



Dr. Thomas - musician



Dr. Wray - cyclist



Dr. Massart - baker



Dr. Rafiq - motivator



Dr. Mandal - runner

## Celebrating the people, not just the profession, this National Hospitalist Day



Dr. Airan-Javia - potter



Dr. Readlynn - painter



Dr. Tagaram - musician



Dr. D'Mello - musician

### IN THE LITERATURE

## Med-lit reviews

The Ohio State  
University Wexner  
Medical Center

### QUALITY

## VTE prophylaxis

Drs. Bruti, Cerasale,  
and Mandal demystify  
this quality process  
measure

VISIT US  
ONLINE FOR  
EXCLUSIVE  
CONTENT



IN THE NEXT ISSUE...

PFACs, Coding Corner,  
QI pearls, and more



HM Voices National Hospitalist Day Contest

The second annual HM Voices National Hospitalist Day Contest is now accepting submissions. HM Voices is *The Hospitalist's* online section where SHM members can unleash their creativity. We showcase creative writing—In Your Words (poetry, essays, etc.) or creative visuals—In Your Eyes (photos, art, digital creations).

In recognition of National Hospitalist Day, the contest theme is Celebrating the Human in Hospitalist. What makes you you? What do you do outside the hospital? Show us through creative visuals or tell us through creative writing.

Email your submissions to [lcasinger@wiley.com](mailto:lcasinger@wiley.com). The deadline is March 31. The top three winners will be published in an upcoming issue of *The Hospitalist*, and all submissions will be published online.

Tell Congress to Support the Improving Seniors’ Timely Access to Care Act

On January 17th, 2024, the Centers for Medicare and Medicaid Services issued a final rule on prior authorization. This rule finalizes time requirements in which Medicare Advantage plans are required to respond to prior authorization requests. However, this rule is just a first step. The lack of consistency in the policies and excessive administrative burdens associated with many Medicare Advantage plans waste time and resources that could be better used in providing direct care to patients.

While this rule will begin to address the problems with prior authorization, Congressional action is still needed to ensure patients get the care they need—when they need it.

SHM supports the Improving Seniors’ Timely Access to Care Act. This legislation will help protect patients from unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program. This legislation will help improve the efficiency, transparency, and accountability of the prior authorization process in Medicare Advantage plans.

You can help by contacting your U.S. senators and representatives and letting them know you support this important legislation (<https://www.hospitalmedicine.org/policy--advocacy/take-action/>).

Earn CME and MOC with Spark 3

SHM’s third edition of Spark brings you the latest updates in hospital medicine to help you feel confident about your recertification. Created by hospitalists, for

hospitalists, Spark Edition 3 has 400 vignette-style multiple-choice questions and updated topics from previous editions. This online or iOS app-based tool allows you to work at your own pace, review detailed learning objectives, build your own practice tests, and define individual areas of strength and weakness.

Spark Edition 3 covers the following topics:

- Allergy, Immunology, Dermatology, Rheumatology (AIDR)
- Cardiology
- Endocrinology
- Gastroenterology and Hepatology
- Hematology and Oncology
- Neurology
- Nephrology and Urology
- Quality, Safety, & Clinical Reasoning
- Palliative Care, Medical Ethics, and Decision-making
- Perioperative Medicine and Consultative Co-management
- Pulmonary Disease and Critical Care Medicine

Visit us online for more information <https://www.hospitalmedicine.org/professional-development/Spark-Edition3/>

JHM’s February Issue

The February issue of the *Journal of Hospital Medicine* includes original research on these topics:

- Short stay unit led by pediatric hospital medicine advanced practice providers
- “We’re all truly pulling in the exact same direction”: A qualitative study of attending and resident physician impressions of structured bedside interdisciplinary rounds
- Length of stay in the clinical wards in a hospital after introducing a multi-professional discharge team: An effectiveness improvement report

You’ll also find brief reports on the hourly variation in the average daily census on a hospital medicine service; how much magnesium sulfate is needed to keep total serum magnesium above 2.0 mg/dL; rates of diabetic ketoacidosis with empagliflozin use during hospitalization for acute heart failure; and more.

Scan the QR code for the February issue of the *Journal of Hospital Medicine*.



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SHM’S DIVERSITY AND INCLUSION STATEMENT

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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*The Hospitalist* is the official newspaper of the Society of Hospital Medicine, reporting on issues and trends in hospital medicine. The Hospitalist reaches more than 35,000 hospitalists, physician assistants, nurse practitioners, medical residents, and health care administrators interested in the practice and business of hospital medicine.

*The Hospitalist* (ISSN 1553-085X) is published monthly on behalf of the Society of Hospital Medicine by Wiley Periodicals LLC, 111 River Street, Hoboken, NJ 07030-5774. Postmaster: Send all address changes to The Hospitalist Wiley Periodicals LLC, c/o The Sheridan Press, PO Box 465, Hanover, PA, 17331. Printed in the United States by Sheridan of Ohio, Brimfield, OH.

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Join us for SHM Converge 2024, April 12-15 in San Diego

# SHM Converge 2024

The hospitalist experience you need!

**By Carrie Herzke, MD, MBA, FAAP, FACP, SFHM**

If you're anything like me, you need something to look forward to in the spring after the dark days of winter. Enter Converge 2024, in sunny San Diego, next month!

On behalf of the Annual Conference Committee, comprising academic and community physicians, advanced practice practitioners, and the SHM staff, we're excited to share highlights of the conference with you.

First, we are on the San Diego Harbor with an amazing view. However, we think you'll be so busy with three days packed with educational content, research competitions, speed mentoring, Special Interest Forums, exhibitors, and, new for 2024, the MED-TED teaching competition, that you may not have much time to take in the scenery. Don't worry though, you'll have plenty of time to reconnect with old friends and make new ones with our dedicated networking time at various locations throughout the conference. And if you do find time to take in the sites, check out Things to Do in San Diego on page 11.

## More clinical content than ever before

We've promised to continue adding clinical content, and this year, you will see more clinical content than ever before, including the return of favorites like "Things We Do For No Reason" and "Updates in Critical Care!" We encourage you to take in the scientific abstract competition and learn from our poster presenters, scan through the program,

pick those "must-attend" sessions (see what *The Hospitalist's* editorial board members recommend on page 9), and get engaged by attending a workshop. Also new are Late Breaking Sessions, spread throughout the conference, which will cover some of the most vital topics making the news and impacting our day-to-day practice.

## Announcing Parul Somani, this year's Converge keynote

We're very excited to welcome mindset expert Parul Somani as our keynote speaker for her session, "The Kinetic Life: Your Power to M.O.V.E. Through Change with Intention." During her keynote on Saturday, April 13, she will lead us through a practical, step-by-step guide to embracing change, making hard decisions, and thriving with intention—lessons we can all benefit from after the past few years.

## Focused on research or academic hospital medicine? We've got you covered!

For those interested in academics, we have our Academic and Research track planned by our Academic and Research Committees, which includes the popular Shark Tank session. We also have sessions on teamwork, workload, clinical reasoning, mentoring, and much more. For those of you in academic leadership, I hope you'll join us at the Academic Leadership Summit. This year, the focus will be on factors challenging hospitalists to remain academic and strategies to overcome them. Guaranteed networking!

## Come early for Advanced Learning Courses!

For those who want to focus on a particular topic, we offer three Advanced Learning Courses on April 12, the day before the main conference begins:

- Ultrasound (morning and afternoon sessions)
- Perioperative (back by popular demand!)
- Beyond the Bedside: Transforming Your Career

## Tips for first-timers at SHM Converge!

If you're a first-time attendee, we know the conference can be a lot to take in! We encourage you to check out Updates in Hospital Medicine, which is an annual tradition, featuring two speakers who whiz through a year of literature with humor and grace. I dare you not to chuckle and walk away with several takeaways that will impact your practice back home. We offer both a pediatric and an adult-medicine version. We also invite you to attend the new member and first-time attendee breakfast on Saturday, April 13, from 7 to 8 a.m.

## Are you excited yet?

Every year, we use your feedback as we plan the conference for the next year. For the past few years, your submissions—all 1,241!—have inspired most of the content at SHM Converge, like this year's new MED-TED Teaching Competition. Visit the Special Events page of the SHM Converge website at [shmconverge.org](http://shmconverge.org) to find out more about the competition, the Chapter Corner, Converge Central, and more!



Dr. Herzke

*Dr. Herzke is the chief medical officer and an associate professor in the department of medicine for the Medical University of South Carolina, in Charleston, S.C. She is also trained in pediatrics. Dr. Herzke is the course director for SHM Converge 2024 and faculty for the Academic Hospitalist Academy.*

All told, I suspect the biggest problem will be picking what you won't attend, as there is something for everyone—hospitalists, practice managers, and people who like hospitalists and/or want to be hospitalists!

If you haven't registered, what are you waiting for? Scan the QR code below for Converge details and registration information.

See you in San Diego this spring! ■





# The Ohio State University Wexner Medical Center Medical Research Reviews

By Jennifer Allen, MD, Vijay Duggirala, MD, FACP, FHM, Phillip Hamilton, MD, Brian Doyle, MD, Philicia Duncan, MD, FHM, Nathan O'Dorisio, MD, FHM, Lucas McKnight, MD, Matt Emery, MD, Ashley Fang, DO, FACP, Eric Schumacher, DO, MBA, FACP, SFHM, Angela Fielder, MD, Vignesh Doraiswamy, MD, Daniel McFarlane, MD, SFHM, Allison Rossetti, MD, FACP, Eric Nolan, MD, FHM, Kristen Lewis, MD, FHM, Jaimie Patel, MD, Chirag Patel, MD, Charles Redman, MD, and Claire Sevov, MD, FHM

*The Ohio State University Wexner Medical Center in Columbus, Ohio*

## IN THIS ISSUE

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By Jennifer Allen, MD, and Vijay Duggirala, MD, FACP, FHM

### 1 Time to rethink AF treatment: prolonged benefits of cryoballoon ablation

**CLINICAL QUESTION:** Does initial therapy with catheter cryoballoon ablation reduce progression to persistent atrial fibrillation (AF) in patients with symptomatic, paroxysmal AF when compared to antiarrhythmic therapy?

**BACKGROUND:** Atrial fibrillation can progress from a paroxysmal to a persistent form due to electrical and structural remodeling of the heart. The Early Aggressive Invasive Intervention for Atrial Fibrillation (Early-AF) trial concluded that initial treatment of symptomatic, paroxysmal AF with cryoballoon ablation resulted in lower recurrence of arrhythmias compared to antiarrhythmic drug therapy alone during one year of follow-up. However, it was unclear if catheter cryoballoon ablation reduced progression to persistent AF compared to antiarrhythmic therapy.

