thiamine.

Limitations include possible undercounting of patients with AUD by using ICD-9 codes, given restrictions on clinical data when reviewing de-identified charts.

This study is the largest to date on the benefit of thiamine, and the first large study of the effectiveness of thiamine use in the U.S.

BOTTOM LINE: Administration of thiamine to patients with AUD hospitalized for pneumonia is associated with a significant reduction in mortality and morbidity. The current underutilization of thiamine treatment in patients with AUD presents an opportunity to save lives.

CITATION: Baron SW, et al. Early treatment with thiamine and mortality among patients with alcohol use disorder who are hospitalized for pneumonia. *J Hosp Med*. 2022;17(8):585-93.

Dr. Chace is an assistant clinical professor of internal medicine and pediatrics at the University of California, San Diego.

By Nhan Vuong, MD

5 Low-dose buprenorphine initiation is a safe and effective alternative to standard-dose buprenorphine in hospitalized patients with OUD

CLINICAL QUESTION: Is low-dose buprenorphine initiation in hospitalized patients safe and effective for the management of opioid use disorder (OUD)?

Dr. Vuong

BACKGROUND: OUD is a chronic relapsing disease that has become an epidemic in the U.S. Medications for opioid use disorder (MOUD) have been shown to be effective in preventing overdose-related deaths. Buprenorphine has a good safety profile and accessibility. However, standard dose initiation has been limited by requiring complete cessation of opioids or a withdrawal period prior to initiation, which may not be feasible in the inpatient setting.

STUDY DESIGN: Retrospective cohort study

SETTING: Urban, academic medical center

SYNOPSIS: 68 patients seen by an addiction-medicine consult service were initiated on low-dose buprenorphine. Low-dose buprenorphine was chosen over standard dosing for the following reasons: co-occurring pain (91.7%), anxiety surrounding withdrawal (69.4%), history of precipitated withdrawal (9.7%), opioid withdrawal intolerance (6.9%), and other (18.1%). Of these, 50 patients (69.4%) completed initiation as inpatient, nine patients (12.5%) transitioned to complete initiation as outpatient, and 13 patients (18.1%) did not complete initiation. Patients experienced mild generalized symptoms, but the study was unable to conclude if they were related to low-dose buprenorphine or acute illness.

The authors describe specific practice considerations for low-dose buprenorphine initiation in the above scenarios. They found that low-dose

initiation removed the barrier of a withdrawal period, provided more flexibility for buprenorphine initiation, did not result in increased pain, required less intensive nursing staff monitoring, supported methadone transitions, and allowed for rapid titration protocols.

Study limitations include limited patient diversity, performance at a single site, lack of follow-up after hospitalization, and applicability to other health care systems without an addiction-medicine consult service.

BOTTOM LINE: Low-dose buprenorphine is a safe and effective alternative to standard-dose buprenorphine initiation for hospitalized patients with OUD. Hospitalists have increasing options for OUD treatment and with shared decision making can safely initiate therapy in the inpatient setting.

CITATION: Button D, et al. Low-dose buprenorphine initiation in hospitalized adults with opioid use disorder: a retrospective cohort analysis. *J Addict Med*. 2022;16(2):e105-e111. doi:10.1097/ADM.0000000000000864.

Dr. Nhan Vuong is an assistant clinical professor of medicine in the division of hospital medicine at the University of California, San Diego.

By Charles Hammond, MD

6 Aggressive or moderate fluid resuscitation in acute pancreatitis

CLINICAL QUESTION: Is early, aggressive, fluid resuscitation in acute pancreatitis or moderate fluid resuscitation the best and safest way to prevent progression to moderately severe or severe pancreatitis?

Dr. Hammond

BACKGROUND: Early, aggressive, fluid resuscitation is widely recommended and used in the management of acute pancreatitis. However, subsequent studies have shown this strategy may result in increased adverse events without significantly improving morbidity and mortality.

STUDY DESIGN: Investigator-initiated, multicenter, open-label, randomized, clinical trial

SETTING: 18 medical centers in four countries (Italy, India, Morocco, Spain)

SYNOPSIS: 249 patients were enrolled and randomly assigned to receive either aggressive or moderate fluid resuscitation for acute pancreatitis. Aggressive fluid resuscitation was defined as a bolus of 20 mL/kg lactated Ringers followed by an infusion at 3 mL/kg/hr. Moderate fluid resuscitation was defined as a 1.5 mL/kg/hr lactated Ringers infusion for all patients, preceded by a 10 mL/kg bolus only if there were clinical signs of hypovolemia. Moderately severe or severe pancreatitis was defined per the Revised Atlanta Classification as the development of one or more of the following: creatinine >1.9; systolic blood pressure <90 despite fluid resuscitation; PaO2/FiO2 <300; exacerbation of a pre-existing condition; or local pancreatic complications on imaging. Exclusion criteria included a medical history of congestive heart failure, uncontrolled hypertension, hypernatremia, hyponatremia, hyperkalemia, hypercalcemia, chronic pancreatitis, chronic kidney disease, decompensated cirrhosis, or presenting with moderately severe to severe pancreatitis.

The trial was halted at its interim analysis due to significant between-group differences in the safety outcome with no significant difference in the primary outcome. Development of fluid overload (safety outcome) was 20.5% in the aggressive fluid resuscitation group versus 6.3% in the moderate group (adjusted relative risk, 2.85; 95% CI, 1.36 to 5.94). Progression to moderately severe or severe pancreatitis (primary outcome) was 22.1% in the aggressive fluid resuscitation group versus 17.3% in the moderate group (adjusted relative risk 1.30; 95% CI 0.78 to 2.18).

BOTTOM LINE: Moderate fluid resuscitation in patients with acute pancreatitis is preferred as it reduces the risk of fluid overload without increasing the risk of the development of moderately severe or severe pancreatitis.

CITATION: de-Madaria E, et al. Aggressive or moderate fluid resuscitation in acute pancreatitis. *N Engl J Med*. 2022;15;387(11):989-1000.

Dr. Hammond is an associate physician at the University of California, San Diego.

By Bryan Huang, MD, CHCQM-PhyAdv, FHM

7 Increased familiarity between residents and nurses improves team performance and communication

CLINICAL QUESTION: Does an increased familiarity between medical residents and nurses improve team performance and communication?

Dr. Huang

BACKGROUND: Prior studies suggest that familiarity promotes an environment of safety, in which providers are comfortable speaking up, asking for help, and admitting errors. Failures in team communication are often cited as contributors to medical errors.

STUDY DESIGN: 12-month, randomized, controlled trial

SETTING: Single quaternary medical facility

SYNOPSIS: 15 randomly selected PGY-1 internal medicine residents were assigned to the intervention group, spending four month-long general-medicine rotations on the same floor for a year. 18 PGY-1 residents made up the control group and were randomly assigned to one of five floors for each of their rotations. Physician rounds and multidisciplinary rounds were structured similarly on each floor. Team performance on medical simulations, time-motion observations of communication, and surveys were assessed for both the intervention and control groups.

At the end of 12 months, the intervention group had higher performance on a medical simulation, achieving a higher score for leadership and management (composite teamwork score 2.47 versus 2.17; *P*=0.045), and were more likely to work as a single unit and negotiate with the patient to achieve the desired outcome. Intervention teams were more likely to have nurses present when rounding on patients (47% versus 28%; *P*=0.03). Surveys at six months found that nurses were more likely to report an excellent to outstanding relationship with PGY-1 residents in the intervention group (74% versus 40%; *P*=0.003); differences diminished after 12 months.

Limitations include Covid-19-related study interruptions, differences in baseline performance on an initial simulation, technical difficulties limiting analysis of simulations in some of the intervention and control groups, and that the study was performed at a single institution.

BOTTOM LINE: Increased familiarity between residents and nurses resulted in improved performance on complex tasks in medical simulations and improved interprofessional communication.

CITATION: Iyasere CA, et al. Effect of increased interprofessional familiarity on team performance, communication, and psychological safety on inpatient medical teams. *JAMA Intern Med*. 2022;182(11):1190-8.

Dr. Huang is a professor of medicine and physician advisor at the University of California, San Diego. ■

Celebrating the 2022 Chapter Excellence Status Awards Recipients

The Chapter Excellence Awards are bestowed annually to recognize outstanding work conducted by chapters to carry out the SHM mission locally. They're comprised of Status Awards and Exemplary Awards. Please join *The Hospitalist* and SHM in congratulating the 2022 recipients.

