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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), 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.

Dosage and administration

- Administration should take place under conditions where management of severe hypersensitivity reactions, such as anaphylaxis, is possible.

ECMO=extracorporeal membrane oxygenation.

In the ACTT-1 overall study population, patients experienced



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 endpoint¹

- 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 endpoint¹⁻³

- 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 placebo¹

- 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**, 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 hospitalized and require invasive mechanical ventilation and/or ECMO, the recommended total treatment duration is 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 for outpatient use.

• **Testing prior to and during treatment:** Perform hepatic laboratory and prothrombin time testing prior to initiating VEKLURY and during use as clinically appropriate.

• **Renal impairment:** No dosage adjustment of VEKLURY is recommended in patients with any degree of renal impairment, including patients on dialysis. VEKLURY may be administered without regard to the timing of dialysis.

Pregnancy and lactation

• **Pregnancy:** A pregnancy registry has been established for VEKLURY. Available clinical trial data for VEKLURY in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes following second- and third-trimester exposure. There are insufficient data to evaluate the risk of VEKLURY exposure during the first trimester. Maternal and fetal risks are associated with untreated COVID-19 in pregnancy.

• **Lactation:** VEKLURY can pass into breast 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 an underlying maternal condition. 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.; 2023. 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/nejm2007764_appendix.pdf



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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), 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.

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: No dosage adjustment of VEKLURY is recommended in patients with any degree of renal impairment, including patients on dialysis. VEKLURY may be administered without regard to the timing of dialysis.

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, one Phase 3 study in 279 non-hospitalized adult and pediatric subjects (12 years of age and older weighing at least 40 kg) with mild to moderate 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). Study GS-US-540-9012 included non-hospitalized subjects, who were symptomatic for COVID-19 for ≤7 days, had confirmed SARS-CoV-2 infection, and had at least one risk factor for progression to hospitalization treated with VEKLURY (n=279; 276 adults and 3 pediatric subjects 12 years of age and older weighing at least 40 kg) for 3 days.

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.

Remdesivir and its metabolites are in vitro substrates and/or inhibitors of certain drug metabolizing enzymes and transporters. Based on a drug interaction study conducted with VEKLURY, no clinically significant drug interactions are expected with inducers of cytochrome P450 (CYP) 3A4 or inhibitors of Organic Anion Transporting Polypeptides (OATP) 1B1/1B3, and P-glycoprotein (P-gp).

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

Pregnancy

Risk Summary: A pregnancy registry has been established for VEKLURY. Available clinical trial data for VEKLURY in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes following second- and third-trimester exposure. There are insufficient data to evaluate the risk of VEKLURY exposure during the first trimester. Maternal and fetal risks are associated with untreated COVID-19 in 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

Risk Summary: A published case report describes the presence of remdesivir and active metabolite GS-441524 in human milk. Available data (n=11) from pharmacovigilance reports do not indicate adverse effects on breastfed infants from exposure to remdesivir and its metabolite through breastmilk. There are no available data on the effects of remdesivir 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

No dosage adjustment of VEKLURY is recommended for patients with any degree of renal impairment, including those on dialysis.

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.

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

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Annual Report

Message from Dr. Eric Howell: The Society of Hospital Medicine Annual Report

By Eric E. Howell, MD, MHM

As we begin a new year, it's common to set goals and identify areas for improvement—both in our personal and professional lives.

In 2023, SHM released its inaugural Annual Report outlining the Society's progress towards the four strategic goals recently established by the Board of Directors:

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

In previous issues of *The Hospitalist*, we have talked about our accomplishments throughout the year and emphasized SHM's commitment to promoting diversity, equity, and inclusion (see the June, September, and November 2023 issues). We have also aimed to build the SHM community (see the July issue for Converge coverage and SIG and chapter spotlights in nearly every issue).

In this article, I wanted to highlight our goals specific to advocating for you and the field of hospital medicine, and our efforts to advance our field through scientific research and innovation as we



Dr. Howell

enter into a new year together.

SHM Goal: Advocate for the members and the field of hospital medicine

SHM has been actively advocating for hospitalists and their patients and has achieved several significant wins in 2023.

One of the most notable victories was on the split/shared billing issue. The SHM advocacy department, along with the Public Policy Committee, worked tirelessly to ensure that medical decision making could still be used to determine who performed the "substantive portion" of the visit.

The Centers for Medicare and Medicaid Services (CMS) had proposed that only time could be used for split or shared visits, which

would have made it difficult for hospitals and physicians to bill accurately. Thanks to SHM's efforts, routine inpatient bills can now be either time-based or based on medical decision making. It's important to recognize that wins like this, where a potential hardship is averted, can be overlooked, but SHM acted quickly and effectively to prevent it from happening.

The split/shared billing victory is only one of many examples of our work and impact in 2023.

SHM successfully nominated two members to serve on committees for the new partnership for quality measurement, which reviews and provides recommendations on quality measures used by CMS.

We also organized Hill Day 2023, where members from the Public Policy Committee and chapters visited more than 43 congressional offices (see page 11). As the year came to a close, we worked hard to raise the awareness of the payment cuts, which go into effect in 2024. We will continue to advocate to stop these cuts this year.

We made progress on many of our policy priorities, including reauthorizing the Conrad 30 program, reforming prior authorization, and protecting the hospital

medicine and broader health care workforce.

At SHM, it has never been just about the money. Our advocacy has been focused on our patients, too. For example, under the leadership of Dr. Ann Sheehy, SHM has started to reengage on the observation issue. Our goal is to ensure that every day spent in the hospital, whether admitted or as observation, counts towards the three-day stay requirement for skilled nursing facility coverage.

We led the development of a multistakeholder support letter for the Improving Access to Medicare Coverage Act, which received support from more than 30 signing organizations.

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

SHM has a long history of promoting and advancing the science of hospital medicine. Through our publications, *The Hospitalist* and the *Journal of Hospital Medicine*, our advocacy and practice management departments, as well as our successful center for quality improvement, we continue to support members and our field in providing high-quality care and

enhanced patient outcomes.

There are two specific areas I wanted to highlight as part of our efforts in 2023, including the revised *State of Hospital Medicine Report* and a retreat SHM hosted at our national office, which focused on the future of hospital medicine research.

SHM's *State of Hospital Medicine Report* was published in the summer of 2023. This report has been a key resource for many years on hospital medicine group composition and finances, including salary and hospital financial support. Hospitalists now earn as much as \$323,500 annually!

But just as importantly, given the pivotal role played by hospitalists during the COVID-19 pandemic, SHM deployed a new, first-ever Workforce Experience Survey which captured patient load, perceived safety, and hospitalist well-being.

With more than 560 survey responses, there was a mixed picture of how hospitalists are doing. About 68% of respondents reported feeling at least some burnout, but at the same time, 86% reported their work as meaningful. So, we all have work to do to support and uplift our hospital-medicine workforce.

We are continuing to work with our staff and membership to develop new resources for hospitalists, based on the outcomes of this survey, and remain committed to being a partner to members like you.

Another key area where SHM is advancing the science of hospital medicine is partnering with our academic colleagues. To that end, in October, SHM hosted a group of hospital-medicine research leaders to explore areas where SHM could contribute to advancing research in hospital medicine.

Key opportunities identified during the one-day discussion included strategies we will explore for facilitating deeper representation of hospitalists in the development of guidelines, reviewing pathways modeled by other specialties (including emergency medicine and pediatric research), and defining a prioritized hospital-medicine research agenda.

I'm excited to partner with you to continue advancing not just these two goals, but all four, in the year ahead, to better meet your needs and the needs of all our hospital medicine team members. For more information on SHM's recent accomplishments, I invite you to view the full SHM Annual Report! ■





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Billing for Straightforward Pneumonia in a Hospitalized Patient

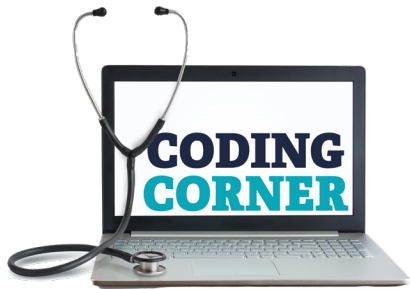
By Arunab Mehta, MD, MEd

A 64-year-old woman with a history of heart failure with reduced ejection fraction (HFrEF) was admitted to the hospital with decompensated heart failure one day ago. On day two, the patient is still short of breath and now develops a temperature of 100.9 degrees F. You order blood cultures, urinalysis (UA), and a chest X-ray. You review the UA and personally review the chest X-ray with findings documented that reveal left lower lobe pneumonia. Complete blood count and basic metabolic panels from the same day are also reviewed. The patient's oxygen saturation is 92% on room air.

You start intravenous ceftriaxone and oral azithromycin and decide against monitoring for toxicity in this patient.

Q: What level of billing does this qualify for?

A: This would qualify for level 2 (99232) billing. She would qualify for acute illness with systemic symptoms by virtue of having pneumonia (moderate level in the complexity of the problem addressed) and prescription drug therapy (moderate level for risk



of complication). Even though her complexity of data reviewed is high (for reviewing three unique tests and independently reviewing a chest X-ray), she achieves a moderate level of medical decision making in two out of three elements.

Tip

Always look at the "medical decision making" table when billing. A straightforward pneumonia without respiratory failure or sepsis is an "acute illness with systemic symptoms" and qualifies for a moderate level of medical complexity. A chest X-ray is a common test that can be independently interpreted and documented by the clinician to count as a category for the complexity of data to be reviewed.

Dr. Mehta is the medical director and an assistant professor of medicine at the University of Cincinnati Medical Center in Cincinnati.

Hospitalists Discover Research Can Extend Their Patient Care Impact

Education and mentoring are crucial to success

By Sue Coons, MA

Through their integral role in patient care, hospitalists are uniquely situated to identify problems on medical wards and to design research interventions to address these issues. Clinicians who've gone down this path have found it incredibly rewarding but emphasize that education and mentoring are crucial steps to research success.

Looking at why

A research career for hospitalists starts with the question, "Why?" Researchers often share three common characteristics: curiosity, attention to detail, and creativity, according to Chris Bonafide, MD, MSCE, (@chris_bonafide), associate division chief for research integration in the general pediatrics division at the Children's Hospital of Philadelphia, and associate professor of pediatrics at the University of Pennsylvania in Philadelphia. This includes wanting to speak to clinicians, patients, and the families who are affected most by the issue, and a willingness to view research "outside the box."



Dr. Bonafide

"In my experience, these sorts of skills have predicted a lot of success both in researchers as well as research staff," he said.

The type of research initiated by hospitalists can vary widely. Margaret Fang, MD, MPH, MHM, division chief of hospital medicine at the University of California San Francisco Health, and director of research and the University of California San Francisco academic hospital medicine fellowship, originally wanted to be a clinician educator, but a quality-improvement elective during residency made her realize the importance of research skills. A project to improve inpatient heparin administration was her first experience running a study. "It was clear I needed to know a lot more to do quality improvement well," she said.



Dr. Fang

Dr. Fang then enrolled in a general-medicine fellowship to gain formal research training. "Fellowship showed me how fun it was to ask questions and design studies to answer them, and how research could impact the care of many more patients than I ever could as a clinician," she said.