**STUDY DESIGN:** Multicenter, open-label, randomized trial with blinded end-point adjudication

**SETTING:** 18 centers in Canada

**SYNOPSIS:** Patients with symptomatic, paroxysmal AF were randomly assigned to rhythm control with either cryoballoon ablation (n=154) or antiarrhythmic drug therapy (n=149). All 303 patients had an implantable loop recorder placed. Crossover between groups was restricted and all patients received their assigned strategy before the primary endpoint event. Patients were followed for 36 months with the primary

endpoint being the first occurrence of persistent AF. Secondary outcomes included arrhythmia burden, quality of life, health care utilization (defined as emergency department visits), hospitalizations, cardioversion or non-protocol ablation, and serious adverse events defined as death, functional disability, or new or prolonged existing hospitalization.

After 36 months, three patients (1.9%) in the ablation group developed persistent AF compared to 11 patients (7.4%) in the antiarrhythmic drug group. Recurrent atrial tachyarrhythmia affected 87 patients (56.5%) in the ablation group and 115 patients (77.2%) in the antiarrhythmic drug group. The ablation group was associated with lower AF burden, improved quality of life, lower health care utilization, and less serious adverse events when compared to the antiarrhythmic drug group.

**BOTTOM LINE:** In treatment-naïve patients with symptomatic, paroxysmal atrial fibrillation, cryoballoon ablation should be utilized as an initial strategy to delay progression to persistent atrial fibrillation, as opposed to antiarrhythmic therapy.

**CITATION:** Andrade JG, et al. Progression of atrial fibrillation after cryoablation or drug therapy. *N Engl J Med.* 2023;388(2):105-16.

*Drs. Allen and Duggirala are clinical associate professors in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

By Phillip Hamilton, MD, and Brian Doyle, MD

### 2 Longer-term outcomes in critically ill patients with COVID-19 in the REMAP-CAP trial

**CLINICAL QUESTION:** What is the longer-term (180-day) mortality effect of common therapies on critically ill patients with COVID-19?

**BACKGROUND:** Most randomized clinical trials for patients with COVID-19 focus on short-term outcomes such as 28-day mortality or organ failure. Trials evaluating longer-term outcomes of therapeutic interventions are needed.

**STUDY DESIGN:** Randomized adaptive-platform trial

**SETTING:** International multicenter trial (197 sites in 14 countries)

**SYNOPSIS:** 4,869 critically ill patients were enrolled from March 2020 through June 2021. Patients were randomized to one of six treatment arms (immune modulation, convalescent plasma, antiplatelet [subdivided into aspirin, P2Y12 inhibitor, or no antiplatelet], therapeutic anticoagulation, antivirals, and corticosteroids). The primary outcome was 180-day mortality calculated with adjusted hazard ratios (aHR). Futility was defined as the probability there was not more than 20% relative improvement in outcome. Harm was defined as the probability that the adjusted HR was >1. Secondary analyses included 90-day mortality, health-related quality of life, and disability at 180 days.

Criteria for high probability of benefit were met by IL-6 receptor antagonists (>99.9% probability) and antiplatelet treatment (95% probability). Futility criteria were met by therapeutic anticoagulation, convalescent plasma, and lopinavir-ritonavir while hydroxychloroquine had a high probability of harm (96.6% probability). Results of secondary outcomes were consistent with the 180-day mortality analysis. Limitations include missing data from some sites on disability and health care quality of life scores. Additionally, the trial was run while prior variants of COVID-19 were prevalent and prior to widespread vaccination. Finally, while the trial suggested a high probability of benefit from antiplatelet agents compared to the remaining interventions, it is notable that the credible interval for the aHR included the value 1, and other trials evaluating antiplatelet agents in patients hospitalized with COVID-19 produced mixed results. Overall, these results suggest previously reported initial effects are consistent through six months.

**BOTTOM LINE:** This randomized, adaptive-platform, clinical trial of critically ill patients with COVID-19 demonstrated a high probability that IL-6 receptor antagonists and antiplatelet agents improved six-month survival while therapeutic anticoagulation, convalescent plasma, and antiviral therapy with lopinavir-ritonavir did not improve long-term outcomes. Hydroxychloroquine produced a high probability of causing harm.



**CITATION:** Writing Committee for the REMAP-CAP Investigators; Higgins AM, et al. Long-term (180-Day) outcomes in critically ill patients with COVID-19 in the REMAP-CAP randomized clinical trial. *JAMA*. 2023;329(1):39-51.

*Drs. Hamilton and Doyle are clinical assistant professors at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

**By Philicia Duncan, MD, FHM, and Nathan O'Dorisio, MD, FHM**

### 3 Main causes of costly inappropriate hospital admissions are premature admission and the potential for outpatient management

**CLINICAL QUESTION:** How prevalent and costly are inappropriate hospital admissions and are patients' intrinsic risk factors (IRFs) or comorbidities associated with inappropriate hospital admissions?

**BACKGROUND:** Health care resource overuse (inappropriate hospital admissions) has a significant economic impact on U.S. health care spending. While previous studies have focused on the frequency and non-clinical patient factors linked to improper hospital admissions, this article explores the economic consequences of such admissions and the connection between IRFs or comorbidities and inappropriate hospital admissions using the Appropriateness Evaluation Protocol (AEP).

**STUDY DESIGN:** Cross-sectional, descriptive, observational study

**SETTING:** Hospitalized patients in a high-acuity, 901-bed hospital in Spain

**SYNOPSIS:** 593 patients were analyzed, revealing an 11.9% prevalence of inappropriate admissions. Patients with one or two IRFs were more likely to experience inappropriate hospital admission (16.9%, versus 2.7% among those with 0 IRFs;  $P=0.036$ ), with the association being stronger than for those with more than three IRFs. Inappropriateness was also significantly higher among patients with a likelihood of recovery with residual disability (16.5%, versus 12.1% among patients with a prognosis of full recovery;  $P=0.003$ ) and among patients with scheduled admissions (18.4%, versus 8.7% among those with urgent admissions;  $P<0.001$ ). Surgical admissions were also associated with a higher risk of inappropriateness (17.9%, versus 7.6% among those with medical admissions;  $P<0.001$ ). The main causes of inappropriate admission were premature admission (56.3%) and the potential for outpatient management (39.3%). Premature admissions were noted in 78.4%

of planned admissions, and 58.8% of urgent admissions had the potential for outpatient management. Inappropriate admissions resulted in 559 avoidable hospital days, with a total cost overrun of \$151,618.31.

**BOTTOM LINE:** Inappropriate hospital admissions are a significant issue with economic implications. Focusing on admission practices for patients with moderate comorbidities and improving outpatient care networks may mitigate the financial impact of inappropriate hospital admissions.

**CITATION:** San Jose-Saras, et al. Inappropriate hospital admission according to patient intrinsic risk factors: an epidemiological approach. *J Gen Intern Med*. 2023;38(7):1655-63.

*Dr. Duncan is a clinical assistant professor and Dr. O'Dorisio is a clinical associate professor in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

**By Lucas McKnight, MD, and Matt Emery, MD**

### 4 DOACs versus LMWH and recurrent VTE in patients with cancer

**CLINICAL QUESTION:** Are direct oral anticoagulants (DOACs) acceptable compared to low-molecular-weight heparin (LMWH) for preventing venous thromboembolism (VTE) with a safe bleeding risk in cancer patients?

**BACKGROUND:** LMWH has long been the standard of care in cancer patients with VTE and for future VTE prevention. Are DOACs now a viable option?

**STUDY DESIGN:** Randomized clinical trial

**SETTING:** 67 U.S. member centers of the Alliance for Clinical Trials in Oncology research network

**SYNOPSIS:** 671 participants were randomized to either the DOAC or LMWH group. Rates of VTE were 6.1% in the DOAC group and 8.8% in the LMWH group, consistent with a non-inferior outcome. Major bleeding occurred in 5.2% of the DOAC group and 5.6% of the LMWH group, also showing DOACs to be non-inferior. Severe adverse events (anemia, death) occurred in 33.8% of the DOAC group and 35.1% of the LMWH group. The study included a wide range of disease states, including numerous types of cancer, the presence of metastatic disease, impaired performance status, and reduced hepatic and renal function. This likely broadens the application of its result. Conversely, its low proportional recruitment of Asian, Hispanic, and Black individuals may limit its generalizability in those populations. Additionally,

around 10% fewer participants were "taking [the medication] as prescribed" at three and six months in the LMWH group. This may reflect reduced adherence with injectable medications, as physicians might anticipate, though it could also lead to an underestimate of both the benefit and the side-effect profile from LMWH medications.

**BOTTOM LINE:** In adult patients with active cancer and VTE, DOACs are non-inferior to LMWH for preventing VTE over a six-month follow-up period. The most common serious events of anemia and death occurred similarly in both groups.

**CITATION:** Schrag D, et al. Direct oral anticoagulants vs low-molecular-weight heparin and recurrent VTE in patients with cancer. *JAMA*. 2023;329(22):1924-33.

*Drs. McKnight and Emery are clinical assistant professors in the department of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

**By Ashley Fang, DO, FACP, and Eric Schumacher, DO, MBA, FACP, SFHM**

### 5 Use of amiodarone with apixaban or rivaroxaban increases risk for bleeding-related hospitalizations

**CLINICAL QUESTION:** Does the use of amiodarone in patients with atrial fibrillation increase the risk for bleeding-related hospitalizations when used with apixaban or rivaroxaban?

**BACKGROUND:** Amiodarone is a potent antiarrhythmic drug used in patients with atrial fibrillation and is known to inhibit the elimination of apixaban and rivaroxaban; however, the clinical effects of this interaction are not yet known. Conversely, flecainide and sotalol are antiarrhythmic drugs that do not inhibit the elimination of these anticoagulants.

**STUDY DESIGN:** Retrospective cohort study

**SETTING:** U.S. Medicare beneficiaries aged 65 years or older

**SYNOPSIS:** A review of bleeding events in 91,590 Medicare beneficiaries with atrial fibrillation on either apixaban or rivaroxaban demonstrated a significantly increased risk of bleeding-related hospitalizations in those treated with amiodarone ( $n=54,977$ ), compared to those treated with flecainide or sotalol ( $n=36,613$ ), with a rate difference (RD) of 17.5 events per 1,000 person-years (HR, 1.44; CI, 1.27 to 1.63). Further, the risk for bleeding-related hospitalizations in those on both amiodarone and rivaroxaban was greater than that

for amiodarone and apixaban (RD: 28.0 events per 1,000 person-years versus 9.1 events per 1,000 person-years).

This study was observational, and the Medicare data lacked information on several potential confounding factors, thereby limiting the ability to establish a causal relationship. However, hospitalists who are initiating antiarrhythmic drugs for atrial fibrillation should consider the potential increased risk for bleeding-related hospitalization in patients concurrently taking apixaban or rivaroxaban.

**BOTTOM LINE:** Amiodarone, when used in conjunction with apixaban or rivaroxaban, increases the risk of bleeding-related hospitalization when compared to the use of flecainide or sotalol.

**CITATION:** Ray WA, et al. Risk for bleeding-related hospitalizations during use of amiodarone with apixaban or rivaroxaban in patients with atrial fibrillation: a retrospective cohort study. *Ann Intern Med*. 2023;176(6):769-78.