2022 Status Awards

PLATINUM CHAPTER EXCELLENCE AWARD

Atlanta
Connecticut
Hampton Roads
Houston
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Kansas
Kentucky
Los Angeles
Maryland
Michigan
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Minnesota
Nebraska
New Mexico
North Carolina Triangle
North Florida
NYC/ Westchester
Utah

GOLD CHAPTER EXCELLENCE AWARD

Long Island
Memphis
North Dakota
North Jersey
Pacific Northwest
Rocky Mountain
Pittsburgh
St. Louis

SILVER CHAPTER EXCELLENCE AWARD

Arizona
Lake Erie/Northern Ohio
San Diego
Western Massachusetts

BRONZE CHAPTER EXCELLENCE AWARD

Charlotte Metro Area
Hawaii
Oregon/SW Washington
Pee Dee
Rhode Island
Wisconsin

2022 Exemplary Awards

OUTSTANDING CHAPTER OF THE YEAR

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OUTSTANDING MEMBERSHIP RECRUITMENT & RETENTION

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Veklury®
remdesivir 100 MG FOR INJECTION

For patients hospitalized with **COVID-19**,[1]

HELP REDUCE DISEASE PROGRESSION AND SHORTEN RECOVERY TIME[1,2]

INDICATION

VEKLURY is indicated for the treatment of COVID-19 in adults and pediatric patients (≥28 days old and weighing ≥3 kg) with positive results of SARS-CoV-2 viral testing, who are:

- Hospitalized, or
- Not hospitalized, have mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death.

IMPORTANT SAFETY INFORMATION

Contraindication

- VEKLURY is contraindicated in patients with a history of clinically significant hypersensitivity reactions to VEKLURY or any of its components.

Warnings and precautions

- **Hypersensitivity, including infusion-related and anaphylactic reactions:** Hypersensitivity, including infusion-related and anaphylactic reactions, has been observed during and following administration of VEKLURY; most reactions occurred within 1 hour. Monitor patients during infusion and observe for at least 1 hour after infusion is complete for signs and symptoms of hypersensitivity as clinically appropriate. Symptoms may include hypotension, hypertension, tachycardia, bradycardia, hypoxia, fever, dyspnea, wheezing, angioedema, rash, nausea, diaphoresis, and shivering. Slower infusion rates (maximum infusion time of up to 120 minutes) can potentially prevent these reactions. If a severe infusion-related hypersensitivity reaction occurs, immediately discontinue VEKLURY and initiate appropriate treatment (see Contraindications).
- **Increased risk of transaminase elevations:** Transaminase elevations have been observed in healthy volunteers and in patients with COVID-19 who received VEKLURY; these elevations have also been reported as a clinical feature of COVID-19. Perform hepatic laboratory testing in all patients (see Dosage and administration). Consider discontinuing VEKLURY if ALT levels increase to >10x ULN. Discontinue VEKLURY if ALT elevation is accompanied by signs or symptoms of liver inflammation.
- **Risk of reduced antiviral activity when coadministered with chloroquine or hydroxychloroquine:** Coadministration of VEKLURY with chloroquine phosphate or hydroxychloroquine sulfate is not recommended based on data from cell culture experiments, demonstrating potential antagonism, which may lead to a decrease in the antiviral activity of VEKLURY.

Adverse reactions

- The most common adverse reaction (≥5% all grades) was nausea.
- The most common lab abnormalities (≥5% all grades) were increases in ALT and AST.

Drug interactions

- Drug interaction trials of VEKLURY and other concomitant medications have not been conducted in humans.

Dosage and administration

- **Dosage:**
  - For adults and pediatric patients weighing ≥40 kg: 200 mg on Day 1, followed by once-daily maintenance doses of 100 mg from Day 2, administered only via intravenous infusion.
  - For pediatric patients ≥28 days old and weighing ≥3 kg to <40 kg: 5 mg/kg on Day 1, followed by once-daily maintenance doses of 2.5 mg/kg from Day 2, administered only via intravenous infusion.

ECMO=extracorporeal membrane oxygenation.

In the ACTT-1 overall study population, patients experienced

5 DAYS SHORTER RECOVERY TIME WITH VEKLURY[1]

Median 10 days with VEKLURY vs 15 days with placebo; recovery rate ratio: 1.29 (95% CI, 1.12 to 1.49), p<0.001[1,2]

- Recovery was defined as patients who were no longer hospitalized or hospitalized but no longer required ongoing COVID-19 medical care

Significantly greater likelihood of improvement in clinical status, a key secondary endpoint[1]

- Patients were 54% more likely to have improved clinical status on Day 15 vs placebo; odds ratio for improvement: 1.54 (95% CI, 1.25 to 1.91)

Helped reduce progression to more severe disease, an additional secondary endpoint[1-3]

- 7% absolute reduction in incidence of new noninvasive ventilation or high-flow oxygen with VEKLURY (17%, n=307) vs placebo (24%, n=266) in patients who did not receive either at baseline (95% CI, -14 to -1)
- 10% absolute reduction in incidence of new mechanical ventilation or ECMO with VEKLURY (13%, n=402) vs placebo (23%, n=364) in patients who did not receive either at baseline (95% CI, -15 to -4)

Adverse reaction frequency was comparable between VEKLURY and placebo[1]

- All adverse reactions (ARs), Grades ≥3: 41 (8%) with VEKLURY vs 46 (9%) with placebo; serious ARs: 2 (0.4%)* vs 3 (0.6%); ARs leading to treatment discontinuation: 11 (2%)† vs 15 (3%)

ACTT-1 was a randomized, double-blind, placebo-controlled, phase 3 clinical trial in hospitalized patients with confirmed SARS-CoV-2 infection and mild, moderate, or severe COVID-19. Patients received VEKLURY (n=541) or placebo (n=521) for up to 10 days. The primary endpoint was time to recovery within 29 days after randomization. Secondary endpoints included clinical status of patients on Day 15 as assessed on an 8-point ordinal scale and incidence of new high-flow oxygen requirement or new mechanical ventilation or ECMO.[1]

*Seizure (n=1), infusion-related reaction (n=1).

†Seizure (n=1), infusion-related reaction (n=1), transaminases increased (n=3), ALT increased and AST increased (n=1), GFR decreased (n=2), acute kidney injury (n=3).

IMPORTANT SAFETY INFORMATION (cont'd)

Dosage and administration (cont'd)

- **Treatment duration:**
  - For patients who are hospitalized and require invasive mechanical ventilation and/or ECMO, the recommended total treatment duration is 10 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19.
  - For patients who are hospitalized and do not require invasive mechanical ventilation and/or ECMO, the recommended treatment duration is 5 days. If a patient does not demonstrate clinical improvement, treatment may be extended up to 5 additional days, for a total treatment duration of up to 10 days.
  - For patients who are not hospitalized, diagnosed with mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death, the recommended total treatment duration is 3 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19 and within 7 days of symptom onset.
- **Testing prior to and during treatment:** Perform eGFR, hepatic laboratory, and prothrombin time testing prior to initiating VEKLURY and during use as clinically appropriate.
- **Renal impairment:** VEKLURY is not recommended in individuals with eGFR <30 mL/min.
- **Dose preparation and administration:**
  - There are two different formulations of VEKLURY: VEKLURY for injection (supplied as 100 mg lyophilized powder in vial), the only approved dosage form of VEKLURY for pediatric patients weighing 3 kg to <40 kg; and VEKLURY injection (supplied as 100 mg/20 mL [5 mg/mL] solution in vial). See full Prescribing Information.
  - Administration should take place under conditions where management of severe hypersensitivity reactions, such as anaphylaxis, is possible.

Pregnancy and lactation

- **Pregnancy:** A pregnancy registry has been established. There are insufficient human data on the use of VEKLURY during pregnancy. COVID-19 is associated with adverse maternal and fetal outcomes, including preeclampsia, eclampsia, preterm birth, premature rupture of membranes, venous thromboembolic disease, and fetal death.
- **Lactation:** It is not known whether VEKLURY can pass into breast milk. Breastfeeding individuals with COVID-19 should follow practices according to clinical guidelines to avoid exposing the infant to COVID-19.

Please see Brief Summary of full Prescribing Information on the following page.

References: 1. Veklury. Prescribing Information. Gilead Sciences, Inc.; 2022. **2.** Beigel JH, Tomashek KM, Dodd LE, et al; ACTT-1 Study Group. Remdesivir for the treatment of COVID-19—final report. *N Engl J Med*. 2020;383(19):1813-1826. doi:10.1056/NEJMoa2007764 **3.** Beigel JH, Tomashek KM, Dodd LE, et al; ACTT-1 Study Group. Remdesivir for the treatment of COVID-19—final report. Supplementary appendix. *N Engl J Med*. 2020;383(19):1813-1826. Accessed May 24, 2022. https://www.nejm.org/doi/suppl/10.1056/NEJMoa2007764/suppl_file/nejmoa2007764_appendix.pdf

GILEAD

VEKLURY® (remdesivir)
Brief summary of full Prescribing Information. Please see full Prescribing Information. Rx Only.