The overall mission of her research program is now to equip clinicians and patients with the information they need to make good decisions when considering anticoagulants, Dr. Fang said. This includes how to balance the risk of thrombosis when off anticoagulants with the risk of bleeding while on them, as well as which patients should take which drugs.

Questioning work practices

The early studies of Marisha Burden, MD, MBA, FACP, SFHM (@marishaburden), professor of medicine and division head of hospital medicine



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at the University of Colorado School of Medicine in Aurora, Colo., delved into various aspects of work practices, including curbside consults, patient flow, a randomized controlled trial assessing the "bare below the elbows" policy's impact on bacterial contamination of newly washed scrubs compared to white coats, and several investigations into gender inequities in leadership, speaking opportunities, and authorship.



Dr. Burden

Her research now centers around building and implementing evidence-based work-design practices. As her leadership roles expanded, she saw the profound impact of work design on outcomes such as the workforce, patients, and even organizational outcomes.

Researching health care disparities

Sagar Dugani, MD, PhD, MPH, FHM, initially focused on translational biology. However, providing care to patients from rural areas in the U.S. Midwest sparked an interest in health care disparities.



Dr. Dugani

"Rural populations experience disparities in various care settings (e.g., hospital, outpatient)," said Dr. Dugani, an assistant professor of medicine at Mayo Clinic in Rochester, Minn., where he also serves as division of hospital internal medicine research chair and as director of the Hospital Experiences to Advance Goals and Outcomes Network (HEXAGON).

He now evaluates these disparities to design smarter interventions that work across care settings. "Our work leverages national, regional, and hospital datasets to understand how rurality (and related social determinants of health) affect outcomes."

Practicing implementation science

During his residency, Dr. Bonafide became interested in issues surrounding patient safety and the implementation of improvement processes.

"I felt there was a gap between understanding what we needed to measure to understand if these [processes] were really improving things for patients, doctors and nurses, and other staff and families," he said.

Through a research fellowship and a course in implementation science, he learned how to design research studies to help bridge the gap between existing evidence and practice. Dr. Bonafide now works as an implementation scientist. "Implementation science is figuring out how to change the behavior of folks to align their practice with the best available evidence and also how to eliminate unnecessary practices that don't benefit patients and families and may also potentially be harmful," he said. He has studied alarm fatigue and strategies that help physicians decrease the amount of ineffective monitoring.

Improving patient care transitions

After developing an interest in research during medical school, Sunil Kripalani, MD, MSc, FACP, SFHM, decided early on to pursue an academic career. "Getting a foundation in research methods, including clinical trial design and survey research, was critical for me," he said. Dr. Kripalani is a professor of medicine at Vanderbilt University Medical Center in Nashville, Tenn., and director of Vanderbilt's Center for Health Services Research and Center for Clinical Quality and Implementation Research.



Dr. Kripalani

Dr. Kripalani's research primarily involves developing interventions to improve patient care transitions, mostly from hospital to home but also transitions involving emergency departments, intensive care units, and skilled nursing facilities. "Over time, I've shifted from testing interventions on a smaller scale to studying their implementation hospital-wide as we've learned what interventions are effective," he said.

Balancing act

These hospitalist researchers said their clinical work and research work inform each other and add to the knowledge base. "My clinical work

serves as a vital source of insights to inform workplace practices, and I believe we need more of this perspective in organizational decision-making processes,” Dr. Burden said.

Keeping focus on current work also helps balance the patient-care and research aspects. Dr. Kripalani found that spacing out his clinical weeks gave him large blocks of time when he could focus on research. “When I’m on service, I rely more on my research team to move things forward,” he said.

Synergizing or aligning clinical and research is ideal, the hospitalist researchers said. Dr. Fang feels very fortunate that her clinical and research interests are aligned. “From a practical standpoint, being a hospitalist allows me to focus on taking care of patients when I am on service, but then shift that attention to my research when I am off clinical service.”

Balancing clinical and research interests has been challenging, Dr. Burden said, because of her passion for all aspects of her work, including leadership, research, clinical practice, and education. “Because there is so much overlap in these areas, I’ve worked to integrate and synergize these efforts.”

Dr. Bonafide finds that time with residents gives him energy and

ideas for new projects. “For me, the clinical and research work are nicely intertwined in a way that’s fun. It’s a wonderful balance.”

Getting the education

Hospitalists interested in research will require both a defined interest and formal training such as a master’s or PhD program, Dr. Fang said.

“Having a formal framework to design studies, analyze data, and interpret results is imperative to your own research program and to understanding others’ research,” Dr. Dugani said.

Completing a master’s degree or research fellowship is essential, with several outstanding programs around the country, Dr. Kripalani said. “These are good stepping stones to a career development award that will provide more time and support for mentored research.”

Hospitalists interested in research should be comfortable with writing frequent papers and grants, and comfortable with being rejected. “My grants, papers, proposals, etc., have been rejected,” Dr. Dugani said. “While painful, there was always something to learn, which helped [me] make better decisions.”

Collaborating and mentoring

Another common theme among hospitalist researchers is understanding the importance of collaboration and mentoring, both in the roles of mentor and mentee.

Dr. Burden said her educational efforts have evolved to focus on mentorship, particularly in the areas of helping mentees think about career growth and building the research pipeline. “It’s important to acknowledge that research is a collaborative effort,” she said. “The success of any research endeavor is a testament to the collective effort of a dedicated team.” She said she was grateful to have had an invaluable research partner throughout her career.

“If you’re just starting out, be sure you have great research mentors and enough time devoted to growing your research career,” Dr. Fang said. “It’s really hard to launch a successful research career when you have a lot of clinical responsibilities.”

Dr. Dugani advises hospitalists interested in research to reach out to colleagues and meet with senior researchers at conferences. “Don’t hesitate to explore, even if in a small way,” he said. “Every step you take will make the next one easier, and you will suddenly find yourself immersed in research and enjoying the process.”

Hospitalists with research interests should find a strong mentorship team, including mentors with expertise in decision making, their specific research-area interest, and scientific methodology, Dr. Bonafide said. For junior hospitalists, a sponsor could also help build connections to colleagues and opportunities. Choosing skilled research assistants is critical, he said, and collaborations with researchers with similar interests can be productive as well.

Over time, Dr. Fang has found mentoring to be one of the most fulfilling aspects of her research career. “I have learned so much from my mentees,” she said.

Taking the plunge

Dr. Burden said hospitalists considering entering into the research field should take the plunge.

“Research in hospital medicine can and does have a profound impact, both locally and beyond,” she said. “Witnessing the transformative potential of a study, even one undertaken with limited resources but fueled by dedication and perseverance, is incredibly empowering.” ■

Sue Coons is a medical writer in Chapel Hill, N.C.



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The Promise of a New Year

SHM chapter leaders offer resiliency, hope, and change

By Lisa Casinger

New years typically start with goals, and preparations for things to come. We caught up with several SHM chapter leaders and asked about their chapters' goals, what they're looking forward to (professionally and/or personally), and what they think the biggest challenge in health care will be for 2024. Here's what they had to share.

Atlanta chapter president Mohamad Moussa, MD, SFHM

Hospitalist at Emory University in Atlanta, and site director of Emory Johns Creek Hospital in Johns Creek, Ga.



Chapter goals: Our goal is to expand our reach by intentionally planning meetings with academic sessions outside the Atlanta metropolitan area, to come near where hospitalists are. We hope to attract more members who might get more involved with the SHM mission and vision.

I'm looking forward to: Getting more involved in SHM national committees and learning more about the steps taken by SHM to improve the well-being of hospitalists nationwide. On the local level, I am looking forward to nurturing and mentoring more leaders to ensure the continuous growth of leadership at our chapter.

Biggest health care challenge in 2024: The biggest challenge is becoming more efficient by cutting the cost of care without compromising quality and satisfaction. Since the COVID-19 pandemic, health care systems across the nation have suffered financially due to the great resignation, inflation, and the high cost of locum nurses and ancillary services, which make it hard to survive even for nonprofit institutions.

Hampton Roads chapter president Gwendolyn R. Williams, MD, FHM

Hospitalist at Sentara CarePlex Hospital in Hampton, Va.



Chapter goals: This will be a year of transformation for our chapter. We expanded leadership opportunities and will have a new governing board in 2024. Our chapter members extend across a large geographic region, and we aim to fulfill a myriad of interests through chapter meetings and community engagement.

Beyond the clinical lectures, we're looking forward to bringing speakers to engage and educate members on topics such as billing, documentation, health policy, advocacy, trauma-informed ethical care, and moral injury. We're focused on improving the well-being of hospitalists and will launch quarterly Reset, Refresh, and Recharge immersive activities that members and their loved ones can engage in.

Our chapter strives to cultivate a culture that prioritizes diversity, equity, inclusion, and belonging intertwined with self-compassion and compassion as these elements are essential and at the very core of transforming ourselves and our world, to alleviate suffering, increase

well-being, and inspire cultural humility. We are also looking forward to partnering with community organizations and inviting members to participate in local events. Our mantra for 2024 is "Life is a journey, not a destination," and we will work intentionally and mindfully on embracing change and thriving in our evolution.

I'm looking forward to: Personally and professionally, I am looking forward to living in the now. When I became president of the chapter, I also became president of the Sentara CarePlex Hospital Medical Executive Committee, along with many other leadership positions, while also having an infant daughter. In 2024 I'm looking forward to prioritizing what is truly important and being intentional in the decisions I make. Cultivating mindfulness, compassion, and emotional intelligence will allow me to forge pathways to personal and professional purpose. I am looking forward to embracing the pauses and enjoying the beauty of life around me. I am looking forward to an inspirational change in my professional life and the soul-growing transformation that will accompany it.

Biggest health care challenge in 2024: As physicians and health care professionals, the erosion of trust is an insidious and pervasive threat, and a critical issue facing our profession today. How we address this problem will shape the future of medicine. In our time, trust has been broken, abused, misplaced, and violated in all facets of society, and mistrust has grown. Trust is essential, not only to the practice of medicine but to the survival of all human civilization, as every kind of peaceful cooperation is primarily based on mutual trust. To restore trust in science and medicine, we need to evolve individually, and collectively we need to work together to reform the systems we work in. We must restore confidence in the integrity of health care because it cannot survive without the support of those it serves and the health care professionals who give it life. We cannot allow the human dimension of patients, physicians, and leaders to be lost.

Hawaii chapter president Lisa Tan, MD, MBA, SFHM

Hospitalist at The Queen's Medical Center in Honolulu



Chapter goals: Our goals are to provide a supportive space for hospitalists to share ideas, promote physician wellness, and provide education.

I'm looking forward to: Promoting hospitalist wellness and making it a sustainable profession.

Biggest health care challenge in 2024: Physician burnout is spiking to an all-time high of more than 50%. COVID-19 continues to stress hospitalists and the health care system. The current health care system may not be sustainable, and there are a lot of opportunities for improvement.

Kansas chapter president Ali Rafiq, MD, FACP

Hospitalist with Sound Physicians, at Ascension's Via Christi St. Francis Hospital in Wichita, Kan.