*Dr. Fang is a clinical assistant professor and Dr. Schumacher is a clinical associate professor in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

**By Angela Fielder, MD, and Vignesh Doraiswamy, MD**

### 6 Initial aggressive diuresis in patients hospitalized with acute heart failure

**CLINICAL QUESTION:** For patients admitted with acute heart failure, is early and aggressive diuresis associated with improved dyspnea without an associated worsening in renal function?

**BACKGROUND:** Acute heart failure is one of the leading causes of hospitalization in the U.S. and intravenous loop diuretics are considered the mainstay of therapy. Data and guidelines regarding diuretic goals and the safety of early aggressive diuresis are lacking.

**STUDY DESIGN:** Retrospective, pooled-cohort analysis

**SETTING:** Merged data from the DOSE, ROSE, and ATHENA-HF trials

**SYNOPSIS:** A pooled cohort of 807 patients admitted with acute heart failure was assorted into quartiles based on median net fluid status at 48 hours post study enrollment. There were two primary outcomes observed, including a 72-hour change in creatinine and a 72-hour change in dyspnea. Dyspnea was measured using the visual analog scale (VAS). The secondary outcome was a composite 60-day rehospitalization or mortality.

Increasing net negative fluid sta-



tus was associated with improved creatinine up to 3.5 L. After 3.5 L, there was no statistical association between net fluid status and creatinine improvement or worsening. Similarly, each liter net negative was associated with an improvement in dyspnea by a VAS of 1.4 points. Dyspnea reversibility was greater in younger patients and inversely related to higher baseline creatinine.

For the secondary outcome, there was a 12% decrease in odds of 60-day rehospitalization or mortality with each liter net negative. Increased odds of 60-day rehospitalization or death were seen in higher baseline creatinine and each 80-mg increase of furosemide.

The findings demonstrate that each liter net negative up to 3.5 L was associated with improvement in creatinine and dyspnea. Additional diuresis beyond 3.5 L did not have any impact on 72-hour creatinine levels, but did show continued improvement in dyspnea. Readmission and mortality risk reduction was also associated with each liter net negative.

Study limitations include lack of follow-up data beyond 72 hours and possible confounding factors such as diuretic efficiency and diuretic resistance, as well as sample generalizability.

**BOTTOM LINE:** For patients admitted with acute heart failure exacerbations, aggressive net fluid targets within the first 48 hours were associated with effective relief of patient self-reported dyspnea as well as reduced 60-day rehospitalization and mortality without adversely affecting renal function.

**CITATION:** Chen AY, et al. Association of 48-h net fluid status with change in renal function and dyspnea among patients with decompensated heart failure: a pooled cohort analysis of three acute heart failure trials. *J Hosp Med.* 2023;18(5):382-90.

*Drs. Fielder and Doraiswamy are clinical assistant professors in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

By Daniel McFarlane, MD, SFHM, and Allison Rossetti, MD, FACP

**7** **Periprocedural management of patients with AF receiving a DOAC undergoing a digestive endoscopy**

**CLINICAL QUESTION:** How long should patients with atrial fibrillation (AF) on a direct oral anticoagulant (DOAC) hold anticoagulation when undergoing endoscopy?

**BACKGROUND:** Given limited direct evidence, recommendations on the timing and duration of

DOAC cessation vary for patients with AF undergoing procedures. Efforts to mitigate the risk for thromboembolism and post-procedural gastrointestinal (GI) bleeding after digestive endoscopy need to be considered when directing patients when to hold and resume anticoagulation therapy.

**STUDY DESIGN:** Prospective clinical trial

**SETTING:** Outpatient procedure center

**SYNOPSIS:** This study established a standardized periprocedural DOAC management strategy based on medication pharmacokinetics, including creatinine clearance and procedure risk. The authors analyzed outcomes for 556 adult patients with AF who were treated with DOACs, undergoing an elective digestive endoscopy, and who were able to adhere to the defined DOAC interruption protocol. The mean duration of DOAC interruption was 3.9 ±1.6 days. There were low rates of thromboembolism (0.7%) and GI bleeding (2.5%).

Procedure details were unavailable for those with bleeding complications and most complications occurred around 10 days post-procedure, suggesting that holding anticoagulation longer post-procedure would not have been preventative. Notably, procedures were elective, and thus, results might not directly apply to inpatient medicine.

**BOTTOM LINE:** The adoption of this standardized regimen for a temporary interruption of DOAC should be considered for most patients with AF undergoing elective digestive endoscopic procedures, given the low rates of thromboembolism and GI bleeding complications.

**CITATION:** Hansen-Barkun C, et al. Periprocedural management of patients with atrial fibrillation receiving a direct oral anticoagulant undergoing a digestive endoscopy. *Am J Gastroenterol.* 2023;118(5):812-19.

*Dr. Rossetti is a clinical associate professor and Dr. McFarlane is a*

*clinical assistant professor in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

By Eric Nolan, MD, FHM, and Kristen Lewis, MD, FHM

**8** **Opioids confer risk without improved pain control**

**CLINICAL QUESTION:** How effective and safe are opioids for the treatment of acute, non-specific low back and neck pain?

**BACKGROUND:** Despite the lack of evidence of the effectiveness of opioids for the treatment of low back and neck pain, patients presenting with these symptoms are often prescribed opioid analgesics. This is the first placebo-controlled, randomized trial to measure the short- and long-term efficacy and side effects associated with opioid use for spinal pain.

**STUDY DESIGN:** Triple-blinded, randomized controlled trial

**SETTING:** Primary care and emergency department sites in Sydney, Australia

**SYNOPSIS:** A total of 347 patients presenting with 12 weeks or less of low back or neck pain of at least moderate intensity, and without known or suspected serious spinal pathology, were enrolled. 174 participants received guideline-recommended care plus modified-release oxycodone-naloxone with a dose of up to 20 mg oxycodone daily, and 173 participants received guideline-recommended care plus placebo. Naloxone was added to oxycodone to reduce opioid-related constipation and improve blinding. Treatment continued until adequate improvement or for a maximum of six weeks. Mean pain scores at six and 12 weeks did not statistically differ between the two groups, though at 52 weeks mean pain scores slightly favored placebo. The proportion of participants reporting adverse events did not differ between the two groups. The risk of opioid misuse did not differ early in the trial but was

significantly higher in the opioid group at week 52, with 20% of opioid recipients at risk of misuse compared with 10% of placebo recipients. The participant population limits its transferability to the hospital setting and to situations besides acute non-specific spinal pain.

**BOTTOM LINE:** Short courses of opioids for acute, non-specific low back and neck pain did not result in improved pain control but did increase the long-term risk of opioid misuse.

**CITATION:** Jones CMP, et al. Opioid analgesia for acute low back pain and neck pain (the OPAL trial): a randomised placebo-controlled trial. *Lancet.* 2023;402(10398):304-12. Erratum in: *Lancet.* 2023;402(10402):612.

*Dr. Nolan is a clinical assistant professor and Dr. Lewis is a clinical associate professor at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

By Jaimie Patel, MD, and Chirag Patel, MD

**9** **Reducing the use of NPO after midnight for inpatient diagnostic and therapeutic procedures: a quality improvement initiative**

**CLINICAL QUESTION:** Can an interprofessional quality improvement team reduce the use of nil per os (NPO) after midnight orders prior to inpatient diagnostic and therapeutic procedures requiring anesthesia or sedation?

**BACKGROUND:** Evidence suggests that the aspiration risk is actually quite low for many diagnostic and therapeutic procedures requiring anesthesia or sedation. Current guidelines support reducing fasting durations prior to these procedures, however, the use of NPO after midnight is still common practice. This practice results in unnecessarily long NPO durations and results in adverse effects.

**STUDY DESIGN:** Single-arm pre-post interventional study

**SETTING:** Single academic health system; University of Texas Medical Branch

**SYNOPSIS:** An interprofessional quality-improvement team was created to identify and reduce the use of unnecessary NPO after midnight orders. The team revised outdated protocols and updated electronic health record order sets for diagnostic procedures that did not require fasting. Pre-procedure clear liquid diets, nurse-driven NPO protocols based on procedure start times, and focused staff education were also implemented. The goal of a 50% reduction in NPO orders was achieved almost immediately and was sustained

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over two years. This reduction was further amplified when focused re-education was implemented.

It is difficult to ascertain which components of their strategy were most impactful. The authors report mostly changes in diagnostic-procedure NPO orders but did not outline what percentage of the effect was attributable to changes in therapeutic-procedure interventions, which the introduction focused on. As this is only a single-center study and their pre-intervention diagnostic protocols could be significantly different from other institutions, it may be difficult to generalize the ability to significantly reduce NPO after midnight orders using this approach at other institutions.

**BOTTOM LINE:** The creation of a multidisciplinary quality improvement team to address the overuse of NPO after midnight orders was a successful intervention at this academic institution, however, it is unclear what proportion of the reduction was driven by each component of their multifaceted approach.

**CITATION:** Hommel E, et al. Reducing the use of nil per os past midnight for inpatient diagnostic and therapeutic procedures: a quality improvement initiative. *J*

*Hosp Med.* 2023;18(5):375-81.

*Drs. Patel and Patel are clinical assistant professors in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.*

By Charles Redman, MD, and Claire Sevov, MD, FHM

## 10 Aspirin thromboprophylaxis is non-inferior to LMWH for prevention of death and pulmonary embolism after orthopedic trauma

**CLINICAL QUESTION:** Is aspirin as effective as low-molecular-weight heparin (LMWH) for thromboprophylaxis in patients with orthopedic trauma?

**BACKGROUND:** Studies have outlined the benefits of thromboprophylaxis in patients with traumatic orthopedic injuries to prevent thromboembolic complications and death. Recent studies suggest aspirin may be an effective alternative to LMWH in patients who have undergone total joint arthroplasty. However, similar data in patients with orthopedic trauma is limited.

**STUDY DESIGN:** Pragmatic, multicenter, randomized, noninferiority trial

**SETTING:** 21 adult trauma centers across the U.S. and Canada

**SYNOPSIS:** 12,211 adult patients with an extremity fracture requiring operative management (excluding fractures of the hand or forefoot) or any pelvic or acetabular fracture regardless of management strategy were randomly assigned to receive aspirin thromboprophylaxis (81 mg twice daily orally) versus LMWH (30 mg twice daily subcutaneously, with flexibility in dosing based on weight, renal function, or other individual patient factors) while admitted. The duration of post-discharge therapy was left to the treating physician's discretion. Results indicated noninferiority of aspirin versus LMWH in the prevention of all-cause mortality (0.78% versus 0.73%; 96.2% CI, -0.27 to 0.38;  $P < 0.0001$ ). The authors also found no difference in the secondary outcomes of pulmonary embolism, bleeding complications, wound complications, or surgical site infections. The 90-day incidence of deep-vein thrombosis (DVT) was 2.51% in the aspirin group versus 1.71% in the LMWH group (95% CI, 0.28 to 1.31). Notably, adherence

to the prescribed regimen after discharge was greater for the aspirin group (94.4%) than the LMWH group (86.6%) with a median duration of 21 post-discharge days prescribed in both groups.