INDICATIONS AND USAGE

VEKLURY is indicated for the treatment of COVID-19 in adults and pediatric patients (≥28 days old and weighing ≥3 kg), with positive results of SARS-CoV-2 viral testing, who are:

- Hospitalized, or
- Not hospitalized, with mild-to-moderate COVID-19, and at high risk for progression to severe COVID-19, including hospitalization or death.

DOSAGE AND ADMINISTRATION *[Also see **Warnings and Precautions, Adverse Reactions, and Use in Specific Populations**]*:

Testing Before Initiation and During Treatment: Perform eGFR, hepatic laboratory, and prothrombin time testing prior to initiating VEKLURY and during use as clinically appropriate.

Recommended Dosage in Adults and Pediatric Patients ≥28 Days Old and Weighing ≥3 kg:

- For adults and pediatric patients weighing ≥40 kg: 200 mg on Day 1, followed by once-daily maintenance doses of 100 mg from Day 2, administered only via intravenous infusion.
- For pediatric patients ≥28 days old and weighing ≥3 kg: 5 mg/kg on Day 1, followed by once-daily maintenance doses of 2.5 mg/kg from Day 2, administered only via intravenous infusion.

Treatment Duration:

- For patients who are hospitalized and require invasive mechanical ventilation and/or ECMO, the recommended total treatment duration is 10 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19.
- For patients who are hospitalized and do not require invasive mechanical ventilation and/or ECMO, the recommended treatment duration is 5 days. If a patient does not demonstrate clinical improvement, treatment may be extended up to 5 additional days, for a total treatment duration of up to 10 days.
- For patients who are not hospitalized, diagnosed with mild-to-moderate COVID-19, and at high risk for progression to severe COVID-19, including hospitalization or death, the recommended total treatment duration is 3 days. VEKLURY should be initiated as soon as possible after diagnosis of symptomatic COVID-19 and within 7 days of symptom onset.

Renal Impairment: VEKLURY is not recommended in individuals with eGFR <30 mL/min.

Dose Preparation and Administration *[See full **Prescribing Information** for complete instructions on dose preparation, administration, and storage]*:

VEKLURY must be prepared and administered under supervision of a healthcare provider and must be administered via intravenous infusion only, over 30 to 120 minutes. Do not administer the prepared diluted solution simultaneously with any other medication.

- VEKLURY for injection (supplied as 100 mg lyophilized powder in vial) must be reconstituted with Sterile Water for Injection prior to diluting in a 100 mL or 250 mL 0.9% sodium chloride infusion bag.
- Care should be taken during admixture to prevent inadvertent microbial contamination; there is no preservative or bacteriostatic agent present in these products.

Dosage Preparation and Administration in Pediatric Patients ≥28 Days of Age and Weighing 3 kg to <40 kg:

The only approved dosage form of VEKLURY for pediatric patients ≥28 days of age and weighing 3 kg to <40 kg is VEKLURY for injection (supplied as 100 mg lyophilized powder in vial). Carefully follow the product-specific preparation instructions.

CONTRAINDICATIONS *[Also see **Warnings and Precautions**]*:

VEKLURY is contraindicated in patients with a history of clinically significant hypersensitivity reactions to VEKLURY or any of its components.

WARNINGS AND PRECAUTIONS *[Also see **Contraindications, Dosage and Administration, Adverse Reactions,** and **Drug Interactions**]*:

Hypersensitivity, Including Infusion-related and Anaphylactic Reactions: Hypersensitivity, including infusion-related and anaphylactic reactions, has been observed during and following administration of VEKLURY; most reactions occurred within 1 hour. Monitor patients during infusion and observe for at least 1 hour after infusion is complete for signs and symptoms of hypersensitivity as clinically appropriate. Symptoms may include hypotension, hypertension, tachycardia, bradycardia, hypoxia, fever, dyspnea, wheezing, angioedema, rash, nausea, diaphoresis, and shivering. Slower infusion rates (maximum infusion time ≤120 minutes) can potentially prevent these signs and symptoms. If a severe infusion-related hypersensitivity reaction occurs, immediately discontinue VEKLURY and initiate appropriate treatment.

Increased Risk of Transaminase Elevations: Transaminase elevations have been observed in healthy volunteers and in patients with COVID-19 who received VEKLURY; the transaminase elevations were mild to moderate (Grades 1-2) in severity and resolved upon discontinuation. Because transaminase elevations have been reported as a clinical feature of COVID-19, and the incidence was similar in patients receiving placebo versus VEKLURY in clinical trials, discerning the contribution of VEKLURY to transaminase elevations in patients with COVID-19 can be challenging. Perform hepatic laboratory testing in all patients.

- Consider discontinuing VEKLURY if ALT levels increase to >10x ULN.
- Discontinue VEKLURY if ALT elevation is accompanied by signs or symptoms of liver inflammation.

Risk of Reduced Antiviral Activity When Coadministered With Chloroquine or Hydroxychloroquine: Coadministration of VEKLURY with chloroquine phosphate or hydroxychloroquine sulfate is not recommended based on data from cell culture experiments, demonstrating potential antagonism which may lead to a decrease in the antiviral activity of VEKLURY.

ADVERSE REACTIONS *[Also see **Warnings and Precautions**]*:

Clinical Trials Experience: The safety of VEKLURY is based on data from three Phase 3 studies in 1,313 hospitalized adult subjects with COVID-19, four Phase 1 studies in 131 healthy adults, and from patients with COVID-19 who received VEKLURY under the Emergency Use Authorization or in a compassionate use program. The NIAID ACTT-1 study was conducted in hospitalized subjects with mild, moderate, and severe COVID-19 treated with VEKLURY (n=532) for up to 10 days. Study GS-US-540-5773 (Study 5773) included subjects hospitalized with severe COVID-19 and treated with VEKLURY for 5 (n=200) or 10 days (n=197). Study GS-US-540-5774 (Study 5774) was conducted in hospitalized subjects with moderate COVID-19 and treated with VEKLURY for 5 (n=191) or 10 days (n=193).

Adverse Reactions: The most common adverse reaction (≥5% all grades) was nausea.

Less Common Adverse Reactions: Clinically significant adverse reactions reported in <2% of subjects exposed to VEKLURY in clinical trials include hypersensitivity reactions, generalized seizures, and rash.

Laboratory Abnormalities: In a Phase 1 study in healthy adults, elevations in ALT were observed in 9 of 20 subjects receiving 10 days of VEKLURY (Grade 1, n=8; Grade 2, n=1); the elevations in ALT resolved upon discontinuation. No subjects (0 of 9) who received 5 days of VEKLURY had graded increases in ALT.

Laboratory abnormalities (Grades 3 or 4) occurring in ≥3% of subjects receiving VEKLURY in Trials NIAID ACTT-1, Study 5773, and/or Study 5774, respectively, were ALT increased (3%, ≤8%, ≤3%), AST increased (6%, ≤7%, n/a), creatinine clearance decreased, Cockcroft-Gault formula (18%, ≤19%, ≤5%), creatinine increased (15%, ≤15%, n/a), eGFR decreased (18%, n/a, n/a), glucose increased (12%, ≤11%, ≤4%), hemoglobin decreased (15%, ≤8%, ≤3%), lymphocytes decreased (11%, n/a, n/a), and prothrombin time increased (9%, n/a, n/a).

DRUG INTERACTIONS *[Also see **Warnings and Precautions**]*:

Due to potential antagonism based on data from cell culture experiments, concomitant use of VEKLURY with chloroquine phosphate or hydroxychloroquine sulfate is not recommended.

Drug-drug interaction trials of VEKLURY and other concomitant medications have not been conducted in humans. Remdesivir and its metabolites are in vitro substrates and/or inhibitors of certain drug metabolizing enzymes and transporters. The clinical relevance of these in vitro assessments has not been established.

USE IN SPECIFIC POPULATIONS *[Also see **Dosage and Administration** and **Warnings and Precautions**]*:

Pregnancy

Risk Summary: There are insufficient human data on the use of VEKLURY during pregnancy to inform a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. COVID-19 is associated with adverse maternal and fetal outcomes, including preeclampsia, eclampsia, preterm birth, premature rupture of membranes, venous thromboembolic disease, and fetal death.