Chapter goals: The Kansas chapter aims to continue its growth in 2024. We are looking forward to expanding our leadership structure by creating a specific position for advanced practice practitioners. This will be in addition to our resident champion position. We will continue our outreach efforts with in-person presentations to various hospital medicine groups across the state. These presentations help highlight the value of SHM membership and encourage the recruitment of prospective members. We will also encourage members to consider applying for fellowships, as this designation highlights their commitment to SHM.

I'm looking forward to: Personally, I look forward to 2024 being another year of frequent travel. I am excited about SHM Converge, and it helps that it is in San Diego, a city I have never visited! I also have a pile of books lying on my nightstand that keep staring at me every day, and I hope to give them their due time before the end of the year. I don't currently anticipate any major changes in my professional role, which mainly revolves around caring for patients at the bedside and being involved in hospital committees to improve the care that we deliver.

Biggest health care challenge in 2024: I feel 2024 will continue to be a challenging year for health care. We must make health care equitable for our communities and enjoyable for our clinicians. On top of that, it needs to be delivered sustainably. Moral injury of clinicians should be treated as an emergency, and appropriate reforms should take place to prevent the crisis from worsening. It might be a difficult task to achieve, but I feel the only way forward is if all stakeholders work together on multiple fronts toward a common goal. Technology can play a vital role in that, coupled with the active involvement of health care leaders in shaping public policy. The current state of health care appears to be diseased itself, and the remedy requires a combination of grit and innovation.

Long Island chapter president Bryant Faria, MD, FACP, FHM

Co-director of inpatient quality, and hospitalist at Long Island Jewish Medical Center in New Hyde Park, N.Y., and assistant professor of medicine at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell in Hempstead, N.Y.



Chapter goals: Our chapter's goals for this year are to foster a return to in-person meetings and engagement. Connecting with colleagues from across the Long Island region face-to-face has been truly invigorating. We aim to continue promoting networking and education throughout our chapter, with a strong focus on addressing health equity, diversity, and inclusion. Our upcoming workshop on microaggressions is sure to be a valuable and engaging experience for our attendees.

I'm looking forward to: On a professional level, I eagerly anticipate the return of in-person meetings and networking as the norm. The personal interactions and collaboration that come with in-person events are invaluable, and I believe they will contribute significantly to our professional growth and development in hospital medicine.

Biggest health care challenge in 2024: Looking ahead, the most significant challenge, in my view, will be keeping pace with the ever-evolving world of technology. We need to effectively integrate advances in artificial intelligence into our day-to-day health care practices. Leveraging AI has the potential to provide higher-value care to our patients and may even revolutionize the way we approach professional development for health care workers.

Maine chapter president Anne Dean, MD, MPHS, FHM

Associate medical director, hospital medicine, Maine Medical Center in Portland, Maine, and associate professor, Tufts University School of Medicine in Boston



Chapter goals: Our goals for 2023-2024 have been to reconnect with members, re-establish a strong foundational structure, and spread the good word of SHM to medical professionals beyond our physicians. We have seen increased engagement with advanced practice professional (APP) membership and hope to embrace more APPs, residents, and medical students while simultaneously increasing access to SHM offerings.

In the past eight months, we have executed two open chapter meetings with good attendance, but still need to grow beyond the usual suspects. Inertia has been stickier than we would like. We're looking forward to 2024. The chapter leaders would like to reach more members and recruit needed member support for specific roles and special interest groups, as well as establish a predictable meeting calendar that coincides with SHM Converge. We anticipate a symposium with the non-profit leadership group at Hanley to deliver leadership content, promote SHM opportunities, and expand on the professional development SHM offers.

North Carolina Triangle chapter president Evan Raff, MD

Associate professor of medicine and co-director, UNC School of Medicine foundation phase medical science courses, physician chair, UNC Medical Center adult rapid response committee, and medical director, UNC Home Health, University of North Carolina School of Medicine in Chapel Hill, N.C.



Chapter goals: We've dedicated the past two years to rejuvenating the cohesion among hospitalists in our region. In the aftermath of the COVID-19 pandemic, the local decline in SHM membership and participation was palpable, evident in diminished meetings, fewer professional connections, and a wane in academic, research, and innovative pursuits.

Our mission has been to revive the spirit of hospitalists in our area, a goal we've achieved through various initiatives. Notably, we've organized social events during the last two SHM Converge conferences, orchestrated CME events at venues conducive for learning and relationship building, and successfully hosted two of the most captivating and well-attended Research, Innovation, and Vignette Competitions in our chapter's history.

Looking ahead to 2024, our goal is to sustain this momentum. We aim to persistently champion hospitalists as essential contributors to our health care system, supportive and com-

passionate colleagues, and shining examples of the tremendous rewards a professional career in hospital medicine can offer. In harmony with this vision, our chapter has been honored with a Chapter Initiative Grant to orchestrate the inaugural "Celebrating Local Excellence in Hospital Medicine" Awards Night. This prestigious event will recognize and applaud exceptional local hospitalists for their outstanding contributions to the field.

This initiative aligns with the mission and vision of SHM by acknowledging and promoting excellence in hospital medicine across diverse realms, including advocacy, high-value care, education, inclusivity, research and innovation, and chapter engagement. By spotlighting the contributions of hospitalists, the event aims to inspire excellence and cultivate a robust sense of community within the local chapter, thereby reinforcing SHM's overarching mission of fostering an inclusive community and advancing health care delivery and research.

I'm looking forward to: In the professional realm, my anticipation for 2024 centers on advancing hospitalists as educators. My objective is to exemplify, through tangible actions, the influential role that hospitalists can play as leaders in the education of students and trainees. The distinct nature of our specialty uniquely positions us to excel as experts in various clinical domains, staying abreast of advancements in knowledge and evidence-based practices across specialties. I am enthusiastic about showcasing the potential for hospitalists to emerge as trailblazers in medical education.

Biggest health care challenge in 2024: I believe the foremost challenge in health care for 2024 will revolve around sustaining resilience, extending beyond the realm of hospitalists to encompass everyone who works in the medical field. Collectively, we have navigated the turbulent seas of the COVID-19 pandemic, and as we emerge from its aftermath, the task ahead involves reconstructing the fragments left in its wake. This process is undoubtedly arduous, yet undeniably invaluable, demanding a continuous commitment to our practice, a collaborative spirit that reinforces mutual support, and a steadfast understanding that our work, caring for others, is what matters above all else.

Rhode Island chapter president Bradley J. Collins, MD, FACP, SFHM

Associate professor of medicine, clinical educator, at the Alpert Medical School, Brown University, hospitalist at the Miriam Hospital, both in Providence, R.I.



Chapter goals: Our goals for 2024 are to increase membership and to continue to deliver high-quality meetings. In 2024 we plan to host Dr. Megan Ranney, dean of the Yale School of Public Health and CNN contributor, to talk about the intersection between public health and hospital medicine. We are especially excited to take on more advocacy roles at the state level.

I'm looking forward to: A successful year of taking care of patients and working to improve systems of health care delivery. I am hoping to publish an article for my research as it relates to fear of asking or answering questions in the medical school clerkship years because of perceived consequences, which will hopefully shine a light on the educational system and how we can improve.

Biggest health care challenge in 2024: I think the biggest challenge will continue to be the

focus on shifting care delivery to health instead of sickness. Substantively addressing social determinants of health and reducing barriers to care should be top priorities. Hospitals are in crisis because of emergency department overuse and discharge throughput issues. Specifically addressing health and wellness can decrease burdens on hospitals and allow them to be a place to take care of those that need to be there.

San Francisco Bay Area chapter president William Collins, MD

Hospitalist and clinical assistant professor of medicine at Stanford University School of Medicine in Stanford, Calif.



Chapter goals: Continued growth post-COVID-19. Our chapter has had great success returning to in-person events in 2023, and we hope to expand in-person and hybrid events to bring in more interested hospital medicine practitioners and trainees.

Biggest health care challenge in 2024: I have two—the consequences of the COVID-19 pandemic on both patients and providers; and the rise of artificial intelligence in medicine. The first, I think, has still many years to play out, but the mental and physical toll has been high. We still need time and grace to reckon, heal, and move forward. The second is an accelerating disruption to many fields that could be amazing and also could be terrible and probably will be some combination of the two. I'm excited to see hospitalists face these challenges and celebrate the successes along the way.

I'm looking forward to: Meeting the challenges of the COVID-19 recovery and artificial intelligence. We can learn and grow a lot from this experience.

Southwest Florida chapter president Shaheen Faruque, MD, FACP, FHM

Hospitalist, nocturnist, telenocturnist, and transition care specialist at St. Mark's Hospital in Salt Lake City, and locum tenens hospitalist and nocturnist in Florida



Chapter goals:

- Organize my cabinet and distribute portfolios to new cabinet members
- Arrange meetings and presentations quarterly
- Work on chapter funding
- Communicate with other chapters to learn and grow
- Work with sponsoring organizations and groups

I'm looking forward to: Becoming a front-line hospitalist leader—a superior-quality, dependable, physician specialist in inpatient medicine. Working to create awareness of the silent suicide epidemic and worsening mental health crisis. Encouraging the use of palliative care in appropriate cases; the practice of meditation and mindfulness to prevent burnout, increase sleep and resilience, and improve long-term memory. Derationalizing fear and anxiety and guarding against disinformation. Championing the importance of voting and supporting and working to sustain democratic norms and peace processes.

Biggest health care challenge in 2024: Sustainable health care coverage for all members of society. ■

SHM's 2023 Hill Day

Continuing the conversations with legislators

By Lisa Casinger

Each year SHM members and staff converge in Washington, D.C., to meet with legislators and discuss key concerns and policy issues that affect hospitalists, their patients, and the health care industry.

On October 19, 2023, members from 16 states, including SHM's Public Policy Committee (PPC) and chapters, attended SHM's Hill Day. Having chapter members in attendance this year was a boon in that it "al-

lowed the group access to some state offices that historically we haven't had a relationship with; it expanded our



Dr. Hilger

reach on the Hill," said Rick Hilger, MD, SFHM, SHM PPC chair, and the system utilization and care management medical director at HealthPartners in Minneapolis.

The group spent the day meeting with their Congressional offices, and in some cases, directly with their Representatives. During these meetings, attendees educated staffers about the role of a hospitalist and the importance of hospital medicine. They visited 43 different offices, and many got a chance to attend a House Committee on Energy and Commerce Health Legislative Hearing: "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors" in which the new director of the Centers for Medicare and Medicaid Services (CMS), Dr. Meena Seshamani, was testifying.

"It was fascinating and super encouraging," said Claudia Geyer, MD, SFHM, system chief of hospital medicine and the hospital medicine fellowship at



Dr. Geyer

Central Maine Healthcare in Lewiston, Maine. "It was clear there was bipartisan understanding of many of the things that are most difficult for us in terms of provision of care, prior authorizations, access to care, payment. Both parties agreed we need to fix these things for doctors and patients. I was pleasantly surprised by that, honestly."

Dr. Geyer attended her first Hill Day in 2019. And, while gun violence wasn't on the agenda this year, the recent mass casualties



SHM members and staff visited the U.S. Capitol for SHM Hill Day 2023.

in Lewiston made her even more aware of the importance of advocacy.