Previous studies indicate that patients strongly favor aspirin versus LMWH due to ease of administration and cost considerations. Hospitalists caring for patients with orthopedic trauma may now consider aspirin as an alternative to LMWH while acknowledging the increased incidence of DVT with this strategy.

**BOTTOM LINE:** Aspirin is non-inferior to LMWH in patients with orthopedic trauma for the prevention of all-cause mortality and pulmonary embolism.

**CITATION:** Major Extremity Trauma Research Consortium (METRC); O'Toole RV, et al. aspirin or low-molecular-weight heparin for thromboprophylaxis after a fracture. *N Engl J Med.* 2023;388(3):203-13.

*Dr. Sevov and Dr. Redman are clinical assistant professors in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio. Disclosure: Dr. Sevov's spouse receives consulting fees from Merck, AbbVie, and Eli Lilly. ■*

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# How Hospitalists Play a Leading Role in Responding to Mass-Casualty Incidents

Planning and responding effectively

By Vanessa Caceres

Mass shootings. Bioterror attacks. Natural disasters. Wars. There's seemingly no shortage of potential mass-casualty incidents (MCIs) that can lead health care professionals, including hospitalists, into response roles. Knowing how to respond in the moment to an MCI can be overwhelming, but planning can help. Here are some ways to plan for and respond to MCIs that could affect your hospital.

### Why hospitalists play such a critical role in MCIs

Hospitalists can and should play a critical role in responding to MCIs for a few reasons.

One major reason is that hospitalists are used to being flexible, and they know how to navigate a hospital quickly and safely, said Riley Jones, MD, MSc, FACP, an assistant clinical professor of medicine and global health with the department of medicine, division of hospital medicine, at the University of Florida in Gainesville, Fla. All of this will come in useful during an MCI response. Dr. Jones is active with the nonprofit group MedGlobal and helps hospitals prepare for a war footing and for coming under direct attack. He has assisted in war zones such as Syria and Ukraine.



Dr. Jones

The role that hospitalists can play in responding to a larger-scale emergency became evident during the COVID-19 pandemic, said Jason Persoff, MD, SFHM, an associate professor of medicine and assistant director of emergency preparedness at the University of Colorado Hospital in Aurora, Colo. With COVID-19, the disaster unfolded over several years, and that required proper stewardship of inpatient care for those who were ill. "Many hospitalists don't realize just how important their participation in an unfolding multi-casualty trauma incident can matter," Dr. Persoff said.



Dr. Persoff

Plus, hospitalists are well-positioned to assist those who may require prolonged hospitalizations and the worsening of their chronic medical problems due to displacement and disrupted care, said Maria (Gaby) Frank, MD, FACP, FAOS, SFHM, a hospitalist in the division of hospital medicine and medical director of the bio-containment unit at Denver Health Hospital Authority in Denver. Dr. Frank is chair (and Dr. Persoff is co-chair) of the SHM's Disaster Preparedness and Management Special Interest Group.



Dr. Frank

It also helps that hospitalists have a broad range of medical knowledge, which aids in responding to a range of disasters, Dr. Frank added.



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### Preparing in advance

One key part of responding to a mass-casualty incident is preparation, on the part of both hospitalists and the hospital as a whole. There are several ways to make sure your hospital does what it can to prepare for a potential MCI:

- Work with hospital leadership on an MCI response plan. Your hospital already may have such a plan but if not, now's a good time to get one in order. Many hospitals developed recovery plans (although not necessarily response plans) after the terrorist attacks on Sept. 11, 2001, Dr. Jones said. Of course, medicine has evolved since then, and the need for a proactive response plan is crucial. Hospitalists should work with administrators as well as emergency department (ED), surgical, and critical-care leaders to draft a plan. "Hospitalists should not assume that everyone else at the hospital has a plan," Dr. Persoff said.
- Continually update existing response plans and other disaster-related documents. Make disaster management a regular part of business meetings or grand rounds, Dr. Persoff advised. That way, both hospitalists and other relevant emergency managers at the hospital keep plans up-to-date and can always identify clinical skills that may need to be addressed before an MCI. As you update plans, make sure to consider where an influx of additional patients may stay, Dr. Jones advised.
- Advocate for an MCI simulation at your hospital. "The more you practice these skills, the more comfortable you will feel in a critical scenario," said Sheena G. McKenzie, MD, MBA, FAAP, a pediatric hospitalist with Advocate Children's Hospital – Oak Lawn in Oak Lawn, Ill. Dr. McKenzie said these skills helped her feel prepared to respond to the Highland Park, Ill., mass shooting in 2022 while working at the Highland Park hospital because she had practiced and reviewed roles, processes, and



Dr. McKenzie

timelines ahead of time in a simulation.

- Use continuing medical education to address any additional skills you may need during an MCI or to focus on MCI preparedness overall. Joe Anderson, DO, FAAP, a pediatric hospitalist with Central Maine Healthcare in Lewiston, Maine, helped respond to the mass shooting that occurred there last year. He credits a Stop the Bleed course he took at the CME conference a few years ago to teach him how to apply tourniquets and how to use combat gauze to help control traumatic bleeding. "These topics are not consistently covered in medical school or residency training depending on your specialty," he said. You also can use available resources, such as webinars from the SHM's Disaster Preparedness and Management SIG and free just-in-time resources from the Mountain Plains Regional Disaster Health Response System, Dr. Frank said.
- Work with family members to plan who will care for kids, older family members, and pets should you be responding to an MCI, Dr. Frank suggested.



Dr. Anderson

### In-the-moment tasks for hospitalists

If an MCI has happened, there's probably the urge to try to do everything and anything, all at once. Instead, take a step back. "Don't just do something, stand there. Take a beat and get organized," advised Dr. Persoff, a former EMT and long-time storm chaser who volunteered to respond when an EF-5 tornado destroyed one of two hospitals while he was chasing a tornado in Joplin, Mo., in 2011. "The ED will be very busy, and rushing down there on your own without a plan for continuity of operations of patients you're already caring for is a mistake."

Ideally, your hospital will have a response plan in place that you can follow should a disaster strike. Yet there are other guiding ideas to keep



in mind:

- Check in with your Hospital Incident Command System to find out where you can be most helpful. “Don’t try to figure this all out on your own, or you will be overwhelmed and ineffective,” Dr. Persoff said. In advance of a possible MCI, find out in advance if your hospital has such a system.
- Plan on doing tasks that are suited for hospital medicine, Dr. Frank advised. This includes:
  - Offloading in the intensive care unit
  - Helping the ED to triage and manage patients
  - Managing surgical patients on the floor while surgeons are in the operating room
  - Streamlining discharges so that more beds become available
- The specific tasks you’ll do may already be spelled out in the disaster response plan.
- Even with specific roles, find other ways you can help. During the Highland Park mass shooting response, Dr. McKenzie helped trauma-surgery and emergency-medicine peers to care for pediatric patients in the ED (she now works at Advocate Children’s Hospital). This included assisting in a pediatric code, communicating status updates between operating-room staff and patients’ families, arranging transportation for patients who needed to be transferred, and eventually helping with vital signs on adult patients in the ED. However, there was also a lot of time spent with families to share hugs, hand holding, and expressing emotions, she added.
- Reach out for additional resources earlier

rather than later if you think you’ll need them. Don’t wait until you feel short-handed, Dr. Anderson advised. “We were fortunate to have two pediatric-hospitalist colleagues from a local private practice who responded quickly to our call for help,” he said.

- If you’re home, don’t rush to the hospital unless you’re asked to do so, Dr. Frank advised. She added that you don’t want to be in the way, and there will still be a need for fresh and rested responders during a second shift. When planning, disaster-response groups should consider staffing for the next eight hours after an MCI occurs as well as for the following few days, Dr. Persoff said.
- Take a moment to pause. “After the busiest part of the day in the ED, the team took a few minutes to come together and pause,” Dr. McKenzie said, referring to the Highland Park shooting response. “We stood together in silence reflecting on the lives saved and lives lost that day.”

### Helping process what happened

After a mass-casualty incident, it’s normal to feel a range of emotions, from sad to mad to exhausted. Some hospitalists said they still aren’t sure how to handle the emotional impact of an MCI. Still, there are some things you can do to help manage your emotional health.

Seek help—don’t try to tough it out. Take advantage of employer resources, therapy, and structured listening sessions that help you to process what happened. “Suicide, burnout, and drug and alcohol addiction all occur with very

high rates in individuals who try to ‘be tough’ and not talk about their feelings,” Dr. Persoff said. Dr. McKenzie found it helpful to take part in an open-forum discussion in the pediatric hospitalist group to work through emotions out loud.

Realize that what helps you emotionally may be very different from what works for your colleagues, even if you all worked side by side during the incident, Dr. Anderson said. It’s all okay, so long as it works toward healthy healing.

Try to separate the humanity of treating patients from the injustice that occurred, Dr. Jones said. This is something he reflected on after witnessing war-zone injuries in places like Ukraine. If possible, find a time to focus on and heal from your role as a physician during an MCI, and then find a separate time or way to process the injustice or bigger-picture issues that are involved.

Advocate. Responding to gun-violence incidents led both Drs. Anderson and McKenzie to turn to advocacy. Dr. McKenzie is now involved with several local and federal advocacy opportunities related to gun-violence prevention. “I have learned to heal from the trauma of that day by sharing with others and advocating for safer communities for children,” she said. Dr. Anderson is part of a recently formed multi-specialty coalition of physicians and advanced practice providers, called Maine Providers for Gun Safety, calling for common-sense gun-safety legislation. ■

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

## Converge

# Editorial Board Picks for Must-Attend Converge 2024 Sessions

If you’re attending SHM Converge 2024 in San Diego next month, you’ve probably already checked out the jam-packed schedule and may have even started circling the sessions you want to attend. We checked in with some of *The Hospitalist’s* editorial board members to see which sessions they’re most excited about. You can find the full schedule at <https://shmconverge.hospitalmedicine.org/interactive-schedule/>.

### Andrea Hadley, MD, FAAP, FHM

*Internal medicine and pediatric hospitalist, division chief, acute care pediatrics at Corewell Health/Hel-*



Dr. Hadley

*len DeVos Children’s Hospital and assistant professor of internal medicine and pediatrics, Michigan State University College of Human Medicine in Grand Rapids, Mich.*

As a med-peds hospitalist, I try to find the highest yield way to keep up with the massive amount of

new information in both fields of practice. This is why I’m excited about so many of the sessions at SHM Converge 24. I always enjoy the Pediatric Update—Top 10 Articles, which this year will be presented by Dr. Jaclyn Vargas and Dr. Merritt ten Hope, at 5:30 p.m. on April 14. I appreciate the impactful literature of the year broken down and analyzed for me in a way that will allow me to apply the evidence to my practice more effectively.