Lactation

Risk Summary: There are no available data on the presence of remdesivir in human milk, the effects on the breastfed infant, or the effects on milk production. In animal studies, remdesivir and metabolites have been detected in the nursing pups of mothers given remdesivir, likely due to the presence of remdesivir in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for VEKLURY and any potential adverse effects on the breastfed child from VEKLURY or from the underlying maternal condition. Breastfeeding individuals with COVID-19 should follow practices according to clinical guidelines to avoid exposing the infant to COVID-19.

Pediatric Use

The safety and effectiveness of VEKLURY for the treatment of COVID-19 have been established in pediatric patients ≥28 days old and weighing ≥3 kg. Use in this age group is supported by the following:

- Trials in adults
- An open-label trial (Study GS-US-540-5823) in 53 hospitalized pediatric subjects

Geriatric Use

Dosage adjustment is not required in patients over the age of 65 years. Appropriate caution should be exercised in the administration of VEKLURY and monitoring of elderly patients, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of potential concomitant disease or other drug therapy.

Renal Impairment

All patients must have an eGFR determined before starting VEKLURY and while receiving VEKLURY as clinically appropriate. VEKLURY is not recommended in patients with eGFR less than 30 mL/min.

Hepatic Impairment

Perform hepatic laboratory testing in all patients before starting VEKLURY and while receiving VEKLURY as clinically appropriate.

OVERDOSAGE

There is no human experience of acute overdosage with VEKLURY. Treatment of overdose with VEKLURY should consist of general supportive measures including monitoring of vital signs and observation of the clinical status of the patient. There is no specific antidote for overdose with VEKLURY.

214787-GS-006

GILEAD

Important Lessons from Hospitalists Who Love Their Jobs


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By Larry Beresford

Job stress, moral injury, burnout, the great resignation—these are very real concerns for the field of hospital medicine, exacerbated by but not limited to the unprecedented challenges of the COVID-19 pandemic over the past three years.

But despite all the turmoil, some hospitalists say they love their jobs and still enjoy practicing acute medicine in the hospitals where they work. How do they go to work every day with smiles on their faces? How are they able to enter the hospital's sliding glass front doors filled with hope, anticipation, and curiosity?

We asked several hospitalists to share their stories and their secrets for job satisfaction and job-stress management. What mindsets, perspectives, or techniques are helpful to them? We learned how differently individual hospitalists can approach these questions and how they have found their own highly personal paths to job satisfaction. But what they have in common is a commitment to rediscovering and renewing the passion and joy that first inspired them to become doctors.

An environment for engagement

For Richard M. Wardrop III, MD, PhD, FAAP, FACP, FHM, a hospitalist at the Cleveland Clinic in Cleveland, Ohio, program director of its internal medicine residency, and vice chair of its academic department of medicine, his commitment to medicine as a profession, almost as a higher calling, has been a foundation from which he draws strength and optimism. "Something as simple as walking through the hospital in a white coat and seeing patients look at you with hope in their eyes. People want to be cared for and they look to us as someone who will care for them," he said.


Dr. Wardrop

"Ever since I left medical school, I have considered myself a physician first. That centrality of my identity has never wavered. I feel the part on a daily basis and am very comfortable in that role," Dr. Wardrop said. "Part of my identity is also about engagement with interprofessional relationships, which I see as an antidote to burnout. I actually feel pretty happy coming up to the hospital wards. It's a target-rich environment for engaging with people."

Yet he's not immune to the "Sunday Scaries," starting on the day before, dreading to go back to work Monday morning. "That's a thing," he said. "But for me, by 10 a.m., I'm wondering what I was so worried about. This is what I'm supposed to be doing, what I'm trained to do and like to do."

Dr. Wardrop has also tried to bring a more frankly philosophical frame of mind to the existential career questions that are being raised by many of his hospitalist peers. He is also coming to terms with having reached midlife.

"As a parent of three kids in their 20s and late teens, trying to be a better father, a better husband, but also a better person—and not fear aging—I find some hope in philosophy and my own study of it." He's deliberate about scheduling exercise, bicycle rides, and spiritual meditation.

"One of my satisfiers of a good day is to be able to read for a half-hour at night before I go to bed." That reading includes the Stoic philosophers of ancient Greece, like Epictetus who maintained that the foundation of philosophy is self-knowledge, and the meditations of Roman emperor Marcus Aurelius.

"Today I had several things happen to me as a doctor and as a leader that were pretty fantastic. Of course, interspersed with that was total chaos—all kinds of things happening in the hospital. But I felt I was effective as a physician, educator, coach, and leader," he said.

"For a patient I saw in clinic yesterday, I was concerned about his case, waiting for results of a test, which came back this morning. I was glad to find that everything turned out for the better. I was also surprised by a graduating resident who came to share good news about landing a job. It was the ultimate affirmation that we had done all the right things (in his training). And I had an important meeting with the chair of our cancer institute. Tonight, I'll go home and watch TV with my wife and eat pizza."

An entrepreneurial approach

Atashi Mandal, MD, practices clinical hospitalist shifts at four different hospitals, three in the Los Angeles/Orange County metro area and a fourth in the isolated mountain hamlet of Bishop, Calif., population 3,820, a four-hour drive from the LA basin. That mix includes both adult and pediatric hospital medicine, reflecting her dual specialty training, and is largely conducted nocturnally.


Dr. Mandal

"I love the career I have carved for myself over the past two decades," Dr. Mandal said. "I'm grateful for the opportunities I have been afforded, but it also took some wherewithal and sense of entrepreneurship on my part to craft my career as I have it currently." She started out as a traditional full-time, one-hospital hospitalist. But after about three years she realized she wasn't enjoying the job, wasn't getting much opportunity to practice pediatrics, and needed more variety than one job could offer.

As a lifelong night owl, she was also finding it increasingly difficult to get up at 5:30 a.m., while frequent migraines caused her primary physician to suggest that she needed to make some changes in her life. "That was the moment I decided I had to do something different, even if I didn't know quite what that would be."

Dr. Mandal's willingness to work night shifts made several hospitals eager to employ her on a part-time, contractual basis. "I realized I could work independently, making my own schedule, while working to demonstrate my reliability, collegiality and excellent patient care." Then, in 2018, she was recruited to work shifts at 25-bed Northern Inyo Hospital in Bishop, Calif.

"I have benefitted so much from my exposure to different settings in health care delivery, geography, and patient populations, as well as my interactions with so many amazing colleagues," she said. For example, after years working in urban settings, she finds it meaningful to contribute her medical skills to the rural community of Bishop.

Dr. Mandal places a high emphasis on taking care of patients, and her jobs are 100% clinical. "I consider myself part of the team. I'm there to assist, enhance, and help the team excel. I'm able to participate in something greater than just doing a shift."

But she is also committed to community service and advocacy. She is active in SHM and other organized medical groups. She serves on a committee convened by a local county sheriff to investigate deaths in vulnerable unhoused populations.

Dr. Mandal says she's managed to avoid the rock-bottom burnout some hospitalists have experienced. "But I have shared the collective exhaustion of doctors over the last three years. I've always kept a finger on my pulse and what gives me joy," she said. That includes maintaining deep connections with friends and colleagues. "These kinds of connections are comforting, especially when life gives us a plate full of unknowns."

She loves being outside, running, and hiking. Also bringing her joy are reading, playing the piano, and walking on a beach at sunset. "Leaning on a rock warmed by the sun just seems to bring everything back home for me. I am fortunate that those simple pleasures are really all I need to fill my cup."

Where might Dr. Mandal go from here? "I've been giving a lot of thought to the glide path to the rest of my life," she said. "I've been successful doing what I want to do. But will it feel the same in 10 years, when shift work starts to feel too rigorous? Will I still want to be working this many night shifts?"

One possible direction might be to give back to medicine through teaching, although that plan has yet to take firm shape. "With the

pandemic ushering in telemedicine, that creates some exciting territory to find other options," she said. "We do ourselves a favor just by thinking ahead."

A service mentality

"I love my job," said Amith Skandhan, MD, FACP, SFHM, a hospitalist for Southeast Health in Dothan, Ala., associate program director of its internal medicine residency program and director of physician integration for Southeast Health Statera Network. "Being a hospitalist demands a balance of three traits: clinical acumen, quality of a collaborator, and the ability to coordinate the patient's care," he said.


Dr. Skandhan

"I find a lot of joy in hospital medicine. But often, you can be overwhelmed by the number of acutely sick patients with complex social and financial needs. I sometimes wonder if we set realistic expectations and provide the tools and skills hospitalists need."