"The health care voice in gun violence in the U.S. has to be heard," Dr. Geyer said. "You can see most heartbreakingly the impact of policy and our laws and whether they're enforced. This is a rural state, always perceived as safe."

The murder of 18 Mainers—in a state that, in the past, had 22 murders per year—understandably shook the state and the nation. One of Maine's Democratic representatives to Congress, Jared Golden, who previously opposed calls to ban AR-15s or similar rifles, even reversed his decision and joined the call to ban their sale and restrict their possession.

Dr. Geyer says the community and the hospital's response was amazing, as were the generosity and goodwill that came from outside Lewiston.

Dr. Geyer—who's been a hospitalist for more than 20 years and in leadership for the last eight—says she, like many other hospitalists, works with incredibly dedicated, hardworking people, who end up facing a system that does not optimally serve. "At this point in my career, I'm so eager to do anything I can to advocate for system change at the policy/legal level and the community level and anywhere else it would be effective."

She says this Hill Day was excellent, a different world post-COVID-19 pandemic, as health care and health care teams are viewed through a different lens.

As anyone who's worked in advocacy or attended Hill Days knows, policy change takes

a long, long time. "In 2019 we were advocating for a bill that would lessen the burden of the three-midnight rule," Dr. Geyer said. "There was bipartisan support for it then and it didn't happen. And even though throughout the pandemic it was suspended, and it worked, we're back in 2023 with the same ask."

Aside from the meetings with legislators and staff, Dr. Geyer said there's a benefit to spending the day with colleagues from across the country. "We became a well-oiled machine by our fourth meeting," she said. "Now I have new contacts who were really great teachers. It's inspiring to me that other people care enough to make this type of effort to reach out."

Much of advocacy is educating. Educating Congressional leaders and their staff about the issues important to hospitalists, and also learning what health care issues are important to them. For example, Dr. Geyer learned that Senator Angus King is interested in fall prevention, and Senator Susan Collins is focused on diabetes.

Dr. Hilger said, "The goal of Hill Day is to chip away at problem issues, and lay the groundwork for future conversations."

This message was stressed to attendees prior to their meetings: "We won't get Congress or CMS to change any laws or rules today, but these conversations really matter long term!" he said.

Dr. Hilger also thought the day went extremely well. "Health care advocacy is a marathon, not a sprint," he said. "Enacting meaningful change requires countless conversations and meetings over

Hill Day Talking Points

- **Reauthorize the Conrad 30 program**—This legislation will reauthorize an existing program that has enabled upwards of 15,000 immigrant physicians on J-1 visas to remain in the U.S. and immediately apply for an H-1B visa or a green card if they work in an underserved area for at least three years. This legislation is an important component to address physician staffing shortages, which have continued to worsen after the pandemic. Support the passage of the Conrad State 30 and Physician Reauthorization Act (H.R. 4942/S. 665).
- **Count observation time toward SNF coverage**—Despite receiving care in the hospital, patients who are under observation are considered outpatients, and that time does not count toward the three inpatient days required for skilled nursing facility (SNF) coverage after their hospitalization. The care they receive is virtually identical to the care for patients admitted as inpatients. Support the passage of the Improving Access to Medicare Coverage Act (H.R. 5138) to make observation days count towards Medicare's three-day requirement for SNF coverage.
- **Medicare payment reform**—In 2024, hospitalists and other clinicians who bill Medicare face another significant cut to their reimbursement rates as a result of budget neutrality adjustments and, the expiration of a legislative update, on top of inflation. The impending payment cuts will exacerbate staffing shortages, hamper efforts to address burnout, and risk further damaging an already vulnerable health care system. To improve the strength and stability of the Medicare payment system, SHM supports the Strengthening Medicare for Patients and Providers Act (HR 2474), which provides inflationary updates based on the Medicare Economic Index and the discussion draft of the Provider Reimbursement Stability Act of 2023. ■

an extended period of time. At its core, it requires educating politicians and their teams about flaws in the healthcare system that need fixing.”

The SHM PPC is made up of a very diverse, dynamic group of leaders from across the country who do a fantastic job of prioritizing topics for SHM to focus its policy work on. SHM’s advocacy efforts have led to substantial changes over the past decade which have directly improved the care of patients and created more sustainable models for colleagues and hospitals.

Common themes in meetings this year included observation reform (allowing observation days to count towards the CMS three-midnight rule for skilled nursing facility coverage), immigration reform in regard to physician staffing of rural areas (the so-called Conrad 30 Bill), and comprehensive Medicare payment reform. ■



Hill Day participants attended a U.S. House Committee on Energy and Commerce Health Legislative Hearing.

Career

Med-Peds Hospital Medicine: A Valuable Resource at Risk?

By David Fish, MD, SFHM, Rachel Peterson, MD, FHM, Madeleine Matthiesen, MD, Alan M. Hall, MD, FAAP, SFHM, and Alyssa M. Stephany, MD, MS, FAAP, PCC (ICF), SFHM

Hospital Medicine has been a growing career choice among combined internal medicine and pediatrics (med-peds) physicians with an increasing number of resident graduates entering the field in recent years. Physicians within this specialty make valuable contributions to hospital medicine through involvement in leadership, education, and advocacy. Med-peds hospitalists also contribute by creating an adaptable workforce as well as one that can provide perspective to assist in specialized areas including the transition of adolescents and young adults with chronic illness. Despite the attributes of this population within the hospitalist community, current challenges threaten its ongoing growth and the careers of established leaders in the field.

A growing and beneficial resource

Over the last several years, hospital medicine has been among the top fields that med-peds residents consider, attracting as many as 26.4% of graduates.¹ Nationally, it’s estimated there are 350 to 400 med-peds hospitalists, making up approximately 10% of the pediatric hospital medicine (PHM) workforce.^{1,2} In a recent survey, 80% of med-peds trained hospitalists responded that they continue to use their training to care for both adult and pediatric populations.³

Med-peds hospitalists bring a breadth of knowledge and experience as well as adaptability to the institutions they serve. This was evident during the COVID-19 pandemic when



Dr. Fish



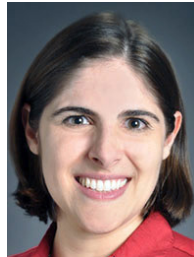
Dr. Peterson



Dr. Matthiesen



Dr. Hall



Dr. Stephany

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patient surges and staffing shortages created significant needs. Many institutions redeployed med-peds hospitalists to adult wards to handle the patient volume when pediatric inpatient volumes decreased. Many med-peds hospitalists also assisted pediatricians who were faced with the care of adults. The Pediatric Overflow Planning Contingency Response Network (POPCoRN) was one of the largest demonstrations of this resourcefulness, created by med-peds clinicians. This network grew rapidly during the early months of the pandemic and created tools to aid pediatric practitioners and other redeployed physicians. It also empowered junior physicians and trainees to engage in the creation of agile educational and operational systems in addition to advancing health equity during a time of crisis.⁴

With the surges in pediatric respiratory viruses in late 2022, med-peds hospitalists continued

to demonstrate adaptability, with many providing extra coverage to overflowing pediatric inpatient units. This population of clinicians and leaders helped innovate within pediatric hospital systems with unique staffing models and operational learning from the surge experience of the COVID-19 pandemic.

Caring for patients with chronic diseases of childhood onset has also been a focus and strength of many med-peds hospitalists. Many of these patients are living longer into adulthood, and many internal medicine providers have limited experience in caring for them. Med-peds providers have played a strong role in caring for this population and providing expertise in transitions of care. Many institutions have developed med-peds consult services that assist with the care of young adults and ensure they are receiving the best, evidence-based care possible.⁵

Changes and threats to growth

The med-peds hospitalist workforce is a valuable resource, but recent changes in hospital medicine have the potential to have a negative impact on the growth and potential longevity of the field.

The largest change has been the introduction of subspecialty certification in PHM by the American Board of Pediatrics. This certification, which was approved in 2016, requires physicians to complete a fellowship in PHM in order to be eligible to take the board subspecialty exam. While a practice pathway for physicians who completed residency prior to 2019 is available for a limited time, it requires specific criteria to be met, limiting the number of those who may qualify. While recognition of PHM as a subspecialty has numerous potential benefits to advance the field, there are significant unintended consequences of the current certification process affecting those looking to become, and those already practicing as, med-peds hospitalists.⁶

These changes have had a significant impact on trainees and their career aspirations. While more than 97% of med-peds residents previously considered a career in hospital medicine during their residency, that number has decreased by more than 90% with the recent changes to the PHM board-certification process.⁷

Key factors dissuading residents from pursuing PHM fellowship include forfeited earnings during the fellowship, and student-loan and family obligations. The vast majority of residents also feel that residency training has adequately prepared them to practice both adult and pediatric inpatient medicine.⁸ Even for those who remain interested, there are significant concerns that the current number of fellowship spots is insufficient to accommodate these trainees as there are approximately 104 positions available to graduates of pediatric and med-peds programs nationally. Additionally, few programs are able to provide training that will allow graduates to maintain their adult medicine skills; approximately 30% of programs currently have the ability to accommodate adult clinical opportunities.⁹

Faculty who have been practicing as med-peds hospitalists for years are also facing potential threats from these recent changes. Due to strict criteria that must be met to become board-certified via the practice pathway, many established practitioners and leaders in the field are encountering challenges in the certification process. This includes leaders in medical education who are unable to meet the minimum clinical hours to become board-eligible

due to administrative commitments. These strict criteria have also negatively impacted those resourceful physicians who were redeployed to have more clinical adult time to meet the needs of their institutions thereby reducing their clinical pediatric time. These changes are potential barriers to career options, as more hospitals are limiting their hiring to those who are board-eligible or board-certified.

Additional threats to the field include the ongoing lack of parity that exists between the fields of adult and pediatric hospital medicine. With pediatric hospital medicine providing less compensation, most med-peds hospitalists already take a pay cut by caring for children instead of exclusively for adults. Now, the PHM fellowship requirement adds additional years of reduced compensation that further magnifies these financial discrepancies.

Future concerns

One additional worry is how the impact of these changes will spread beyond the individuals in the field of med-peds hospital medicine to the systems in which we work and care for patients.

Trainees' decreased interest in hospital medicine and limited opportunities will reduce the number of physicians in the pipeline needed to care for children and adults with complex conditions of childhood when admitted to the hospital.¹⁰ This could result in decreased quality of care that this vulnerable population receives, as prior studies have shown that 40% of internists do not feel comfortable caring for these patients.¹¹

The reduction in this adaptable workforce could also have negative implications for the agility of many hospitals to respond to crises. As noted above, the flexibility of med-peds hospitalists during these times is a resource that has helped direct expertise where needed and promote institutional resilience.¹² This would add to the stress that some systems may already be experiencing with the decrease in pediatric providers who are entering careers in PHM.

Hope for the future

As med-peds hospitalists and trainees continue to navigate this evolving field, it will be important for this group to advocate and have representation within the organizations that have been driving these changes. Unfortunately, many physicians are involved in various professional societies, resulting in independent work in silos and a lack of awareness of what like-minded colleagues are actively pursuing. Though we are worried about the hurdles described above, we are hopeful that,

with continued collaboration and representation, we can overcome obstacles to further develop this powerful team of physicians so they may continue their influential work benefiting patients, institutions, and colleagues.