As a leader in a children’s hospital dealing with worsening respiratory surges each year in the setting of the overall decreasing number of pediatric beds around the country, I am also particularly interested in No Beds at the Inn—the Pediatric Surge presented by Dr. Daniel Rauch, at 8:00 a.m. on April 14. I hope to learn from how other children’s hospitals are navigating and problem-solving for this issue.

Among many other sessions of interest, you’ll find me at San DieGO TO THE BEDSIDE: How Adult Medical Providers Can Incorporate Patient and Family Centered Rounds Into Their Practice, presented by Dr. Katherine Krause, Dr. Kathryn Westphal, Dr. Vignesh

Doraiswamy, and Dr. Emily Levoy, on April 15 at 10:15 a.m. This round-table model, which has been shown to improve communication, quality/safety, and patient experience, is the standard of care in our pediatric spaces but it seems more challenging to accomplish in the adult spaces and I am ready to learn how! In a world where spending so much time behind computer screens and on the phone leads to burnout, it is prudent to be reminded of how much more fulfilling it is to be at the bedside!

### Venkat P. Gundareddy, MBBS, MPH, SFHM

*Assistant professor and associate director division of hospital medicine at Johns Hopkins School of Medicine, in Baltimore*



Dr. Gundareddy

This year I look forward to Dr. Flora Kisuule’s president-elect address on April 13 at 8:05 a.m. Dr. Kisuule is my mentor and a leader par excellence, super excited to see

her take on the mantle as the SHM president.

The Converge Shark Tank (April 13 at 11 a.m.) has always been a favorite and I will be there to hear about innovations in the field of hospital medicine. This year the speakers are Dr. Jennifer Myers, Dr. Luci Leykum, Dr. Hardeep Singh, and Dr. Thomas Barrett.

Another talk that will be a delight that I am looking forward to is The Art and Science of Hospitalists Workloads: Designing and Implementing Evidence-informed Strategies for Optimal Patient, Workforce and Organizational Outcomes, on April 13, at 2:40 p.m. Who else to learn this from other than the OG Dr. John Nelson and new age thought leader Dr. Marisha Burden?

One other talk that caught my attention and am looking forward to is 2,000 Years of Patient Stories in Hospitals: How That Helps You Become a Better Hospitalist Today and in the Future, presented by Dr. Jordon Messler, on April 13, at 4:40 p.m.

One of the workshops I am looking forward to includes Put Me in Coach! The Essentials of Physician



Coaching in Healthcare presented by Dr. Christopher Russo, Dr. Alyssa Stephany, Dr. Justin Boer, and Dr. Leah Jones, on April 15 at 10:15 a.m.

Arunab Mehta, MD, MEd

Medical director and an assistant professor of medicine at the University of Cincinnati Medical Center in Cincinnati.



Dr. Mehta

MED-TED Teaching Competition, presented by Dr. Christopher Whinney, Dr. Joseph Sweigart, Dr. Annie Massart, and Dr. Daniel Steinbergon, on April 13, at 2:40 p.m.

Being a clinician educator myself, I am looking forward to watching and learning new teaching styles from early career physicians and watching them compete for the best one. My inner nerd will be excited to see who wins this one.

Don't Throw Away Your Shot: Negotiations for Hospitalists, presented by Dr. Joanna Bonsall, Dr. Alyssa Stephany, and Dr. Carrie Herzke, on April 14 at 8 a.m.

I'm hoping to wake up on time to

make this workshop. No one really tells you what you need to do and can negotiate when you leave residency, and this is a hard skill to pick up. I hope my employers don't know I'm attending this one.

Building a Successful Hospitalist Medicine Procedure Service is More than Just Doing Procedures, presented by Dr. Jeremy Gentile, on April 15 at 10:30 a.m.

I know many hospitals would love to have a procedure service, but no hospitalist wants to maintain these skills because there is never time on busy wards to perform procedures when you have discharges, new admits, and AMAs breathing down your neck. Most places would likely benefit from a dedicated procedure service, so this would be an interesting session to learn how to start such a service.

The Pills That Play Tricks: A Look at Commonly Overprescribed Medications, presented by Dr. Niti Patel and Dr. Thomas Chen, on April 15 at 11:30 a.m.

I am always looking forward to a clinical update. It's possible that I might be guilty of using some medications more than I should or am reluctant to stop some when their time might be up. This talk seems like it might help me learn better strategies to improve this.

Anika Kumar, MD, FAAP, FHM

Staff physician, Department of Pediatric Hospital Medicine, Cleveland Clinic Children's, assistant professor of pediatrics, Cleveland Clinic Lerner College of Medicine of CWRU, and medical director, Cleveland Clinic Children's Grand Rounds, and pediatric editor of The Hospitalist.



Dr. Kumar

As a pediatric hospitalist, I am always excited to attend the Pediatrics Track content at CONVERGE, especially the Pediatric Update—Top 10 Articles, which this year will be presented by Dr. Jaclyn Vargas and Dr. Merritt ten Hope, at 5:30 p.m. on April 14. Additionally, I am excited to attend the session on No Beds at the Inn—the Pediatric Surge with Dr. Rauch, on April 14 at 8:00 a.m., and Addressing Adolescent Sexual and Reproductive Health, presented by Dr. Vanessa McFadden and Dr. Abbey Masonbrink, on April 14 at 4:30 p.m.

Amanda Green, MD, FACP, SFHM, HMDC, CPPS

Chief medical officer, Paris Regional Health, in Paris, Texas



Dr. Green

Once again, as I look at the Converge schedule, I have a hard time choosing which great presentations to attend as there are three or four per hour that directly apply to some aspect of my work. Let's Get Physical: Exam Maneuvers That Can Improve Your Clinical Judgement, by Dr. Daniel Dressler on April 13 at 4:40 p.m. spoke to me, not only because of my love of Olivia Newton-John, but because as a doctor who has been practicing for 20 years, and has been forced to be more and more efficient, I am interested in the latest teaching of high value-for-the-time exam maneuvers.

Equity combined with reducing readmissions hits two of my work passions. I hope Healthcare Disparities Affecting Readmissions: How Hospitalists Can Make a Difference, by Dr. Tanisha Hamilton on April 15 at 8:30 a.m. will give me some tools I can bring back to my rural, low socio-economic community to help improve readmissions and physician engagement with our patients' needs.

I'll limit my many favorites to three, and end with "You Don't Need to Lecture Me!" and Other High Value Advice in Medical Education, on April 13 at 9:50 a.m. Dr. Lia Logio is one of the presenters

and was one of my favorite teachers when I was at Duke 20 years ago. I'm sure she is only better with time, and with our hospital medicine residency class this summer, I could brush up on my teaching skills!

Last schedule scan addendum: the Dr. Pfeffer brothers are presenting Overcrowded Hospitals—Which Patients are Most at Risk and How Hospitalists Can Help?, on April 13 at 4:40 p.m. I already picked a talk at that time, but this emergency department doc/hospitalist brother team are excellent presenters with practical tips backed with great references. It is going to be a hard choice!

Semie Kang, DO, MS, FHM

Site director division of hospital medicine at Long Island Jewish Medical Center, and assistant professor of internal medicine at Zucker School of Medicine at Hofstra/Northwell, in Hempstead, N.Y.




Dr. Kang

I'm looking forward to Rapid Responses: Approaches to Care for Patients in Need of Urgent/Emergent Situations, presented by Dr. Ethan Molitch-Hou, Dr. Lauren Spaeth, Dr. Noble Maledque, and Dr. Arti Tewari, on April 13 at 9:50 a.m.




I had the opportunity to speak with Dr. Spaeth, and her contagious energy for rapid-response teams was evident. With a background as a former critical care nurse, Dr. Spaeth brings firsthand experience as both a nurse and a physician to the forefront of leading teams in emergent situations. Her passion lies in fostering excellent teamwork and communication, especially when patients rapidly decline.


Dr. Spaeth will kick off the session by delving into the history of rapid-response teams, an area that many hospitalists may not be familiar with. The discussion will then explore approaches to patient care in rapid-response scenarios, the use of early warning scores, and best practices for effective communication with team members, along with providing verbal and written signouts post-rapid-response. The session will cover common clinical scenarios such as acute respiratory distress, altered mental status, tachycardia, and hypotension. Attendees will learn systematic approaches to diagnose, treat, and triage acutely decompensating patients.

Dr. Spaeth and Dr. Molitch-Hou, who serve on the SHM Physicians in Training committee, will present this session as part of the Early Career Track. Whether you are a young or an experienced hospitalist, this is a session not to be missed. ■




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# Things to Do in Sunny San Diego

By Lisa Casinger

**S**HM Converge 2024 is just around the corner, taking place from April 12 to 15. While noting down the sessions you wish to attend and catching up with friends and colleagues (see our editorial board's recommendations on page 9), remember to also enjoy the beautiful city of San Diego.

San Diego is known as the birthplace of California, as it was the first location in the western U.S. where Europeans set foot, specifically Point Loma. It's also the birthplace of the California burrito, which includes French fries and carne asada. The city is home to Comic-Con, the world's largest comics and pop culture event, and the U.S. Navy, with the largest concentration of naval vessels in the country.

San Diego has more small farms than any other city in the U.S., with over 7,000, and it's also the nation's top producer of avocados. With over 70 miles of coastline, it's located about 20 miles from the Mexican border and 120 miles south of Los Angeles.

## See the city

A hop-on hop-off trolley tour is an easy way to explore San Diego. The trolleys run every 30 minutes and stop at 11 locations, including popular tourist destinations like Old Town State Historic Park, San Diego Zoo, USS Midway, and the historic Gaslamp Quarter.

The USS Midway Museum, which is located just a six-minute drive or one-mile walk from the Convention Center, is home to the longest-serving aircraft carrier that's permanently moored at San Diego's Embarcadero. This ship served in the Vietnam War and Operation Desert Storm before becoming the largest museum dedicated to aircraft carriers and naval aviation. Visitors can take a self-guided tour to see more than 30 restored aircraft, the gallery, brig, crew quarters, and other exhibits.

The Gaslamp Quarter, right across the street from the Convention Center, is a 16-block area that has 94 historic buildings, more than 100 restaurants, bars, breweries, and entertainment venues, and a mix of more than 80 boutiques, art galleries, artisan shops, and more.

Petco Park, the home of the San Diego Padres, is only an eight-minute walk from the Convention Center.

Balboa Park, which is around a 10-minute drive from the Convention Center, is one of the top 10 parks in the U.S., according to Trip Advisor. It is home to the San Diego Zoo, the Botanical Building, nearly 30 museums and cultural centers, and myriad gardens. This city park is bigger than Central Park in New York, spanning 1,200 acres. You'll also find the San Diego Natural History Museum, the oldest scientific institution in Southern California, as well as the San Diego Air & Space Museum on the grounds. The San Diego Museum of Art in Balboa Park showcases works by famous artists such as El Greco, Murillo, Goya, Zurbaran, Van Dyck, Rubens, Frans Hals, Gustav Klimt, Egon Schiele, Otto Dix, and more.