A sense of burnout and physical and emotional exhaustion can happen to any hospitalist, Dr. Skandhan said. "To overcome this, we must be self-aware enough to know a problem exists; practice self-care to recharge to develop the strength to tackle the problem; and take ownership to self-manage the problem head-on."

He prioritizes self-awareness and reflection. "If you have a day where something made you happy, stop and reflect on that. What made it a good day or a bad day? What brought you joy?" he said. "I enjoy discussions with families, especially when they face difficult life decisions for themselves or their loved ones." For the hospitalist, it's particularly challenging to quickly develop trust, understand where the patient is currently, provide information, and guide them towards the appropriate treatment plan.

Dr. Skandhan noted a discussion he once had with the chaplain at his hospital. He was surprised to learn that chaplains are trained to recognize when they may be developing burnout and emotional or moral injury. "It is surprising that the profession of medicine, which deals with the sick and suffering, does not provide its healers with these tools," he said.

"To overcome burnout and become resilient, it is crucial to prioritize things that recharge you and promote self-care. Those are different for different individuals. For me, it's traveling, meeting friends and family, and socializing. Without that, it's difficult for me to recharge," Dr. Skandhan said.

"You can't change the circumstances or the environment you are in. You can only change how you respond to the situation. I remember, during the surges of COVID-19, it was getting tough not to lose empathy and [to] take care of our patients. I would catch myself and try to find simple reasons for gratitude. A big one I had was the gratitude for being able to be of service during this difficult time," he said.

"I have often felt that to find meaning in hospital medicine, we have to think about more than treating one patient at a time. Hospitalists deal with every aspect of the acute-care setting. We can see common hurdles. Often, using our qualities of collaboration and coordination, we can work to fix them."

A service mentality is essential and can be expanded to the regional and national levels by joining SHM. Hospitalists can volunteer with SHM local chapters, special interest groups, and committees. "I co-founded and led the Wiregrass Chapter of SHM. Through this chapter, we have improved the quality of inpatient care in our community. Additionally, I have served on multiple committees and the editorial board of *The Hospitalist*."

Promoting wellness

Sarah Richards, MD, FACP, associate professor of medicine at the University of Nebraska, Omaha, and senior medical director for clinician experience for Nebraska Medicine, is also active nationally in promoting wellness and preventing burnout for hospitalists. She recommends accessing the resources SHM has developed in this area, including the "Well-being Advocates Toolkit" and "Check-in Guide for Self & Peers" at SHM's Well-being webpage https://www.hospitalmedicine.org/practice-management/well-being/ and "The Seven Drivers of Burnout in Hospital Medicine" https://www.hospitalmedicine.org/practice-management/well-being/#7_Drivers_of_Burnout_in_Hospital_Medicine.


Dr. Richards

"I think about these things all the time," Dr. Richards said. "Because I'm talking to experts across the country about normalizing and validating job stress concerns, I know we're not alone. I also work closely with our health system's behavioral-health practitioners," she said.

"I happen to be part of a hospitalist group at the University of Nebraska where our leaders really do value the importance of things like flexible scheduling. 80% of our hospitalist shifts are according to personal preference." The leaders practice humility, and colleagues treat each other with respect. That foundation for the group's culture has helped her to continue finding joy in her work, even as growing administrative responsibilities have reduced her shifts as a hospitalist.

"For me personally, it's about focusing on the positive elements of the day, even if there were just one or two. Examples such as a meaningful interaction with a patient or family member, a 'thank you,' a success story, something in their care that went well, a breakthrough moment. Ultimately, we need to focus on those things as a team—and on positive interactions with our colleagues," she said. "When I get to work with a team that is excited to learn, to provide care, that is happy to be at work, that's a good day."

One of the positive things the pandemic brought is that doctors are a little more open, more vulnerable, and willing to talk about how hard things can be achieved. "It's no longer rare for us just to talk about the things that were tough at work, to just be open to share that with our colleagues."

Dr. Richards said people have the impression that she is positive and happy all the time. "So, I am trying to be more honest, telling my real story, sharing my own stresses, the challenges and joys of being a mom with three daughters."

Getting there on time

Nathan Miller, MD, a hospitalist at Avera McKennan Hospital and University Health Center in Sioux Falls, S.D., and clinical vice president of the hospitalist service line at AveraHealth, chose hospital medicine because he loved acute medicine, and he loved the people he worked with. "I think you need both," he explained. "I am fortunate to have landed in the medical field that I am most passionate about."


Dr. Miller

Dr. Miller said he believes in hospital medicine. "I think we have the ability to help patients navigate through their hospital stay—which can be scary and complex, becoming more so all the time. But sometimes at the end of the day the most important thing I've done is just to explain the care plan to the patient and family. Communication might be what you call a softer skill, but it's often the most important thing in medicine."

When he walks into the hospital in the morning, Dr. Miller thinks, "The only thing I truly have control over is getting here on time. I come in with a rough idea of what my day is going to look like, but I can't guarantee somebody isn't going to get clinically a lot worse, and I have to be okay with that. That's what allows me to do what I really enjoy doing," he said. "I'm also a realist. Every single day something is going to frustrate you."

On a typical shift, Dr. Miller sees 13 to 15 patients, most often concentrated geographically, although he also does shifts rounding in the ICU or attending on a teaching service. "I really like the higher acuity of hospital medicine. I can geek out on diagnosing the rare cases, and also the complex interplay of working with the health care team and helping the patient have the best outcome possible for them."

He hopes to do hospital medicine for the rest of his career, until retirement. "I now do 10 shifts a month along with my administrative responsibilities. For our hospitalist group, we talk about how to create a job that can make hospital medicine a sustainable lifetime career."

What has been Dr. Miller's formula for averting job stress and burnout? "What I've learned over 12 years as a hospitalist is not to commit to doing too much on top of clinical care responsibilities. There is a finite number of roles I can do and do well. Past that point, saying no is my guardrail against burnout." It's particularly important not to take too many leadership roles, he said.

"At one time, I had the hospitalist service line and a few other administrative responsibilities on my plate. I had to say they were important, but I can't do everything. I was also head of the teaching service. But we have phenomenal faculty who took over that role and took it to new places," he said.

Did the COVID-19 pandemic make it harder to set limits? "Absolutely. We may not have had the total numbers of COVID-19 cases as a place like New York City, but we're a 450-bed hospital, with 165 to 200 patients on the hospitalist service. There was a time when 120 of 170 patients had COVID-19," Dr. Miller said.

"We were fortunate here at Avera McKennan to have administrative leadership we could work very well with, which is crucial. But it was definitely hard, and for me it was harder when we had a vaccine, and we were seeing patients who could have benefitted from that. It was a hard time overall for medicine, with terrible human suffering and tragedy. We're still trying to work our way out of all that." ■

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

Becoming a Well-being Advocate

By Swati Mehta, MD, FACP, CPXP, SFHM, and Anna Zachwieja, MHA

RECHARGE	INTROSPECT	SEEK HELP	EXPRESS YOURSELF
"What gives me joy outside of work?"	"What can I do to improve the situation?"	"What resources do I need to improve the situation?"	"Whom can I thank? What am I grateful for?"

By now, burnout and its related toll on clinicians nationwide is recognized as a pressing crisis. While burnout among U.S. health care practitioners isn't new, the COVID-19 pandemic exacerbated pre-existing issues and added novel stressors. A recent study showed that burnout, work overload, and COVID-19–associated stressors resulted in one in five physicians and two in five nurses intending to leave their current practice within the next two years.[1] In addition to the ample negative impacts on individuals, burnout is a monumental staffing challenge hospital medicine groups must face.

Read Pierce, MD, chief of the division of hospital medicine at Dell Medical School in Austin, Texas, shared how the pandemic led him to a first in his career: having to sit down with some of his staff and tell them they needed to see a mental health professional. "There's such a stigma around that and we've been trained to set it aside or avoid it. Those were real challenges, and I knew we needed to do more than the usual things to keep people supported," he said.

As 2022 began and the Omicron variant was in full force, Dr. Pierce saw burnout rates nearly double from the prior year, to 50% within his group. As burnout rates increased, the rate of volunteerism among his group drastically decreased, something Dr. Pierce had never seen among his team. He saw the lack of volunteerism as a sign of self-preservation for his group members.

Due to its association with loss of empathy, impaired job performance, and increased incidence of medical errors, burnout has a major impact on patients as well as the health care system as a whole.[2] Dr. Pierce reflected on how he saw in his group and hospital that burnout was linked to effects on patient care. "The patient experience care scores went down, length of stay increased, and patient safety events like infection rose. A lot of measures got worse," said Dr. Pierce.