If you're a med-peds hospitalist or trainee and want to get more involved, please reach out to any of the authors or the Med-Peds Special Interest Group on the Hospital Medicine Exchange, <https://connect.hospitalmedicine.org/home>, to be a part of the collaboration and representation and continue to move our field forward. ■

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How Do You Ethically Integrate a GIP Hospice Service into the Hospital?

By William Frederick, III, MD, PhD, CHCQM-PHYADV, Robin Smith, MSPT, OCS, Sarah McSpadden, MSN, MHA, RN, Diana Childers, MD, CHCQM-PHYADV, FHM, Bryan Huang, MD, CHCQM-PHYADV, FHM, Maryann T. Ally, MD, MPH, CHCQM-PHYADV, FHM, Melody Akhondzadeh, MSN, RN, LSSBB, Analyn Dolopo-Simon, MPH, LSSBB, RN, ACM, CCDS, and Brian Clay, MD, SFHM

Case

An 86-year-old female with a history of metastatic pancreatic cancer and diabetes was admitted for chest pain and dyspnea and found to have an acute pulmonary embolism. The hospital course was complicated by gastric outlet obstruction. She continued to decline despite maximal medical intervention and required intravenous hydromorphone every two hours and scheduled intravenous antiemetics every six hours, despite a nasogastric tube to suction. The patient lacked the capacity to make medical decisions, so her son was assigned durable power of attorney. During goals-of-care conversations, the patient's son felt this ongoing management was inconsistent with the patient's wishes and agreed with shifting focus to comfort. The hospitalist consulted the inpatient hospice team to assess if the patient was appropriate for general inpatient (GIP) hospice.

Hospitalists and palliative care specialists at our health system regularly provide end-of-life care for patients, including symptom control and management of physical and psychosocial stressors. Patients with a life expectancy of six months or less are eligible to enroll in home hospice care at discharge, benefiting from care by a holistic and specialty-trained interdisciplinary hospice team. Similarly, GIP hospice provides holistic end-of-life care and family support in acute-care hospitals. Patients who are appropriate for GIP hospice services often have a life expectancy of hours to days, require care that cannot be delivered at home, and have symptoms that are difficult to control in any other setting.

GIP hospice is an important option to offer patients and families facing end-of-life decisions. Our practitioners recognize the importance of providing a seamless transition to GIP hospice care so patients and families can receive appropriately specialized support at the end of life.

At our hospital, we encourage ongoing goals-of-care discussions throughout a patient's hospital stay to facilitate understanding of their current condition, options for and risks of possible treatments, discussion of personal goals, and symptom management. Following these discussions, if the patient, or their agent under a durable power of attorney, should express interest in learning more about hospice, the treating provider can order an inpatient case management consultation to review available hospice resources, determine if hospice services can be provided in the home, or if hospice services would be provided more appropriately in

the hospital under GIP hospice level of care (see Figure 1).

After the patient is evaluated by a registered nurse hospice liaison (RNHL) and is determined to meet eligibility criteria for GIP hospice level of care (see Figure 2), the RNHL requests signed consent from the patient or durable power of attorney to provide inpatient hospice services. The treating physician then completes a GIP hospice order set to address commonly encountered symptoms and to flag the patient as having GIP hospice status. The RNHL will then work closely with the patient's treatment team to ensure the plan stays focused on patient comfort and end-of-life goals.

Under GIP hospice care, patients are continually evaluated for changes in their clinical condition and symptoms. Patients who become clinically stable or no longer require close adjustment of their symptom management plan may be transferred home or to a lower level-of-care facility while continuing to benefit from hospice services.

Whether or not patients decide to enroll in GIP hospice, symptoms are assessed and palliated via specific order sets that include medications for symptom management, non-medical comfort interventions, and assistance from palliative psychiatrists, social workers, case managers, and clergy. Additionally, these order sets remind providers to address symptoms common in patients at the end of life, including pain, delirium, respiratory distress, nausea, and complex wound care, and to discontinue unnecessary labs, artificial nutrition, vital signs, and cardiac monitoring, and equipment such as defibrillators and pacemakers.

Key Points

- Hospice emphasizes quality, not quantity, of life in patients whose life expectancy is six months or less.
- GIP hospice is appropriate for patients who have a life expectancy of hours to days with care that cannot be delivered at home.
- Creation of an inpatient, comfort-care, order set can help providers determine appropriate treatment options as well as interventions which may be appropriate to stop.

Setting up a GIP hospice program

Creating our GIP hospice program began with partnering with a hospice agency known for its ethical process, quality of care, and established leadership. At the same time, our hospital also agreed to provide ongoing support for a palliative-medicine fellowship that includes a hospice experience.

The hospice agency assigns RNHLs and social workers to our medical center seven days a week to work alongside clinical teams and to ensure appropriate and timely referrals. Hospice RNHLs can access the electronic health record (EHR) and can contact frontline providers using



Dr. Frederick



Ms. Smith



Ms. McSpadden



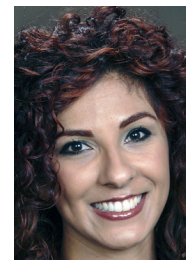
Dr. Childers



Dr. Huang



Dr. Ally



Ms. Akhondzadeh



Ms. Dolopo-Simon



Dr. Clay

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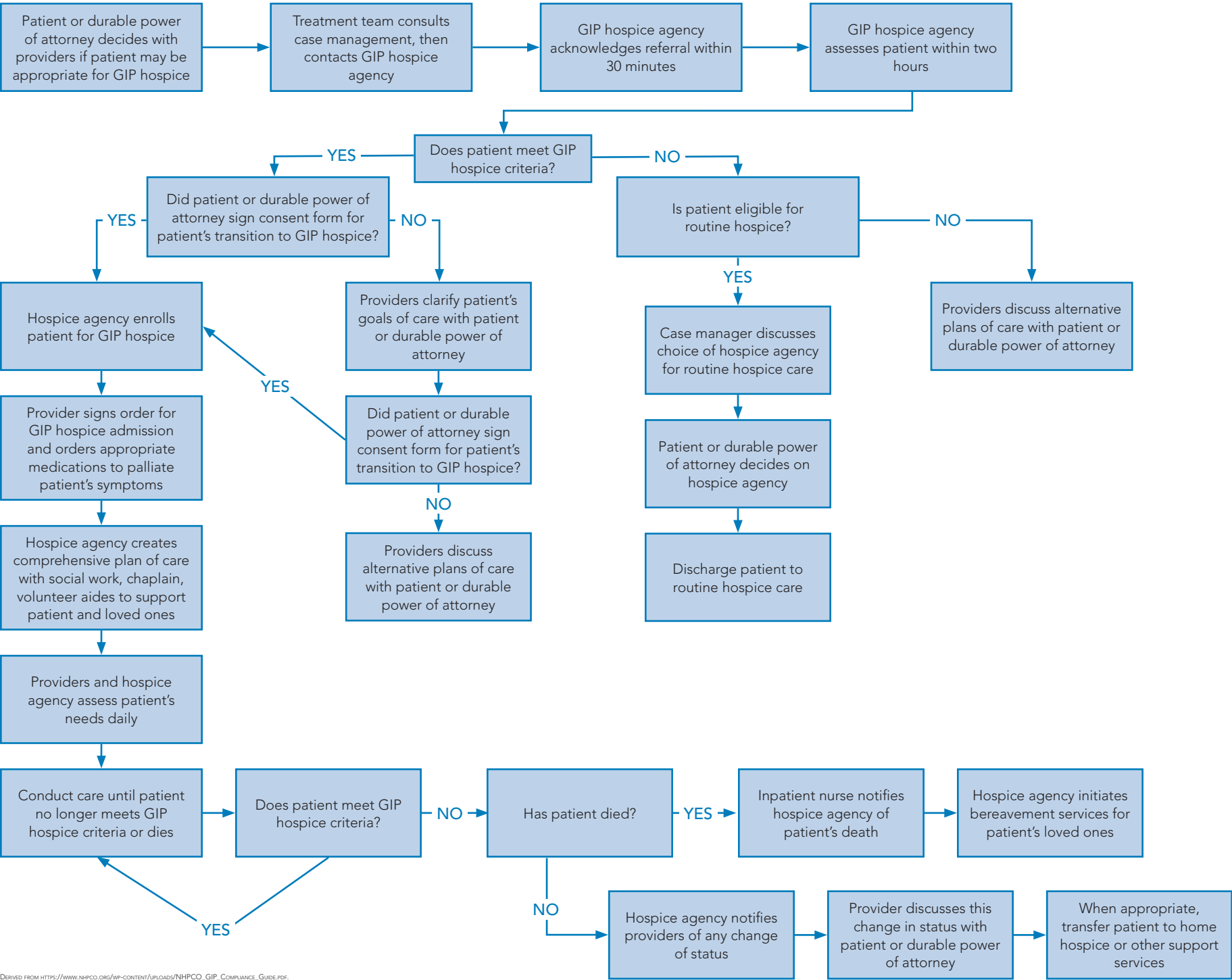
EHR-based secure messaging.

Ongoing training for physicians, residents, advanced practice providers, nurses, and medical students across multiple service lines allows maintenance of this knowledge and provides an opportunity for feedback. This successful collaborative effort has been sustained for six years.

Outcomes and future directions

Our 86-year-old female with metastatic pancreatic cancer transitioned to GIP hospice. She was moved to a private room once one was

FIGURE 1: GIP Hospice Process at UCSD Health System



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available, transitioned to a hydromorphone drip, and was visited by the chaplain. Per family request, all labs were discontinued, cardiac monitoring was stopped, and vital sign measurements were minimized. She passed comfortably three days later.

Since the integration of GIP hospice into our health system six years ago, we have noted several positive results, including:

- A 30% increase in placement of appropriate patients into GIP hospice from 2021 to 2022, followed by a further 10.5% increase in appropriate GIP placements from 2022 to 2023.
- Earlier and more regular discussions on goals of care and advance care planning during each patient-care journey. Our hospital added an “advance care planning” note type in our EHR.
- A reduction in length of stay from time of hospice consult to discharge home.








Future directions for our hospice collaboration include continuing education about GIP hospice to all clinical specialties in our health system, a proposal to lease hospice beds from a local skilled nursing facility for patients stable for hospital discharge but unable to go home, and development of a rapid escalation pathway for liaisons and clinicians to respond to sudden clinical changes in GIP hospice patients.

Bottom line

Creating a GIP hospice workflow with an ethical, collaborative, and trustworthy partner hos-

FIGURE 2: Indications for GIP Hospice Care

INDICATIONS FOR GIP HOSPICE CARE

	Pain or symptom crisis requiring frequent medication adjustments and monitoring
	Intractable nausea/vomiting
	Advanced open wounds requiring frequent dressing changes and close monitoring
	Unmanageable respiratory distress
	Delirium with behavior issues
	Sudden decline necessitating intensive nursing intervention
	Imminent death with concurrent pain or other symptoms requiring skilled nursing

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pice agency has allowed our health system to manage terminally ill patients proactively and reduce associated costs (e.g., re-hospitalizations and emergency department use), while also providing patients with a higher quality of life and a greater sense of dignity at the end of life. ■

Quiz:

1. Which of the following symptoms may be managed by GIP hospice?

- a. Uncontrolled pain
- b. Delirium
- c. Respiratory distress
- d. Intractable nausea
- e. Complex wound care
- f. All of the above

Correct option: F—all of the above. Indications for GIP hospice can include any, or a combination, of these symptoms in patients whose life expectancy is hours to days and whose care cannot be delivered in a setting other than an inpatient setting.