San Diego Zoo is world-famous and was founded by a physician, Harry M. Wedgeworth. It's one of the first zoos to have cageless exhibits. The city is also home to the largest oceanographic museum in the U.S., the Birch Aquarium at Scripps.

Mission Beach has a two-mile-long board-





walk and is home to Belmont Park, the famous beachfront amusement park featuring the Giant Dipper, a wooden rollercoaster on the list of national Historic Landmarks.

Old Town San Diego, considered the birthplace of California, is a mile-long stretch of preserved or reconstructed shops and houses on the grounds of the first European settlement in the area. Visitors can visit Casa de Estudillo, one of the oldest surviving adobe buildings, and the Junipero Serra Museum, in Presidio Park, one of the most familiar landmarks in San Diego.

The Hotel del Coronado, the largest wooden structure in the U.S., is located on Coronado Island, reachable through the iconic Coronado Bridge. The bridge opened in 1969 during the city’s bicentennial and the first person to drive across it was then-Governor, Ronald Reagan. You can catch the Coronado Ferry at the Convention Center and be on the island in minutes.

The Geisel Library at the University of California, San Diego in La Jolla has the largest collection of Theodor Geisel’s (Dr. Seuss’s) work. The author was a longtime resident of La Jolla and it’s said that “Whoville” was inspired by the town. Another famous former La Jolla resident was Dr. Jonas Salk, creator of the polio vaccine.

San Diego’s Little Italy covers more than 48 square blocks, making it the largest Little Italy in the U.S. It’s also one of the oldest areas of the city. Visitors can find shops, restaurants, and even recipes. In Amici Park, there are sculptures of tables with red and white tablecloths. Each table has a food sculpture and a plaque with a recipe in raised lettering. The installation, “A Recipe for Friendship,” was created by Nina Karavassiles in 2001 and invites people to take rubbings of the recipes.

Between December and April, visitors to

San Diego can go whale watching and catch a glimpse of the California Gray Whale as it passes by on its way from Alaska to Baja.

Enjoy the food

San Diego is known as one of the best cities for foodies. It’s a mix of locally inspired flavors, including many farm-to-table options, fresh seafood, traditional Mexican dishes, and everything in between. The city and its surrounding county are also home to more than 140 breweries and distilleries and more than 100 wineries.

- **Harney Sushi**—touted as San Diego’s premier sushi bar and restaurant
- **Bali Hai**—Hawaiian-themed restaurant with bay views
- **The Old Spaghetti Factory**—in the middle of the Gaslamp District, still family-owned and operated, and every entrée is one of three courses
- **Coastera**—upscale, modern, fusion Mexican, with bay views
- **Tacos El Gordo**—Tijuana-style street tacos on handmade corn tortillas
- **Puesto at the Headquarters**—first-generation Mexican American family business that started with tacos made with blue corn tortillas
- **Lou & Mickey’s**—directly across the street from the Convention Center, steaks, seafood
- **Trattoria Don Pietro**—Sicilian-style cuisine, pastas, pizzas, and desserts
- **Callie**—an East Village destination restaurant featuring Cali-Mediterranean food, including house-made pita and hummus, local seafood, and pasta
- **Nobu**—founded by chef Nobu Matsuhisa and Robert De Niro, this chain is known for its

- Japanese dishes crafted with Peruvian ingredients (inside the Hard Rock Hotel)
  - **Hodad’s**—local iconic burger joints now run by third-generation family members
  - **Lucha Libre**—a fast-casual Mexican restaurant with a Mexican professional-wrestling theme
  - **Breakfast Republic**—serving American classics like shrimp and grits and s’mores French toast, along with organic kombucha and local craft beer
  - **Crack Shack**—local eatery known for its fried chicken sandwich
  - **Donut Bar**—award-winning, artisanal donuts including Big Poppa Tart, The Homer, Chocolate Euphoria, and more
  - **Snooze AM Eatery**—breakfast made with responsibly sourced ingredients; the menu includes everything from eggs and pancakes to tofu scrambles, Buddha bowls, and bloody Mary’s
  - **Dae Jang Keum**—cook-your-own Korean BBQ
  - **Sushi Ota**—recognized as one of San Diego’s best sushi places (reservations recommended)
  - **Kansas City Barbecue**—movie buffs will appreciate this place—it’s where Maverick and Goose sang “Great Balls of Fire” in the movie “Top Gun”, which was filmed in San Diego
- Scan the QR code to discover more restaurants and things to do in San Diego. ■



Clinical

# How Can Hospitalists Help Reduce Harmful In-hospital Patient Falls?

Updates in fall prevention

By Larry Beresford

An estimated 700,000 to 1,000,000 falls occur in hospitalized patients in this country every year, with one-quarter to one-third of the falls leading to injuries. At least 10% of those are serious injuries—resulting in fractures, head trauma, and even an estimated 11,000 deaths.<sup>1</sup> The Agency for Healthcare Research and Quality (AHRQ) calls falls “a common and devastating complication of hospital care, particularly in elderly patients.”<sup>2</sup> The Joint Commission considers them sentinel events, and the Centers for Medicare and Medicaid Services does not reimburse hospitals for the additional costs of care associated with a patient’s fall.

“I have seen, even just in the time I have been practicing and thinking about safety over the past five years, subdural hematomas, hip fractures, and a vision-threatening globe rupture,” said Katie Raffel,

MD, FHM, a hospitalist at UCHealth University of Colorado Hospital, and assistant professor of medicine at the University of Colorado, both in Aurora, Colo. “Any type of injury associated with a fall can also be associated with prolonged hospitalization and decreased quality of life.”



Dr. Raffel

Hospitalists may feel that preventing falls lies outside their job responsibilities, but if they are leading the way in creating a culture of quality and safety within their institutions, then this common adverse event on their watch is an obvious target for their leadership, said Dr. Raffel, who co-directs University of Colorado Health’s acute care of the elderly (ACE) unit and supports the hospital’s fall reduction efforts.

The hospitalist’s role in preventing falls is twofold, she added. “There’s the action you take at the bedside, with the patient, and then the action you are taking as a systems leader—someone who’s working to shape the quality of care in the hospital.” For care at the bedside, prescribing and deprescribing among older patients may be guided by the Beers Criteria for potentially inappropriate medication use in older adults, developed by the American Geriatrics Society. “On our ACE service, we huddle daily as an interprofessional team with care management, social work, nutrition, pharmacy, nursing—a robust team reviewing all the patients,” Dr. Raffel said. A pharmacist with geriatric training has a defined role in reviewing the list of high-risk medications prescribed for each patient.

Begin with assessment

Prevention begins with assess-

ing each patient’s risk for falling, although among existing clinical prediction tools, the supporting evidence is not strong, Dr. Raffel said. Fall-assessment tools include the Johns Hopkins Fall Risk Assessment Tool, the Morse Fall Scale, and AHRQ’s STRATIFY Scale for identifying fall risk factors. Using standard risk tools, most patients on medicine units cared for by hospitalists will be considered at high fall risk, she said. “So instead of having a laser focus on the patients who really need the most attention, planning, and response from the team, we have a blunt model that says everybody’s at high risk.” Dr. Raffel’s group is now drawing on internal falls data to develop a homegrown “fall with injury risk prediction model.” They hope to narrow down the proportion of patients identified as at risk for fall with injury. “That way, we can tailor our interventions to a smaller subset of our population.”



For Areeba Kara, MD, MS, MBBS, SFHM, hospitalist and associate professor of medicine at Indiana University School of Medicine in Indianapolis, falls are a particular problem in the hospital because patients are away from their homes, acutely unwell, and experiencing sleep deprivation and polypharmacy. “These are disorienting experiences and the physical space and layout of where you are is completely different from home. So, your universe has changed, and you are not as steady as you thought you were,” Dr. Kara said.



Dr. Kara

Hospitalists have an important role because the causes of falls often are a culmination of multiple events, she said. “A hospitalist may not have control over the existing frailty a patient brings to the hospital. But we do have a responsibility and can pay attention to things like what medications we prescribe. Are these likely to make a patient orthostatic—meaning their blood pressure falls when they stand up? Are we prescribing their diuretic at 7 p.m. so that they’re going to need to get up and go to the bathroom in the middle of the night when it’s dark and they’re disoriented?”

Dr. Kara worked with a team of clinical nurse specialists at Indiana University, including Bethany Radecki and Staci Reynolds, to better understand the issue of patient falls and what can be done about it.<sup>3</sup> “We interviewed patients and asked those who were identified as being at high fall risk what they felt about all this, what we’re doing, what’s working, what’s not working. We found that every patient has a sense of who they are and what they can do (for themselves) and their independence. Unfortunately, the things we do to try to prevent falls interfere with that sense.”

Their conclusion from the research: What’s more likely to work is a patient-centered plan that is co-created with patients and with the families at their bedside, Dr. Kara said. “I think for us to be successful, this is not something we do to our patients but something we create as a safety plan with our patients. Because not being able to get up and self-toilet strips patients of their dignity. That’s not what we mean to do, but that is how it is perceived,” Dr. Kara said.

The hospitalized patient may have a different sense than the clinician of what they are able to do, which requires a meeting of the minds and perhaps a practical demonstration of their abilities, she said. “Show me that you can walk safely. I’ll be here to catch you.’ And you have to do this



repeatedly because things change hour to hour in the hospital and patients may become weaker.”

### Techniques and approaches

The medical literature is full of studies about the various approaches to inpatient falls prevention. A meta-analysis in *Age and Ageing* from last year found that staff and patient education was the only intervention that resulted in a documented reduction in falls, although multi-factorial interventions had a tendency toward positive impact.<sup>4</sup> Various systems for addressing falls include the Center for Disease Control and Prevention’s STEADI Initiative and AHRQ’s Fall TIPS.<sup>5,6</sup>

Devices, techniques, and measures taken to reduce hospital falls include the following, although the evidence for their efficacy is not strong, according to Dr. Raffel:

- Changing the physical environment and setup of the room, including non-slip flooring material, lowering the bed height, opening windows, using whiteboard postings to spell out the patient’s fall risk and the medical plan for it, and having clear sightlines from nursing staff to patients
- Bed alarms to alert staff when the patient tries to get out of bed, including “smart socks” containing pressure sensors that can detect when a patient is trying to stand up
- Attention to issues such as optimal nutrition, hydration, and vitamin D dosing<sup>7</sup>
- Physical therapy, rehabilitation, and exercise
- Allowing patients to sleep through the night
- Non-pharmaceutical approaches such as reorienting, redirecting, and verbal de-escalation
- Patient sitters, also called patient safety assistants or companions, non-clinical staff or volunteers who “sit” with, observe, and talk to patients who are at particular risk for getting up impulsively or otherwise harming themselves

The impact of sitters has not been well studied, Dr. Raffel said, and hospitals may struggle with this scarce human resource and its cost. Alternatively, a virtual sitter, with access to two-way cameras and microphones, can observe multiple patients at the same time. A study of this novel patient-observer technology in *NEJM Catalyst* suggests that it achieved a 40% reduction in fall-related injuries.<sup>8</sup> According to Becker’s Health IT, Community Health Systems in Tennessee reported a 76% drop in falls at some of its hospitals from this approach.<sup>9</sup>

“We have expanded our virtual sitter capacity recently,” Dr. Raffel said. “We have an offsite virtual health center where one person with a big track board in front of them can monitor up to 20 patients at once.”