One study found that physicians experiencing burnout are more likely to be involved in patient safety incidents, fail on critical aspects of professionalism that determine the quality of patient care, and receive lower patient-experience ratings.[3] Physician burnout, along with its downstream effects, is estimated to cost the health care system approximately $4.6 billion a year.[4]

Dr. Pierce, along with 11 hospitalist leaders, joined SHM's Well-being Task Force, which was created early in 2020 to address the new circumstances hospitalists were facing during the COVID-19 pandemic. Task-force members shared their personal experiences and the different tools and interventions they implemented within their groups to ease burnout and promote well-being among physicians, and they quickly realized the potential value of a resource designed to empower individuals at any level to promote and advance well-being at their institutions. The group used an iterative process to assemble and categorize tools and tips that they and their peers used in their hospital medicine groups.

Out of these conversations came the Well-Being Advocates Toolkit, which has practical tools for hospitalists to make real change, however small, in their groups. The resource is organized for hospitalists at any level—whether you have a formal well-being role, a hospitalist leader role, or simply feel compelled as a frontline hospitalist to improve well-being in your team.

One intervention Dr. Pierce began to implement within his group, which can be found in the toolkit, was formal scheduled check-ins using a check-in guide. "Very early on we started using it and doing check-ins. It was important to pause and see how we're doing as human beings before we started the work. I'd always done one-on-one check-ins when I ran into people within my group, but I started two years ago to schedule them to make sure I was supporting them more consistently. They were powerful even if sometimes they were hard. People appreciated that it was a formal focus in the group."

Dr. Pierce has also seen a positive change in his group since he began implementing tools and interventions from the toolkit. "Volunteerism is way back up and we have seen the palpable levels of group anxiety is lower. We'll measure burnout this spring and we expect it to be lower than when we measured it last. When I looked at the rate of turnover compared to those around town, we've done a lot better. I think a lot of these tools really attended to the workforce and its well-being," said Dr. Pierce.

When hospitalists begin to use this toolkit, the first step is to do a quick self-check-in to gauge their own well-being using the R.I.S.E. for self-care (recharge, introspect, seek help, express yourself) mnemonic.

Next, hospitalists should identify which of the three well-being advocate personas best applies to them: The hospitalist—I care, but don't have a formal leadership role; the hospitalist leader—I want to use my position of leadership to make a difference; and the well-being leader—I'm a well-being expert and I need more than just the basics. Within each persona description are activities for hospitalists to adopt and implement in their group or institution.

Hospitalists can start small, even if implementing just one activity and/or change might seem insignificant. Little interventions can have a large ripple effect that far outweighs their effort or cost. The SHM Well-being Task Force believes the strategies and tips in the toolkit can help improve well-being, create supportive hospital medicine workplaces, and contribute to decreasing burnout in hospital medicine.

To access more resources on well-being and burnout prevention, SHM members can visit the Well-Being page of SHM's website and subscribe to the recently established Hospitalist Well-being Special Interest Group (SIG). The SIG was approved by the Board of Directors in February 2023, and it intends to provide an enduring virtual space on the Society's online networking platform Hospital Medicine eXchange (HMX) that connects SHM members who are interested in learning more or engaging around this important topic. ■

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Dr. Mehta

Ms. Zachwieja

Dr. Mehta is the national director of quality and patient experience for Vituity, a physician-led health care innovation company based in Emeryville, Calif., and a practicing hospitalist at CommonSpirit Sequoia Hospital in Redwood City, Calif. She's the chair of SHM's patient experience executive council and a faculty member of SHM's well-being task force. Ms. Zachwieja is a practice management specialist at SHM.

Toolkit Testimonials

Hospitalist Megha Shah, MD, MMM, FHM, from St. Joseph Medical Center in Bellingham, Wash., saw an improvement among her team after instituting strategies from SHM's Hospitalist Well-being Advocates Toolkit. Some of the strategies they used included beginning meetings with kudos, having formal acknowledgements in meetings, flexibility for meetings to be in person or virtual, and sending personalized messages of gratitude to team members. She said, "I was seeing my team struggle during the pandemic and its aftermath of rising census and short staffing. [The changes we implemented] have improved my team's morale and engagement."

Anum A. Niazi, MD, a hospitalist and hospital medicine lead advocacy coordinator for Vituity in Munster, Ind., said "This toolkit is an incredible resource. It allows us to reflect on areas of our own improvement and empowers us to help others use the great R.I.S.E. checklist. The ideas this toolkit can spark can lead to meaningful improvements as it even touches on the importance of DEI [diversity, equity, and inclusion] and tactics to normalize being human. "

Lessons in Redeployment from Adult Hospitalists

By Sydney Katz, MD, Elijah Douglass, MD, and Alice J. Tang, MD, MHPE

Steve Debenport

As emergency rooms and hospitals are increasingly overwhelmed by pediatric patients with respiratory illnesses, concerns about how the current workforce will care for the influx of patients are increasing, and hospitals are beginning efforts to redeploy physicians.[1]

During the COVID-19 pandemic, the redeployment of clinicians was frequently used to care for the influx of patients. However, many physicians and trainees who were redeployed reported high levels of insomnia, anxiety, stress, depression, and low morale.[2,3,4]

In March 2020, as New York City became the COVID-19 epicenter in the U.S., our adult hospitalist group created a Redeployment Task Force to expand our capacity to care for hospitalized patients. We aimed to create a supportive onboarding process and team structure to foster high-quality patient care and clinician well-being.

Our group redeployed more than 125 attendings, advanced practice providers (APPs), and trainees. In this perspective, we recommend a systematic framework for expanding and supporting the workforce using our lessons learned and the best evidence in the literature, which can be applied to the current surge in hospitalizations for pediatric respiratory viral infections.

Establishing a redeployment task force

Assembling a redeployment task force composed of clinicians and administrators with expertise in educational and organizational leadership is key. Members should have strong clinical and institutional knowledge, understand the complexities of delivering care, and be able to support redeployed clinicians.

The redeployment task force should be able to meet daily over virtual platforms, and should have decreased clinical duties during the initial planning and implementation to allow for successful execution.

Administrators on the task force must have access to census numbers and projected staffing needs. Engaging key stakeholders across the institution, including deans, department chairs, division chiefs, and hospital leadership is critical to ensure priorities are aligned in developing and executing a redeployment program.

Recruiting and scheduling the workforce

Recruitment should be thoughtful and should prioritize skills and expertise which can translate to working on the inpatient pediatric service.[5]

We conceptualized recruitment for redeployment on the hospital medicine wards as filling two essential roles—the hospitalist role and the first call provider role, which is in line with what other programs found.

It was more important to recruit based on skill rather than by specialty.[5] Individuals who can take on the traditional pediatric hospitalist role in assessing patients, developing plans of care, and managing medical comorbidities are clinicians with prior hospital medicine experience, outpatient general pediatrics attendings, family medicine attendings, or pediatric subspecialty fellows or attendings.

First-call providers should be well-versed in the electronic medical record and hospital system. They enter orders, collaborate with the interdisciplinary team, and ensure plans are appropriately executed.

Non-pediatric residents and APPs with inpatient experience may fill this role. Ideally, clinicians should be given agency to determine their assignment and the redeployment task force should allow for flexibility in clinical assignments.

Redeployed clinicians with the most experience in pediatric hospital medicine should be scheduled in clinical positions with the highest needs and least supervision (i.e., nights, or less-resourced sites). Faculty with less inpatient experience should be assigned to more resourced teams (i.e., house staff teams). Some faculty may require a training period. Staffing plans should anticipate members of the workforce who are unable to work due to illness or medical conditions.

Preparing for redeployment

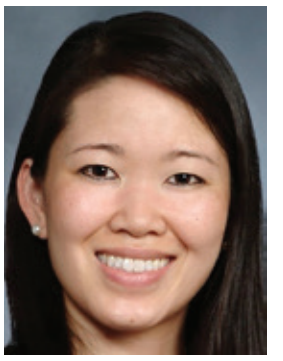
Successful redeployment onboarding includes educating and preparing clinicians for clinical service and fostering a supportive atmosphere.[3,5,6]

A multifaceted approach, which includes compiling key resources onto an online platform and orienting clinicians through video conferencing, is recommended.

Key resources should include clinical best practices, roles and responsibilities of team members, workplace logistics, electronic medical record training, well-being support resources, and contact information. An online platform with materials encourages self-directed learning which is compat-

Dr. Katz

Dr. Douglass



Dr. Tang

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ible with adult learning principles.[6]

The redeployment task force can orient clinicians using an interactive video-conferencing platform.