2. Transition to GIP hospice requires consent by the patient or their agent under a durable power of attorney.

- a. True
- b. False

Correct option: A—true. If a patient meets the criteria for GIP hospice care and the patient or their durable power of attorney agent agree to transition care to GIP hospice care, then the registered nurse hospice liaison requests a signed consent from the patient or their durable power of attorney agent to provide inpatient hospice services.

Budgeting Tips

Advice for keeping your division's finances on track

By Karen Appold

For a hospitalist, managing a budget shouldn't be that much different than maintaining a household budget. "Ideally, you should know approximately how much income you'll generate and how much you expect to spend on a monthly or quarterly basis, and these numbers need to roughly match up," said Daniel J. Brotman, MD, FACP, MHM, director of the division of hospital medicine at Johns Hopkins Hospital, an urban academic medical center with more than 1,000 beds at Johns Hopkins University in Baltimore.



Dr. Brotman

Most commonly, a hospital-medicine group leader who makes staffing decisions and creates staffing models may need to understand how to manage a budget, said Joanna M. Bonsall, (@BonsallJoanna), MD, PhD, SFHM, associate professor of medicine at Emory University School of Medicine in Atlanta and chief of hospital medicine at Grady Memorial Hospital in Atlanta, an urban hospital with about 700 beds.



Dr. Bonsall

Other hospitalists may also benefit from understanding how budgeting decisions are made, such as a hospitalist who would like to propose a new service line or ask for administrative time, Dr. Bonsall continued.

To prepare for a position that requires budget management, take courses or seminars to understand how hospital financing works overall. When taking on a budgeting role, "Ask your business manager or finance team to explain the different budget categories and how funds flow," Dr. Bonsall said. "Have them walk you through their budget sheets so you can understand how everything fits, and so you can see what they see." Hospitalists in junior leadership positions may find it worthwhile to attend annual budget negotiation discussions if permitted.

When you're in a position that requires budgeting, ask someone talented and trained in finance to advise you. "An administrator reviews my budget every month to ensure that revenues and expenses line up with expectations," Dr. Brotman said.

Using data to achieve goals

A budget is comprised of data. People who manage budgets generally use these data to create spreadsheets and to make calculations and predictions about what their revenues and expenses will look like, Dr. Brotman said.

Track all of the metrics that are important to a hospital group or C-suite, Dr. Bonsall advised. Understand what costs are assigned to each metric, such as how much an average patient stay costs the hospital per day. What are your census and admissions trends, and is there variation over time? Having and understanding the data you need can help you make the business case for what you need to ask for.

You can use data to help make the case for additional funding requests, Dr. Bonsall said. For example, if there's a new project you would like to implement that will reduce patients' length of stay, understanding those costs can help you justify the return on investment.

Hospital-medicine group leaders should also be aware of national and regional data trends such as staffing volumes and salaries, said Dr. Bonsall, which is important to share when negotiating on your group's behalf.

Understanding your budget can help you prioritize too; you can shift funds to different categories as needs arise. Understanding budget limits can help you understand what problems you can or can't solve using additional funding, Dr. Bonsall said.

Increasing revenue

Three ways to balance a budget are to increase revenue, decrease expenses, and know when to ask for help. Dr. Brotman recommended using operational data to identify ways to increase revenue. For instance, you can find additional billing opportunities (e.g., identify practitioners who might be systematically underbilling for certain types of services), or use data to generate a business case for more hospital support (e.g., proving the value of a triage service that has limited billing revenue).

You can identify places to save money by changing staffing models. If you pay moonlighters to cover a service at night, for example, you might save money by hiring a nocturnist (even at a salary substantially above what is paid to daytime providers), Dr. Brotman said.

Finally, data, when shared with a team, can be helpful to align incentives. For example, if you have

a bonus program, you may be able to reward practitioners financially for helping the program to meet its budgetary goals through billing optimization or by enhancing hospital payments to your program via shared savings arrangements, Dr. Brotman said.

Keeping costs down

To balance a budget, keeping expenses down may be necessary. Because personnel are almost always the biggest line item for any budget, you may need to start there, Dr. Brotman said—ideally via natural attrition rather than eliminating staff.

In particular, Dr. Bonsall advised evaluating staffing efficiency to keep costs down. For example, compare census and admissions flow with your staffing model, and make sure you're optimizing staff usage.

Are there days when the admissions flow is lighter, or the census is lower? If so, could those be opportunities to downstaff? Are there certain hours of the day when work is heavier or lighter? Be careful though—don't schedule staff too tightly to the census because you'll need to be able to handle routine fluctuations in volume, Dr. Bonsall cautioned.

Another way to lower staffing costs is to figure out if any employees could spread their time across multiple groups, Dr. Brotman said. For example, could a staff person in your academic hospitalist group who provides research support also assist another division with their projects, so their salary is split among divisions?

Be careful when cutting costs, however. "When feasible, ask your hospitalist group for their input on budgetary decisions," Dr. Brotman advised. "Most people are used to managing their own budgets at home and are accustomed to having some discretion over how they manage their budgets."

For example, it may be tempting to eliminate unnecessary expenses such as bi-weekly faculty luncheons. But this can be demoralizing to members. So, consider getting group feedback on what cuts may be the most palatable. Maybe staff would be agreeable to having lunch served at every other meeting, using a cheaper caterer, and skipping dessert, to save money, Dr. Brotman said. If you do need to make cuts on items that may impact well-being, explain the reasoning, and give as much warning as possible so the decisions do not feel arbitrary or capricious.

Challenges in managing budgets

Different people look at budgets in different ways. When working with your finance team or business manager, keep in mind that hospitalists have an intuitive understanding of clinical staffing that non-physicians may not have.

For example, when looking at full-time equivalents (FTEs), who is included? Is administrative time accounted for? Do you work with dollars or FTEs? As an example, Dr. Bonsall has a moonlighting budget that is in dollars, but she has to think of shifts by the number of FTEs needed to fill them. She makes sure she aligns her FTE counts with the dollars required to pay moonlighters when necessary.

Another challenge can stem from the fact that budget cycles frequently don't align with staffing cycles. "You often have to plan months to years ahead, to ensure that you have the increases available when you need them," Dr. Bonsall said. She keeps her own spreadsheet with different categories to track subcategories and staffing details.

When you have a projected shortfall, tell stakeholders (such as hospital or departmental leadership) right away, and don't sugarcoat it. "Open communication is key," Dr. Brotman said. "You don't want to give them any surprises at the end of the fiscal year."

Ultimately, you will have to make tough choices. "You can't always give everyone what they want or deserve, but you should recognize when financial choices impact your colleagues and explain your decisions. People are your most valuable resource, and they deserve open communication," Dr. Brotman said.

Final thoughts

Maintaining a balanced budget can reap benefits beyond your expectations. "Developing a reputation as someone careful and good with finances can help with your future requests and negotiations," Dr. Bonsall said. "Money is often the common denominator in negotiations—if you understand the costs (and sometimes, cost savings), you can be a more effective negotiator." ■

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

To Niche or Not to Niche

Should you subspecialize your career in hospital medicine?

By Paula Skarda, MD, Ethan Molitch-Hou, MD, MPH, SFHM, Melissa Plesac, MD, and Laura Paletta-Hobbs, MD

Hospital medicine has experienced significant growth since its inception as a career within general internal medicine. Over the past 20 years, this expansion has created numerous opportunities for modern-day hospitalists. Historically, the hospitalist's role was to provide comprehensive care for hospitalized patients by leading daily clinical decision making, incorporating consultant expertise, and ensuring high-quality, low-cost care.

The diversity of jobs within the field has traditionally been driven by location and employer. A career in hospital medicine can be spent at large academic centers coordinating care for clinically complex patients or at small rural sites functioning as a safety-net physician, always learning and seeing something new.

The ongoing evolution of hospital medicine has added diversity to the field and has expanded into other domains of medicine. Subspecialty roles within general internal medicine have emerged as hospitalists have become experts in areas such as palliative care, peri-operative care, telemedicine, hospital at home, and procedural medicine. Specialized training outside of traditional fellowships has created opportunities for hospitalists to focus on specialty services such as neurology, hematology and oncology, and addiction medicine.

Today, there are numerous opportunities when entering the field, leading many to wonder if there is one "correct path" that will lead to a long and prosperous career. Fortunately, there is no incorrect answer to this question. The decision to begin a career as a general hospitalist or pursue a specialized niche within hospital medicine is a personal one. A bit of thoughtful introspection of professional values and personal needs can create an interesting and fulfilling career.

Being a generalist

When people think of a hospitalist, they first picture a generalist: the physician in charge of a patient's care from admission to discharge. Hospitalists play a critical role for those requiring inpatient care. As the first internist to receive a patient on admission, they are responsible for the initial diagnostic workup and management of a patient's medical concerns, often

seeing new conditions or unique presentations of common complaints.

Because hospitalists are the primary clinicians for patients who are acutely ill in times of crisis and stress, they can develop strong and intentional relationships with patients and their families. The variety of presentations and diagnoses encountered maintains their broad knowledge base acquired during residency and facilitates opportunities to add to their clinical knowledge. Additionally, hospitalists form collegial relationships with medical and surgical subspecialists, sharing knowledge and patient care decisions in a way that promotes lifelong learning and allows hospitalists to provide current evidence-based care when faced with new clinical dilemmas; these relationships can lead to improved job satisfaction.

Staying generalized allows hospitalists many opportunities to advance in their careers. As experts in inpatient medicine, they are likely to gain leadership roles within the hospital, whether in patient care, teaching, or administration. Hospitalists interact with all health care team members and have a nuanced understanding of the flow of inpatient clinical care, making them effective and collaborative unit medical directors. They are highly skilled clinicians and are the perfect candidates to work on inpatient teaching services leading to opportunities to further develop teaching skills and advance in medical education and academics. As frontline clinicians, hospitalists have a particular understanding of the challenges that affect practitioners every day. They can provide unique perspectives to the administration about key components of the health care system, including the electronic health record, compensation plans, and system processes and policies.

Subspecializing in hospital medicine

For some hospitalists, finding a niche in hospital medicine can be an effective strategy to help build a long-term, fulfilling career. While being a hospitalist is a subspecialty in itself with expertise in inpatient medicine and transitions of care, the scope of practice remains quite general, which precludes extensive depth of knowledge in any particular clinical domain.