### Mobilization is key

Colorado has been a leader in innovative falls management. But Dr. Raffel said it is still a work in progress. With the COVID-19 pandemic, post-pandemic staff departures, and increased complexity of acute patients in recent years, its fall rates have actually gone up.

A lot of the interventions to prevent falls can also restrict the patient’s mobility and may adversely delay recovery from the acute causes of the hospitalization. At UCHHealth, mobilization is measured at every shift, using AM-PAC (the Activity Measure for Post-Acute Care) along with the JH-HLM (Johns Hopkins Highest Level of Mobility) Scale, “which tells us the highest mobility you’re capable of and the highest mobility you’ve achieved today. It gives us the opportunity to look at patients who have been on our fall precautions to get a sense for how much loss of function they have actually experienced,” Dr. Raffel said.

“Some of the innovative work we’ve done recently has been around expanding the team that helps mobilize hospitalized patients—beyond the physical therapist. Now on our medicine units, we have a team member who is

called a mobility technician—a lot like a physical therapy extender, whose entire workday is just mobilizing patients out of their hospital beds.” The mobility tech can work with up to 18 patients a day, having a pretty profound impact without costing as much, Dr. Raffel said.

The team is trying to get a sense of how best to incorporate mobility techs into the team and which patients they should be targeting. “We’re also enhancing our certified nurse assistant staffing ratios and giving them a larger role in promoting activities of daily living—making sure patients are getting out of bed, getting mobilized, getting to the bathroom or shower,” Dr. Raffel said.

“If I had the podium, I’d tell hospitalists they need to be better partners in this work—because this is our most common adverse event, one that can lead to really major consequences for our patients. While we’ve done a lot of study in reducing falls among the geriatric population in the ambulatory setting, more rigorous study needs to happen in the inpatient setting. The science is just not there yet,” she said.

“I feel that’s where hospitalists can really contribute to achieving a more high-fidelity understanding of what works and what doesn’t work. We’re partners with our nursing colleagues. We can bring a more evidence-based medicine approach that may support the critical thinking of the institution.” ■

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

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# Celebrating National Hospitalist Day

Seeing the people, not just the profession

By Lisa Casinger

Many of us spend more time at work than at home, making it easy to become consumed by our jobs. When we describe ourselves, we often mention our profession first. However, we know there's much more to life than just our work. That's why this year's theme for National Hospitalist Day is "Recognizing the Human in You". It's about acknowledging what brings us joy and sparks our interest outside of work. Some SHM members shared their stories on social media, and we are happy to share them with you. Enjoy learning more about the personal side of your fellow members.

**CHARLIE WRAY, DO, MS,** is a hospitalist and assistant clinical professor of medicine at the University of California, San Francisco.

I started biking as a kid and have always loved the sport. There's no better way to explore a new place than on a bicycle. It's even better when you do it with friends.

**SUBHA AIRAN-JAVIA, MD, FAMILIA,** is a hospitalist and associate professor of medicine at Penn Medicine, in Philadelphia.

I believe the best kind of work is that which excites you to wake up every morning. For the past 20 years, I've been fortunate to experience this, serving patients as a hospitalist, enhancing the practice of medicine as a clinical informatician, innovating as a start-up CEO of CareAlign, and now making a meaningful impact through Catherine Gives, a non-profit I founded in memory of my sister Catherine who struggled with mental illness for decades. Her journey deeply influences my mission to support individuals in need.

I also believe in work hard, play hard. Alongside my professional pursuits, I treasure moments spent gardening with my daughter, gaming with my son, and creating—whether it's through knitting, photography, or ceramic arts. These are all essential to allowing me time to unwind, create, and give to others, while still being productive!

**ANNIE MASSART, MD, SFHM,** is an assistant professor of medicine at Emory University, in Atlanta.

As an attending, I bake double batches of everything, so I've got plenty of snacks for my learners and the staff on the unit. Carbs are my love language, and snacks are one way that I love on all my teammates.

**JOSEPH S. THOMAS, MD,** is a hospitalist at Buffalo Medical Group and a clinical instructor for the Buffalo Catholic Health System internal medicine residency and the D'Youville Physician Assistant Program, in Buffalo, N.Y. He also writes the blog *Managing Health Expectations*, serves as a Digital Media Fellow for the *Journal of Hospital Medicine*, and uses social media for education and advocacy.

When I was five years old, I wanted to do everything my father did, so I found joy in medicine and drum lessons. Drumming (both solo and in my band, Mayday Buffalo) has become my favorite release, and there are few feelings as great as a crowd of people dancing and singing along to the music I'm making!



Dr. Wray

Loves exploring new places on his bike.



Dr. Airan-Javia

Escapes through the creativity of pottery.



Dr. Massart

Showers her teammates with baked goodies.

**JENNIFER K. READLYNN, MD, FHM,** is an adult hospitalist and clinician educator at the University of Rochester School of Medicine & Dentistry, in Rochester, N.Y.

I started watercolor painting during the first year of the COVID-19 pandemic. My mental health was not in a good place, and I needed something to distract me. It was also something my kids could do with me and was calming for all of us. I'm no artist but I enjoy the process regardless of the outcome and that's a helpful mindset to get in on tough days.

**SANDHYA TAGARAM, MD, FACP, FHM,** is a hospitalist at UMass Memorial Medical Center, in Worcester, Mass.

As a physician and mom, I strongly feel that self-care is important for our emotional well-being. I enrolled in Taekwondo and South Indian music lessons along with my daughters in 2021.

The tenets of Taekwondo and my journey in music have inspired me to be more mindful of the present moment and trust the process. These activities also helped me understand the concepts of self-awareness, social awareness, and the importance of lifelong learning. They have helped me to prioritize, focus, and balance my passion and goals on both personal and professional aspects. Self-care is certainly one of the virtues that I will share with my medical students, residents, and kids, which will encourage them to develop mental endurance and a resilient mind.

**KEVIN D'MELLO, MD, FACP, FHM,** is a hospitalist and associate program director, internal medicine residency at Cooper University Health Care, and associate professor of clinical medicine at Cooper Medical School of Rowan University, in Camden, N.J.





Joseph S. Thomas



JENNIFER K. READLYNN



Dr. Thomas

**ABOVE:** Revels in sharing his music with the crowd.

**BELOW:** Practices self-care through Taekwondo lessons and playing the veena.



Dr. Tagaram



Dr. Readlynn

**ABOVE:** Paints watercolors with her kids.

**BELOW:** Relaxes by playing his guitar after a long day.



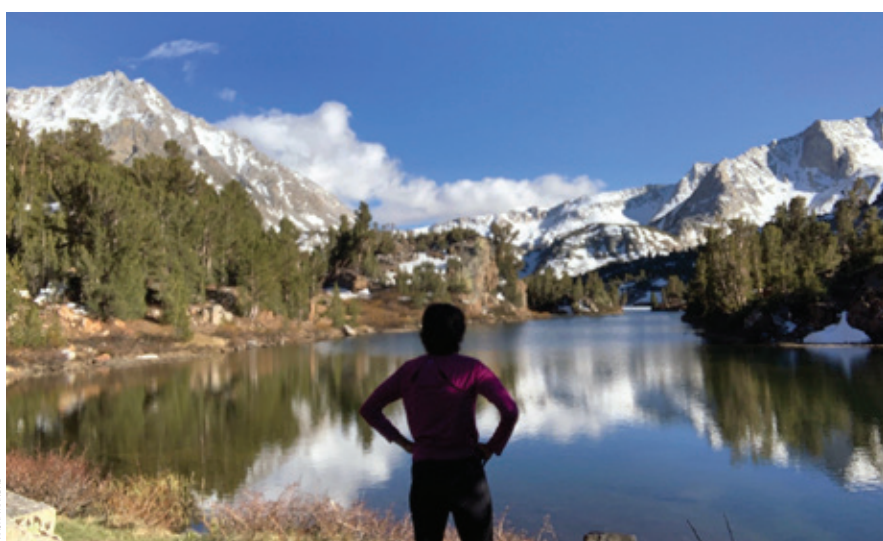
Dr. D'Mello



SANDHYA TAGARAM



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Dr. Mandal



Dr. Rafiq

**LEFT:** Runs the trails in the Sierra Nevada mountains.

**RIGHT:** Finds pockets of meaning and inspiration among his colleagues and fellow SHM members.



Ali Rafiq

Over the past 30 years, my relationship with playing guitar has fluctuated and evolved, and today, it is a major form of relaxation for me, especially after a tough day on the floors. It perfectly combines emotion, intellect, and dexterity, and I do not need to rely on others to do it. It can purely be an expression of me.

**ATASHI MANDAL, MD,** is a med-peds hospitalist in Southern California, whose practice encompasses both community and rural settings.

My work as a rural hospitalist introduced me to my beloved Sierra Nevada mountains. They've changed my life in so many good ways, and I hope to run their trails for as long as my joints will allow. The mountains appear immovable but in fact are always changing, adapting, and evolving, and I strive to follow their example with courage and compassion.

**ALI RAFIQ, MD FACP,** is a hospitalist with Sound Physicians at Ascension Via Christi St. Francis, in Wichita, Kan.

In a rapidly evolving world of health care, hospitalists continue to offer unique insights, thanks to our adaptability. Being a member of SHM is one of the best ways to explore this adaptability. The vision of SHM—to be the professional home of hospitalists dedicated to exceptional and equitable care for acutely ill patients—endorses our role far beyond the walls of the hospital. Handling complex tasks comes naturally to hospitalists, as we can typically maneuver through caring for sick ICU patients, attend cerebral meetings, develop organizational plans, and provide efficient care coordination, all in a day's work.

This intensity, however, can often be paralleled with moral injury. When giving 100% to our jobs, a hospitalist's own well-being can take a back seat. SHM offers several resources for members

to counter this moral injury, and develop habits that can ensure sustainable, meaningful careers. Since the specialty is relatively new, long-term data on hospitalist well-being might be lacking. However, since we spend a humongous proportion of our lives at our workplace, it's worthwhile to explore little pockets of meaning within the work we do. These pockets can come from enriching patient interactions, sharing a laugh with a colleague, enjoying a nutritious meal from the cafeteria, or admiring pieces of history displayed on the walls of our hospitals.