Orientation should relay information about the team structure, logistics, and expectations, and should provide an opportunity for the redeployment task force to connect with anxious colleagues, support them, and help them feel a part of the larger community.

The redeployment task force should acknowledge their sacrifice, validate feelings of anxiety, and answer questions and concerns. Integrating redeployed clinicians into the larger group by including them in division email updates and inviting them to participate in division meetings will help to foster a sense of belonging.

Training the redeployed workforce

Clinicians who are unfamiliar with inpatient pediatric medicine will likely need a supervised period of training and coaching. In fact, redeployed clinicians reported that adequate supervision helped to reduce anxiety during redeployment.[3]

We developed and used a novel team structure that aimed to facilitate supervision and progressive autonomy during the training period. An attending of record, usually a hospitalist, was paired with a redeployed physician as a co-attending, which allowed for supported training toward independent practice. Inpatient-medicine APPs and residents were paired with non-medicine APPs and residents.

We set learning objectives for redeployed providers and communicated nearly daily with attendings to assess co-attendings' progress towards achieving these objectives.

Seeking frequent feedback and allowing for flexibility in staffing

Given the unpredictable nature of the surge, it is essential to maintain open communication with all stakeholders and clinicians and maintain flexibility to allow for frequent adjustments based on needs.[3,5]

Inquiring frequently about the morale of the redeployed clinicians and their questions, concerns, or competency in the inpatient setting is essential to maintain trust and improve the program in real time.

In our program, when clinicians met learning objectives, they were moved to independent practice roles to increase patient care capacity.

We created several models for faculty who were comfortable attending on inpatient teams or who had completed training to increase patient care capacity.

Examples included graduating co-attendings to serve as attending of record to train other redeployed faculty, to run teams independently, or to remain a co-attending on a team with an increased patient cap. When the need for increased capacity decreased, we moved the graduated co-attendings to a "reserve pool" to call upon later, if necessary. For those who were not thriving, we created individualized plans for helping them achieve objectives or considered reassignment to another role.

Following up after the crisis

Just as redeployment should be done thoughtfully, so should the de-escalation of staffing and the return to normal.

Best practices for de-escalation include providing redeployed clinicians with time off to rest and recover, developing mechanisms to monitor and support the mental health and well-being of the redeployed, ensuring trainees can smoothly transition back to their training programs, and expressing gratitude for service.[7]

Operational lessons learned during the COVID-19 pandemic can be applied to future surge states, including the current crisis in pediatric viral respiratory illnesses.

With adequate foresight, planning, and careful redeployment procedures, clinical care capacity can be greatly increased to maintain high-quality care and support the well-being of redeployed clinicians. ■

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Quality

Reducing Mental Health Care Barriers for Hospitalists

By John Gaskill, DO, Richard M. Wardrop III, MD, PhD, FAAP, FACP, FHM, Joshua Allen-Dicker, MD, MPH, SFHM, and Eileen Barrett, MD, MPH

Clinical vignette

MB is a 36-year-old woman who completed her residency three years ago. She has practiced as a hospitalist at a community hospital since that time. Throughout her time in medical school and residency, MB often experienced periods of depressed mood, insomnia, and lack of energy. She was able to access resources for therapy through her medical school, however, she was never given a formal diagnosis of a mood disorder. Now, she feels that her symptoms have returned and continue to worsen. In addition to her depressed mood, she has lost interest in activities she previously enjoyed and has had difficulty focusing while working on the inpatient general medicine service. She has become increasingly concerned that her symptoms will contribute to her making a serious medical error. She feels guilty because of this and has been experiencing passive suicidal ideation for the first time in her life. When she considers reaching out for mental health support, she remembers that her hospital credentialing and state medical licensure applications both ask questions about mental health disorders. She also remembers reading about other physicians experiencing costly legal battles and harmful ramifications from mental health disclosures. For these reasons, she is hesitant to speak with colleagues or access the care she needs.

Discussion

While the above vignette is fictional, it highlights an all-too-common problem that occurs among our friends and colleagues. It has been shown that physicians are more susceptible to and have higher rates of depression than non-physicians.[1] This applies to medical trainees as well, with 15% to 30% higher rates of depression in medical students and residents compared to the general population.[2] Unfortunately, this trend is also reflected in rates of physician suicide. Combined studies have shown that the suicide rate of male physicians is 40% higher than in the general population.[1] Staggeringly, the rate of female physicians completing suicide is 130% higher than in the general population.[1] The increasing rate of burnout also highlights the importance of mental health for physicians. A recent survey of 2,440 U.S. physicians revealed that 62.8% of physicians had some manifestation of burnout, which was an increase of almost 20% when compared to four years prior.[3]

When it comes to medical licensing, physician mental health is a topic that is often asked about on applications. State medical boards have licensing authority over physicians in each state and act to protect public safety by ensuring that physicians can safely practice health care. The questions included on the physician-license applications vary from state to state. A recent audit revealed that 33 states


Dr. Gaskill


Dr. Wardrop


Dr. Allen-Dicker


Dr. Barrett

Dr. Gaskill is a resident at the Cleveland Clinic Foundation in Cleveland. Dr. Wardrop is a program director, vice chair, and staff physician at the Cleveland Clinic Foundation in Cleveland. Dr. Allen-Dicker is an associate attending at Memorial Sloan Kettering Cancer Center in New York. Dr. Barrett is a faculty member of the Institute for Healthcare Improvement, where they're working to remove mental health questions from medical license and credentialing applications.

included questions about mental health conditions on their physician-license applications.[4] The questions tended to be time-specific, but this was also variable, ranging from current to no time limit. If physicians responded "yes" to inquiries about mental health, they were often requested to provide written explanations, the contact information of treating psychiatrists, or access to personal medical records.[4]

Given the information above, it is unsurprising that physicians are hesitant to get the care they need for mental health conditions. A survey of more than 7,000 U.S. surgeons revealed that 60% were reluctant to seek care for mental health issues due to fears that it would affect their medical licensure.[5] Furthermore, an association has been shown between questions on the medical-license application and physicians' willingness to seek care. In states where questions about mental health were not consistent with the recommendations of the American Psychiatric Association and the Federation of State Medical Boards (FSMB), physicians were significantly more reluctant to seek medical care for a mental health condition.[6]

Further advancing this discussion is that, in a recent study, depression was not tied to medical errors, but burnout was, raising additional questions about why questions about mental health are being asked so often.[7] Perhaps in part due to this, several professional medical organizations have given recommendations on how to approach questions about mental health on medical-license applications. The American Psychiatric Association released a position statement on the matter in 2018 where it concluded that "General screening inquiries about past diagnosis and treatment of mental health disorders are overbroad and discriminatory and should be avoided altogether."[8] Instead, it recommends that questions should focus only on conditions that currently impair a physician's capacity to practice medicine.[8] The FSMB also released a report in 2018 where it made a similar recommendation that questions focus only on current impairment "which may be more meaningful in the context of a physician's ability to provide safe care to patients in the immediate future."[9] SHM published an open letter in support of the FSMB recommendations in 2020, citing the increased urgency to address concerns for physician mental health in light of the COVID-19 pandemic.[10] Similarly, the Joint Commission strongly encourages organizations not to ask about the history of mental conditions or treatment and supports the removal of any barriers to mental health care access for physicians.[11] It's therefore reasonable to extend these recommendations to credentialing applications as further recommendations and studies emerge.

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Conclusions and our 'ask' of hospitalists

As we turn our focus back to our clinical vignette, what efforts can we take to help MB and clinicians like her feel more comfortable accessing the mental health resources they likely need? We can reassure her that medical boards have drastically changed their approach to physicians seeking mental health care. One meaningful change would be for all state medical boards *and* hospital credentialing committees to heed existing recommendations and have questions on current impairment rather than on mental health. How these questions are worded has been shown to have a significant impact on physicians' openness to seeking mental health care. Instead, questions should be framed in a non-punitive manner and include language that supports those who are receiving mental health care.[12] Hospital medicine groups can request their credentialing committees remove such questions from applications and replace them with language that doesn't deter help-seeking. Individual hospitalists can also share mental health resources, such as employee assistance programs, within their groups. Additional support and resources for generating change can be found through the Institute for Healthcare Improvement and specifically the Help Health Care Heal Coalition.[13]

Moving forward, hospitalists are uniquely positioned on the front-line of health care and quality improvement to advocate for positive changes. Through education, policy making, and organizational advocacy, hospitalists can help increase access to mental health for physicians. These efforts will benefit not only physicians currently practicing, but also future generations of physicians to come. ■

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SIG Spotlight: Global Hospital Medicine

By Richard Quinn

All of SHM's Special Interest Groups (SIG) look to solve issues, but some are more challenging in scope than others.