Hospitalists may elect to defer to subspecialists when elements go beyond their clinical expertise, which can impact their sense of worth and increase anxiety and burnout. The pursuit and devel-



Dr. Skarda



Dr. Molitch-Hou



Dr. Plesac



Dr. Paletta-Hobbs

Dr. Skarda is a hospitalist, primary care internal medicine physician, and chair of the hospital credentials committee at HealthPartners in Regions Hospital in Saint Paul, Minn.; she's also an associate program director for the University of Minnesota internal medicine residency program. Dr. Molitch-Hou (@EthanMH3) is an assistant professor, the director of hospital medicine sub-intern rotation, core faculty for the internal medicine residency program, and co-director of the Care Transition Clinic at the University of Chicago Medical Center in Chicago. Dr. Plesac (@MelissaPlesacMD) is a hospitalist at MHealth Fairview University of Minnesota Medical Center in Minneapolis, and an associate program director for the University of Minnesota internal medicine residency program. Dr. Paletta-Hobbs is an academic hospitalist and an associate professor of internal medicine at Virginia Commonwealth University in Richmond, Va.

The beauty of a career in hospital medicine lies in its dynamic and flexible career path. Whether you choose to specialize or remain general, there are many opportunities for a fulfilling and sustainable career. As the field continues to evolve, there will always be new chances to change course and grow.

opment of a niche within hospital medicine further refines a particular skill set. Subspecializing allows hospitalists to become subject leaders, promoting a sense of personal and professional value. Development of specific skills can also positively affect clinical confidence: hospitalists can serve as their own consultants as experts in opioid withdrawal treatments, anticoagulation, or inpatient diabetes management. Hospitalists who specialize in a specific area can become valuable colleagues, leaders, and mentors in their field.

Having a specialty can be a defining feature in a career trajectory. It can lead to academic and clinical promotion and make you a more competitive candidate when changing jobs. Developing expertise in a specific niche can also increase job satisfaction by allowing you to integrate personal interests into your work and improve your work-life balance.

Subspecialty knowledge is particularly useful for academic pro-

motion, as it demonstrates a path toward expertise and can help fulfill specific criteria. Additionally, subspecializing can be advantageous for clinical promotion and competitiveness for leadership positions in quality improvement, information technology, education, or administration.

When determining which niche to pursue, consider your passions and career goals. Falling into a niche due to an opportunity can be helpful, but it's important to make sure it aligns with your long-term aspirations. Developing a specific niche within hospital medicine can create an array of clinical and non-clinical service options that total a full-time position and increase the variability of the day-to-day. This allows hospitalists to combine different areas of interest into their everyday work, which can bring joy and purpose and mitigate burnout. Having a niche can also allow for roles that improve work-life balance such as an integration of telemedicine to allow working from home, a procedure service that allows for consistent hours, or a discharge clinic that has weekends free. Fortunately, hospital medicine careers are flexible, and subspecialties can change when new opportunities arise or when interests shift.

Conclusion

The beauty of a career in hospital medicine lies in its dynamic and flexible career path. Whether you choose to specialize or remain general, there are many opportunities for a fulfilling and sustainable career. As the field continues to evolve, there will always be new chances to change course and grow. ■



SIG Spotlight: Health IT

Helping hospitalists understand and best use tech for patient care

By Richard Quinn

The world of 2024 isn't your grandfather's health information technology (IT). Heck, it's not even the world that existed when the first iPhone debuted in 2007.

The breakneck pace of health IT in the past decade-plus—from electronic health records (EHR) to telemedicine to ChatGPT and beyond—makes keeping abreast of the latest best practices a challenge.

Say hello to the Health IT Special Interest Group at SHM. Launched in 2018 as one of the original SHM committees to transition to a SIG, the group has 564 members focused on navigating the ever-evolving landscape.

"This is day-to-day work that hospitalists come across, starting from the EHR or the data or clinical decision support," said SIG chair Mihir Patel, MD, MPH, FACP, CLHM, SFHM. "Whichever way you look, this is important. This SIG is providing a platform for hospital medicine professionals to share knowledge and best practices."

Dr. Patel is the medical director of virtual medicine at Ballad Health in eastern Tennessee, as



Dr. Patel

well as chair of the health system's inpatient clinical informatics council. He's also still a practicing hospitalist. Said another way, he sits at the nexus of doing the daily work that the technology aims to make easier.

Dr. Patel says the SIG provides a forum to figure out what works best—from the people who figured out what works best.

"We come across a lot of different scenarios that one hospitalist is doing the same thing using this workflow, which another hospitalist is doing the same thing using a different workflow," he said. "So, we can understand who is more efficient, and the differences there. That basically sparks this conversation of 'What can we do apart from just lobbying our administration to get the better EHR? What are the common practices that we can adopt, hospital medicine-wide, that can at least help the efficiency and decrease the burnout of the hospitalists?'"

Dr. Patel notes that it's important to focus not just on having or implementing technology, but to work them intuitively into daily workflows. "How you can use some of the commonsense methodology to improve the efficiency of patient care and quality," he said.

That challenge has become more paramount in the years since the COVID-19 pandemic. Rising rates of burnout are a major concern for hospitalists and health care systems nationally, despite technology like virtual medicine that

ostensibly exists to reduce burdens and pressures.

"The rising burnout among health care professionals is due not only to the increased patient load but also because this increase comes with a variation in workflows and resources, requiring them to manage different digital tools, including the various electronic health record systems," Dr. Patel said. "Basically, how you can survive as a health care professional is a lot dependent on how you are informed, and using your time and resources, and that's the digital health resources, including the EHR, in the right way."

Put another way, Dr. Patel estimates that maybe more than 40% of a hospitalist's day—as well as other practitioners—is spent in front of a computer. That number only goes up for hospitalists who are providing telemedicine services outside their geographic area.

"And if you don't know how to use that technology properly, I think that patient care is not going to burn you out, but how to get into the data, how to access data, how to manage the data, and how to get the right care out of that data" will, he said. "I would say it is most important to understand how to tackle that through all these different silos of the EHRs or our daily digital tools."

Dr. Patel points to interoperability issues, user interfaces, and training modules as potential hurdles to the most efficient use of

technology.

"For the past two decades, patient care methods have evolved significantly from traditional pen and paper approaches to more advanced systems," he said. "Today, if these modern systems fail, it becomes nearly impossible to provide patient care effectively. Without functioning systems, medical practitioners can't prescribe medications, and even if they manage to do so, nurses struggle to access these prescriptions from their digital medication dispensing systems. Furthermore, discharging a patient becomes a challenge, as it typically requires digital orders and prescriptions. This shift to digital formats has become integral to contemporary health care practices."

Dr. Patel says the SIG's webinars, relationship networks, events, and white papers offer opportunities for hospitalists at any technological level to participate.

"It's not just about the technology, how it helps the daily work life," he said. "The key factor lies in how you adopt technology, comprehend its functions, and correctly implement it in alignment with the workflow. This aspect is crucial. While new technologies will continually emerge, their improper implementation can result in increased burnout instead of being beneficial." ■

Richard Quinn is a freelance writer in New Jersey.



Chapter Spotlight: Hampton Roads

Meeting members where they are with what they want

By Richard Quinn

The Hampton Roads chapter of SHM in southeastern Virginia was long run by Dr. Thom Miller, so a few years ago when he recruited Gwendolyn Williams, (@Gwenthe-Doctor), MD, FHM, as his successor, she felt she had big shoes to fill.

Well, in her first year, the chapter won a 2022 Platinum Excellence Award and a District 4 Shining Star Award. And she personally won the Unsung Hero Award (for which her board nominated her behind her back).

“You feel this sense of honor and pride,” Dr. Williams said. “You should feel a sense of honor and pride when you take over. You want to make it greater and more amazing. And you want to make that person proud, make your chapter proud. And I feel a lot of integrity in the position I have in the Society of Hospital Medicine through our chapter.”

To Dr. Williams, who is president of the medical executive committee at Sentara Careplex Hospital in Hampton, Va., what the personal and professional awards highlight is more important than the act of winning them.

“What it shows is that we brought our perspective to be im-



Dr. Williams

mensely inclusive,” she said. “People come to our events because we don’t just have one type of event, right? We may have a lecture ... but when the chapter officer and advisory board meet, we brainstorm the array of what everybody wants to see. We may not reach it all, but if somebody is interested in diversity, equity, and inclusion, we should foster that. We should cultivate that interest. If somebody is interested in updates on congestive heart failure or opioid management we bring these topics to life with engaging speakers for our members.

“What other updates are people interested in? When we have speakers who have something important to say, and we have topics that speak to our entire chapter, we bring together members, prospective members, and people we call “friends of our chapter,” and everyone is welcome. That’s really the big takeaway and exactly the reason I stayed with this chapter for so long, is that it’s a place where I feel like I truly belong, and I can be my most authentic and genuine self. And if I can make other people feel they belong somewhere, in the vast insanity that is health care, and they are accepted and celebrated for who they are, then that is a big accomplishment.”

Dr. Williams finds it so important to provide the most targeted services possible to her chapter that she wants to launch another one. The Hampton Roads organization serves a wide geographic

swath that includes large cities like Virginia Beach and Norfolk, but also the state capital of Richmond, some 90 minutes north. But since the bulk of the members are outside the capital region, Dr. Williams wants to start a Richmond outpost to better—and more closely—serve them with local leaders.

“When you’re not there all the time, it’s hard to engage people,” she said. So “we’ve been trying to help them get off the ground. We need to, because then we can collaborate and do things together.”

Meeting folks where they are, collaborating with them, and making them feel included are themes Dr. Williams preaches—and practices.

“When we as a group are meeting someone where they are, you’re honoring and respecting where they are in their life’s journey,” she said. “Not where you want them to be. So, when we’re approaching someone, I want them to be part of our group. I want everyone to be part of our group. Not because I want something out of that, but because I want what they want for themselves. And when you do that, you’re practicing compassion for another human being, you’re practicing empathy and acknowledging our shared humanity.”

For 2024, Dr. Williams and the Hampton Roads chapter are even codifying the approach. The group is launching a quarterly well-being awareness series dubbed “Reset, Refresh, and Recharge” that immerses members and their families in activities. The idea is to do more

than webinars and didactic lectures on the importance of staving off burnout.

“Well-being is extremely important to our entire chapter,” Dr. Williams said. “Working in health care takes a lot of personal sacrifices, so if we can provide a forum where someone can bring their family or loved ones to an event, then they don’t have to choose. They can participate in chapter activities and still spend time with their loved ones, and it’s a win for everyone—a great way to nourish human connections.”

Befitting an award-winning chapter, the activities for 2024 don’t stop there.

“We’re looking beyond the clinical,” Dr. Williams said. “We’re looking to bring in people to talk about health policy. There is a humanitarian crisis happening in the world right now ... how can we help people who we can’t physically reach, but we care deeply and want to save lives and ameliorate suffering beyond Hampton Roads? How do we train our people to do proper advocacy locally, nationally, and internationally? How do we teach our members about trauma-informed care? How do we continue to discuss moral injury in hospital medicine and frontline workers and create meaningful change for us and the next generation?”

And with that, it seems like Dr. Miller’s shoes have been filled just fine. ■

Richard Quinn is a freelance writer in New Jersey.