Those focused on the spread of interdisciplinary rounding, or the improvement of health information technology, for example, can produce tactile examples of success.

But the Global Hospital Medicine SIG?

Defining hard-fought victories can be more ephemeral—if no less profound.

"We really want to normalize the idea of partnership across the board," says SIG chair Khaalisha Ajala, MD, MBA, FHM, an assistant professor of medicine at Emory University School of Medicine in Atlanta. "Not just the idea of charity care in one area, and partnership in the other. It should actually be across the board, and we should be learning from each other.

Dr. Ajala

"And we should be learning about ways to improve what we do here in the U.S. from our partners abroad, from the global north and global south, as we hope to create sustainable ideas and solutions to improve what is done around the world."

Dr. Ajala says the key to tackling a topic as large in breadth as global health is "we start with actionable items."

"We have overall lofty goals," she said. But "for us, it's not to take over the world. For us, it's not the colonial ideal of going out in the world and standardizing hospital medicine across the world. We understand that various hospitals function differently. The key thing, for us, is to be a hub and to be a safe place for hospitalists who are interested in global health and global rights, and hospitalists who are interested in working abroad."

The SIG started in 2021 and has 251 members. Understandably, many practice abroad. And while those folks provide inpatient care to patients, hospital medicine is an American term.

"A lot of us who are hospitalists who work inpatient, still like to travel around the world and care for patients around the world," Dr. Ajala said. "Those places don't necessarily have to be in a hospital."

Dr. Ajala adds that when many think of international medicine, they most often think of countries in the global south, a conceptual term used to describe the countries in Latin America, Africa, Asia, and Oceania. The majority of the world's population lives in the global south—while the U.S. is in the global north.

"Our ideas are to kind of erase those boundaries," Dr. Ajala said. "We want to build that partnership and create that support and spread the message of the idea of quality of care, patient safety, and improving outcomes."

But eliminating boundaries for best practices is not to say that the SIG—or any of its members—want to impose the U.S. standard of health care anywhere else. For that matter, which hospitalist group's standards would be fittest to export?

"Even within hospital practices within the U.S., we're not all the same," Dr. Ajala said. "We do have a lot of common goals that fall under what we learn together. But I just left Converge at SHM, and we learned about practices at other hospitals. We learned about patient safety protocols, and quality improvement in other places. The goal wouldn't necessarily be to standardize in every hospital around the world, whether it be global north or global south, because each actually have individual approaches."

To not respect the practices elsewhere globally "has a strong history in colonial practice" and often causes pushback, Dr. Ajala said.

Instead, the SIG aims "to create a network so we can discuss ideas and trade and learn from each other about the way we practice, so we can help improve that practice."

Dr. Ajala says progress needs to be recognized along the way, such as when professors visit abroad—in either global direction. One victory of late is from Dr. Ashti Doobay-Persaud, one of the SIG's executive committee members, who is helping create a global hospital medicine fellowship at Northwestern University's Feinberg School of Medicine, Chicago, where she is a co-director of the Robert J. Havey, MD Institute for Global Health.

Dr. Doobay-Persaud has also created her first faculty development conference in Kenya, where they taught practices including advanced and basic life support.

"When you go to certain hospitals in other countries, they have more tertiary services, where cardiologists actually have an inpatient service, GI has an inpatient service, renal, hematology, oncology—they all have inpatient services. So, the internal medicine doctors present are (sometimes) more someone who is an outpatient physician, who may come around as a consultant, but doesn't have the same kind of inpatient treatment like a general internal medicine team that rounds specifically in the hospital."

Dr. Ajala says that whether the work is domestic or abroad, the key remains focusing on attainable success.

"You start with key items," she said. "How can we connect? How can we talk about what we're doing in our various countries? How can we collaborate...and talk about what we're all doing within global health and international medicine?" ■

Richard Quinn is a freelance writer in New Jersey.

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Chapter Spotlight: North Florida

By Richard Quinn

Matthew Calestino, MD, FACP, SFHM,—along with Drs. Handel Desa and Calixto Zaldivar—helped found the North Florida chapter of SHM in 2018 with an eye toward building a cohesive network of hospitalists and others who could come together in case of an emergent health care situation. From his base in Gainesville, at the HCA Florida North Florida Hospital, the expectation was shared resources and manpower to help during the annual wave of hurricanes that ravage the Sunshine State each summer and fall.

Dr. Calestino

"One of my biggest concerns was for disaster preparedness—if a hurricane had hit our region—to have contacts in all these other health care systems," said Dr. Calestino, the chapter's immediate past president. "Not only to support one another with ideas and innovations, but also to, in an emergency situation, be able to say, 'Hey, I know the physicians at this hospital, and right now their hospital is hurting. Can we go help?'"

But it was the COVID-19 pandemic in 2020 that first gave the North Florida chapter—and its roughly 80 members—the chance to do what it was built to do.

"I applied for privileges over at the University of Florida so that if needed I'd be more than happy to go over there and support them," Dr. Calestino said. "Out of that were born some excellent lectures that were given by a couple of SHM members, Dr. Nila Radhakrishnan and Dr. Frederick Southwick, who are from the University of Florida.

"They gave state-wide lectures on updates with COVID-19. Again, all virtually, but CME accredited, so our ties to the University of Florida really strengthened with that. That was it, just to help one another in our struggles, because there could be disasters of any kind. This one was particularly scary."

During 2021 and 2022, Dr. Calestino also organized a statewide virtual meeting of chapters. The ability to remotely connect leaders from across the state is exactly what he wants to see as he sets up the future of his chapter.

"One of the things SHM challenges the leaders to do is, you have to hand this off at some point," he said. "It's not a dictatorship. You need to find people who you have developed over the years and are able to take over the reins of the chapter."

While the COVID-19 pandemic shone a brighter spotlight on the value of working together across practice lines and geographies, that value is apparent to Dr. Calestino all the time. And when recruiting new chapter members, he's quick to point out that hospitalists can sometimes be so focused on their patient censuses, they lose sight of a broader perspective. So, Dr. Calestino sees his chapter—and all chapters—as the way to create hospitalists that focus on not just the buildings they work in, but the communities that surround those buildings.

"Try to get engaged," he said. "Go to these medical conferences and scientific symposiums where you can earn your CME credits and meet some new individuals. That is really how we repair as health care providers, physicians, and clinicians of any kind. If you stay within those four walls, there's no room to grow. Go out and get that water and sunlight."

Dr. Calestino is proud of the fact that North Florida, specifically Gainesville, has a place in hospital medicine history. His hospital in Gainesville was once home to Dr. John Nelson, a co-founder of SHM and one of the first three practitioners given the Masters of Hospital Medicine designation.

Looking forward, Dr. Calestino is pleased that the North Florida chapter has its next round of leaders in place. New president Dr. Kaitlin Moran and president-elect Dr. Aleksandara Murawska Baptista, both based at Mayo Clinic Florida in Jacksonville, took over the leadership at SHM Converge in Austin, Texas in March.

"I'm very confident that the chapter is going to continue to grow," Dr. Calestino said. "We're hoping to have another statewide summit later this year, and another scientific symposium. I feel like the chapter is in excellent, excellent hands."

And, to Dr. Calestino's founding hope of forming a chapter to build a diverse network of support, he's also confident that the North Florida chapter will continue to attract not just hospitalists themselves, but all who work in their ecosystem.

"I think that's the biggest misconception, that SHM is just for hospitalists," Dr. Calestino said. "But it's not. It's for everybody who works at a hospital. Whether it's a pharmacist, a nurse, a unit clerk, or a respiratory therapist. It's not the Society of *Hospitalist* Medicine, it's the Society of *Hospital* Medicine."

"There is so much talent that is caged within the walls of their brand, whatever that may be," he said. "The view becomes very myopic because you are dedicated to the system that you're in. But there are so many talented people outside of those walls that have the same victories, the same struggles, the same defeats, the same challenges." ■

Richard Quinn is a freelance writer in New Jersey.

MEDICAL COLLEGE OF WISCONSIN

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The Medical College of Wisconsin (MCW) in Milwaukee, Wisconsin has multiple openings for the position of **Assistant Professor in the Department of Medicine, Division of General Internal Medicine** to provide patient care, teaching, clinical research and administrative/service duties.

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Requires licensure or eligibility for licensure to practice medicine and surgery in the state of Wisconsin.

Interested parties are invited to submit a resume to Nicole Kuehne in HR at **nkuehne@mcw.edu**.

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