Clinical Update: RSV Vaccines for Adults

What hospitalists need to know

By **Conor Kelly, DO, PharmD,**
and **Lauren Spaeth, DO**

Respiratory syncytial virus (RSV) is a common seasonal virus that can cause serious illness in children and adults alike. It was first isolated in a group of chimpanzees in 1956 and was originally known as the chimpanzee coryza agent (CCA). Soon after, in 1957, it was noted to infect the human respiratory syncytium and would be eventually renamed RSV. Since its initial discovery, considerable effort has been placed into better understanding the virus and finding a way to prevent its most severe manifestations.¹

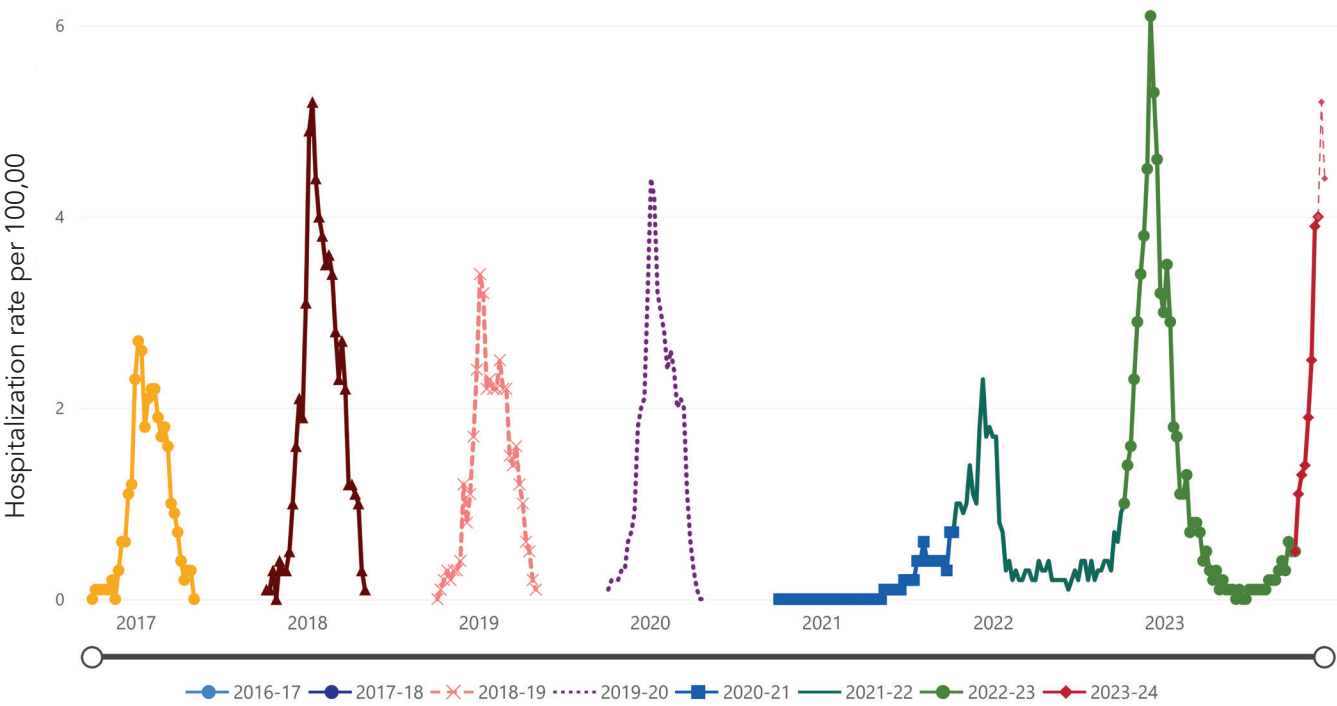
When considering RSV, most will likely think of its infectious syndrome in infants. This is for good reason, as 58,000 to 80,000 children in the U.S. (3.4 million children globally) who are under 5 years of age will be hospitalized due to RSV-associated bronchiolitis or pneumonia every year. It is so prevalent among children that nearly every child will have contracted RSV before 2 years of age.

However, what is often overlooked is severe RSV infections among adults. The Centers for Disease Control and Prevention (CDC) estimates that 60,000-160,000 U.S. adults over the age of 60 will contract RSV. Further estimates show that 6,000-10,000 of those infections will be fatal. The CDC warns that those with high-risk conditions—chronic lung or kidney disease, cardiovascular or cerebrovascular disease, diabetes mellitus—or those who are immunocompromised, adults living in long-term care facilities, frail adults, or those over the age of 75 should take special precautions to avoid RSV infection.

These warnings appear timelier than ever. With most COVID-19-related infection prevention recommendations and requirements now lifted, a resurgence of many viral illnesses has been observed. RSV was certainly no exception as the 2022-2023 RSV season recorded the highest number of hospitalizations for older adults due to RSV since the CDC began tracking this data in 2017,2,3 (Figure 1)

Soon after the discovery of RSV, attempts to create a suitable vaccine began. Initial attempts proved difficult and early vaccine candidates through the 1960s showed that infants who received the initial vaccines went on to have more severe natural RSV infection. This idea of vaccine-induced enhanced disease served as a warning to future researchers which delayed progress. However, efforts again

FIGURE 1: Rates of RSV-Associated Hospitalization for Adults ≥ Age 65, all seasons



SOURCE: RSV-NET, CENTERS FOR DISEASE CONTROL AND PREVENTION. (2023, OCTOBER 25).³

picked up in the 1990s and 2000s, and dozens of new candidates would be studied. Much to the credit of this renewed effort, commercially available RSV vaccines are now available in the U.S. with more in late-stage development.^{4,5,6}

New vaccines

New vaccines in the U.S. are subject to several agencies. The two most important are the U.S. Food and Drug Administration (FDA) and the Advisory Committee on Immunization Practices (ACIP). The FDA evaluates the safety, efficacy, and manufacturing of vaccines and has the final say on approval of vaccines for use in the general population based on this data. Once approved by the FDA, the ACIP will review vaccine- and disease-specific data to provide recommendations on which population to provide the vaccine to. In May of 2023, the FDA approved two new vaccines for the prevention of RSV (Arexvy and Abrysvo). This was followed in June of 2023 by the ACIP which voted to recommend these RSV vaccines to all adults aged 60 years and older using a shared-decision-making model. Those who should be given special consideration are adults with chronic medical conditions or clinical situations already mentioned.

Efficacy

Although both vaccines have data showing efficacy for preventing RSV lower respiratory tract disease (RSV-LRTD), it should be noted that both phase III trials in older adults are ongoing. Arexvy was evaluated against placebo across two RSV seasons (2021-2023)

and this comparison is planned to continue through one more season (2023-2024). Over its first two seasons, a single dose of Arexvy showed efficacy against RSV-LRTD of 82.6% (96.95% CI, 57.9%–94.1%) during the first season and 56.1% (95% CI, 28.2%–74.4%) during the second season. Though not fully powered for this sub-analysis, when patients with one or more pre-existing high-risk comorbidities were analyzed as a subgroup, the efficacy against RSV-LRTD increased to 94.6% (95% CI, 65.9%–99.9%) over the first season and 74.5% (95% CI, 55.7%–86.1%) through the second season.^{7,8}

Abrysvo was approved based on data from an interim 1.5-season analysis in the RENOIR phase III placebo-controlled trial. The RENOIR study was also started during the 2021-2022 season and is planned to run for two complete RSV seasons in the Northern and Southern hemispheres. In the interim analysis, a single dose of Abrysvo was found efficacious against RSV-LRTD with two or more symptoms in 66.7% (96.66% CI, 28.8%–85.8%) over the first season. When stratified for RSV-LRTD with three or more symptoms (used as a marker for more severe disease in this study) it was found to have efficacy of 88.9% (95% CI, 53.6%–98.7%) during the first RSV season and 78.6% (95% CI, 23.2%–96.1%) during the mid-point of the second season.^{7,8}

Safety

Arexvy and Abrysvo had mostly predictable safety profiles with the highest rates of adverse events of injection site pain (61% and 41%), fatigue (34% and 46%), myalgia (29% and 27%), headache



Dr. Kelly Dr. Spaeth

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(27% and 31%), and fever (2% and 3%).^{9,10} There was no statistically significant difference in severe adverse events when each was compared to placebo. In the Arexvy study, 10 patients in the treatment arm did develop atrial fibrillation compared to only four in the placebo group. There were additionally two cases of disseminated encephalomyelitis (ADEM) and one case of Guillain-Barre syndrome (GBS). The two cases of ADEM were diagnosed clinically and were not confirmed with diagnostic imaging, CSF studies, or nerve conduction studies. One of the two cases was fatal, though the diagnosis was later revised to hypoglycemia and dementia. The FDA is requiring a post-market study to assess the risks of GBS and ADEM while the manufacturer is conducting a voluntary post-market study on atrial fibrillation rates. In the Abrysvo study, one patient in the study arm developed GBS, one developed Miller Fisher syndrome, and one developed a hyperreactivity reaction. The FDA is requiring a

post-market study to assess for GBS.^{7,11}

Co-administration with influenza vaccines was assessed in each study and was determined to be safe with all available influenza vaccines. Higher rates of fatigue, headache, and arthralgias can be expected if a co-administration strategy is used.

Timing

The AICP has not yet identified the ideal time to provide either vaccine. RSV historically peaks in the winter months between December and January. However, the 2022-2023 season peaked earlier than expected in late November to early December. Based on initial data for both studies, vaccine efficacy is thought to peak around two months after administration. Given the best initial estimates, the ideal time to administer the vaccine would be between July and October, though recommendations may vary per year. Based on ACIP estimates using projection

models, there does appear to be vaccine efficacy waning that occurs starting at two months after the first Arexvy dose and seven months after the initial Abrysvo dose with no residual protection presumed after 12 and 24 months respectively. Ongoing data will assist with the correct time to dose the vaccine and if re-dosing will be necessary.^{8,11}

Additional information

On August 2, 2023, the manufacturer of Arexvy filed patent infringement against the manufacturer of Abrysvo. It is unclear how ongoing litigation between these companies will affect the availability of the vaccines.

On August 21, 2023, the FDA approved Abrysvo for use in pregnant individuals between 32 and 36 weeks of gestation for protection of the infant from RSV-LRTD through the first six months after birth. Vaccine efficacy in preventing severe RSV-LRTI in infants was 91.1% within 90 days of birth and

76.5% after 180 days after birth. The ACIP voted to recommend a single dose of the Abrysvo for the same population on September 22, 2023 but stated that vaccines should be targeted based on seasonal trends of RSV. It was noted that there was an increased number of (though not statistically significant) preterm births in low to middle-income countries. The FDA concluded that when given between 32 and 36 weeks of gestation, the potential benefits outweighed the risk. Soon after, the American College of Obstetricians and Gynecologists (ACOG) released a statement of support for the use of the RSV vaccine.^{12,13}

An additional late-stage RSV vaccine is being evaluated for approval after the publication of positive results in the ConquerRSV phase III trial. In contrast to the two above vaccines, this vaccine is an mRNA-based vaccine with a vaccine efficacy of 83.7% (95.88% CI, 66.1%-92.2%) in preventing RSV-LRTD with two or more symptoms.¹⁴

Ongoing studies are evaluating

the RSV vaccine in adults aged 50 to 59 and in infants, though no current approval or indication is given to existing vaccines.^{12,13} ■

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