On this National Hospitalist Day, let's work toward finding little pockets of meaning at our workplace. Let's strive to grow and adapt together in the changing health care landscape. Let's continue to support each other through the challenges we face, and embrace the innovation approaching us on the horizon, with the promise of delivering improved patient care. Happy National Hospitalist Day! ■



# Integrating NPs and PAs into Your Hospital Medicine Program

Understanding their similarities and differences

By **Bridget McGrath, MPAS, PA-C, SFHM, Margaret Cecil, APRN, MSN, AGACNP-C, ANP-C, Kasey Bowden, MSN, FNP, AGACNP, ACNP, FHM, Marisha Burden, MD, MBA, FACP, SFHM, Kristin Lindaman, MMS, PA-C, and Mohsin Mirza, MBBS**

The field of hospital medicine is continuously evolving to meet the demands of rising patient numbers and complexity. As a result, nurse practitioners (NPs) and physician assistants or physician associates (PAs) have been incorporated into 84% of adult hospital-medicine programs and 45% of pediatric hospital-medicine programs.<sup>1</sup>

Although NPs and PAs have varying health care backgrounds and diverse educational models, their ultimate goal is to deliver high-quality patient-centered care. Therefore, it is vital to integrate NPs and PAs optimally into hospital-medicine programs while taking into account the unique nuances of each profession. This article aims to explore the similarities and differences between NPs and PAs, enabling health care professionals to foster a high-performing interdisciplinary team.

### Background

Both the NP and PA professions were created in the post-World War II era to fulfill an urgent need for expanded health care delivery and to use the skills of a newly available workforce.

The first NP program was established in 1965 by Henry Silver and Loretta Ford from the University of Colorado School of Medicine in Boulder, Colo. The program emerged due to a significant increase in childbirth rates, which created a significant gap in health care delivery, especially among children and underserved, rural, patient populations.<sup>2</sup> Also, the expansion of Medicare and Medicaid services to include low-income women and children, the elderly, and people with disabilities exacerbated an already critical shortage of primary-care practitioners.<sup>3</sup> Development of the nurse-practitioner profession sought to fulfill these critical needs.

Simultaneously, as World War II drew to a close, a considerable number of army medics and corpsmen transitioned back into civilian life.<sup>4</sup> In 1961, Dr. Charles Hudson identified the opportunity to leverage this vast experience in his

article “Expansion of Medical Professional Services with Nonprofessional Personnel” published in the Journal of the American Medical Association.<sup>5</sup> Dr. Eugene Stead Jr. formalized the PA program, culminating in the inaugural class of physician assistants graduating from Duke University in 1967.<sup>6</sup>

### Educational preparation

Current NPs and PAs graduate with a master's or doctoral degree and undergo rigorous didactic and advanced clinical training. A Bachelor of Science in Nursing (BSN) is a prerequisite for graduate NP education through which applicants gain clinical nursing experience, and many programs require professional experience as a nurse for entry. PA applicants are also required to have a bachelor's degree. Most programs require clinical experience, which may be achieved in various areas such as scribe, respiratory therapist, pharmacy technician, phlebotomist, etc. On average, NP and PA master's programs are approximately 24 months in length. Each program is held to accreditation standards that ensure academic integrity and curricular competencies. Successful completion of a national certifying examination and attainment of state licensure is required before entering clinical practice as an NP or PA. Though not required, both NPs and PAs have the option to obtain a doctoral degree.

NP education is a combination of validated competency in didactic and clinical experiences based on the specialty chosen within the NP field. Core education for NP programs includes advanced pharmacology, advanced pathophysiology, and advanced physical assessment. Clinical rotations and additional didactic content occur in tandem and are tailored to the NP specialty program. While several NP accrediting bodies exist, the predominant organizations in hospital medicine are the American Academy of Nurse Practitioners (AANP) and the American Nurses Credentialing Center (ANCC).<sup>78</sup>

PAs are educated in a generalist medical model. Students complete at least one year of didactic education followed by one or more years of clinical education. The didactic curriculum typically includes core sciences, such as anatomy and physiology, in addition to medical sciences and clinical reasoning. The clinical phase consists of seven core rotations and a variable number of elective rotations. Core rotations include behavioral



Ms. McGrath



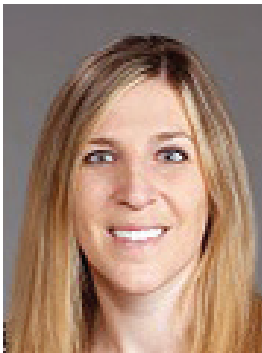
Ms. Cecil



Ms. Bowden



Dr. Burden



Ms. Lindaman



Dr. Mirza

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health, emergency medicine, family medicine, internal medicine, pediatrics, surgery, and women's health. Curriculum content is overseen or guided by the Accreditation Review Commission on Education for the PA (ARC-PA).<sup>9</sup>

Once certified, NPs and PAs may choose to enter clinical practice or pursue optional postgraduate training programs, including doctoral degrees.<sup>10,11</sup> Additional certifications are also available.<sup>12</sup> Completion of credentialing and privileging processes, per institutional policies, is required for both professions.

### Team

Optimal team culture values the

unique backgrounds, characteristics, and skill sets of all team members that comprise a hospital medicine group with a shared goal of providing high-quality, efficient, and evidence-based patient care leading to satisfied patients and satisfied practitioners. Understanding the similarities and differences between NPs and PAs empowers health care professionals to create highly functioning interdisciplinary teams. Hospital medicine practice of NPs, PAs, and their physician colleagues is rooted in many of the same principles: assessment, diagnosis, and treatment; via ordering tests, imaging, lab work, prescribing medications, and other interventions; coupled with patient-centered communication. To build this culture,



leadership has an opportunity to support and demonstrate optimized interprofessional practice through intentional messaging and programming for orientation, collaborative team practice, and professional development inclusive of all disciplines.

### Orientation

A standardized and supportive orientation that is customizable to the clinical and operational experience and background of the NP and PA is vital to ensure high-quality patient-care delivery regardless of the professional role. Hospital medicine leadership has the responsibility of identifying the needs of the hospital medicine program and developing a process for validated competency that focuses on the necessary clinical and operational skill development with the ability to tailor training to the individual. Consideration may be given to years of experience, clinical competencies, and operational competencies. Considerations may include:

- New graduates' possible need of a more detailed and prolonged orientation in comparison to an experienced NP or PA
- Appreciation of types of operational experience to ensure competency in admissions, cross-coverage, rounding, discharging patients, and communication between health care teams and with patients and caregivers
- Background in facility foundational knowledge (e.g., bed management, care coordination, surge capacity, transitions of care)
- Individualized focus based on prior hospital medicine experiences that may differ greatly across different programs (e.g., focused orientation in transplant co-management care)

Multiple resources within SHM exist to help programs accomplish this structured, yet customizable, orientation.

### Collaborative team practice

The importance of understanding that NPs and PAs often function in very similar roles after the initial customized orientation period cannot be understated. In hospital-medicine practices, NPs and PAs work as high-functioning team members in partnership with their physician colleagues to provide high-quality, patient-centered care.<sup>13</sup> An intentional plan for hiring and integration of NPs and PAs into the care-delivery model of the hospital-medicine program should be in place before initiating the hiring process. This will require an understanding of institutional bylaws, rules and regulations, compensation methodologies, and state regulations that should be appreciated for successful NP and



PA incorporation.

While there are some states with restricted and supervisory regulations for NPs and PAs, in the hospital setting these rules are often easily accommodated without jeopardizing autonomy or causing unnecessary administrative burdens for physician colleagues. Oftentimes, simple processes can be put in place to address supervision and collaboration or chart-review requirements. These processes can be easily integrated into already existing workflows and electronic health records for maximal time efficiency.

### Professional development

In addition to clinical practice, NPs and PAs commit to professional development throughout their careers. Both professions require ongoing continuing education hours for license and certification renewal.<sup>7,8,14</sup> Though not required, some NPs and PAs choose to extend their training through a variety of post-graduate training programs, such as fellowships, residencies, doctoral programs, and certificate programs.<sup>10,11,12,15</sup>

Additionally, many NPs and PAs have passions external to the clinical realm such as medical education, clinical operations, quality improvement, and research. This is demonstrated within SHM in forums such as the NP/PA Special Interest Group, the NP/PA track at SHM Converge, and through NP/PA participation in the Research, Innovation, and Vignette scientific-poster competition.<sup>16</sup> SHM also highlights NPs and PAs with diversified interests through the Awards of Excellence program, which includes an award for Clinical Leadership for NPs and PAs and honors members who have made exceptional contributions to

hospital medicine in areas such as system improvement, promotion of clinical knowledge, and patient care.<sup>16</sup>

Through investing in NP and PA professional development, hospital medicine groups have a unique opportunity to cultivate bidirectional mentorship amongst their NP, PA, and physician colleagues to further the mission of excellence for the field of hospital medicine. Effective NP, PA, and physician collaboration yields many positive benefits such as improved patient outcomes, increased efficiency, and improved patient and provider experience.<sup>13,17,18</sup>

### Conclusion

NP and PA integration into hospital medicine practices continues to increase, and optimal integration is vital for excellent patient-care delivery. While the background, educational preparation, and historical underpinnings of NP and PA programs may differ, by focusing on structured and customized orientation coupled with investment in NP and PA professional development, hospital medicine programs will be well prepared for future use of this important workforce. Ultimately, a focus on the team dynamics of hospital medicine physicians, NPs, and PAs working together collaboratively creates a strong foundation to sustain current and future hospital medicine practices. ■

*Disclosure: Ms. McGrath has received a project grant and clinical buy-down from the section of hospital medicine for a project entitled "L.E.A.D from Where You Are: A Framework to Advance the Academic Footprint of Hospitalist Physicians and NP/PAs" effective July 1, 2022. This manuscript counts toward the observed outcomes of the*

*project. Dr. Burden reports funding from the Agency of Healthcare Research and Quality and from the American Medical Association not related to this work.*

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# SIG Spotlight: Interhospital Transfers

Breaking new ground and paving the way

By Richard Quinn

SHM prides itself on connecting teams of like-minded physicians who don't otherwise have folks they can connect with on their chosen niche within hospital medicine.

But what happens when that field of study is so unique that the issue isn't just finding folks who do it, it's figuring out how to even describe what you're doing?

That's part of the work being done by the Interhospital Transfers Special Interest Group, one of the newer entries in SHM's stable of SIGs.

"The SIG is specifically valuable because it's such a new field in hospital medicine," said chair Jessica Dekhtyar, MD, FHM. "We're used to having, in hospital medicine, evidence-based guidelines. But when it came to interhospital transfers, there aren't many studies or publications. I couldn't find a lot of people who were doing what I was doing, and I couldn't find much literature on it to guide me. What are the best practices?"

Well, Dr. Dekhtyar—who founded the SIG—is now writing the book with her fellow group members.

"The real reason behind it is that the health care system, and health care across the nation, is rapidly changing because of shortages of beds, as well as staffing shortages that limited capacity of each hospital," said vice chair Sandeep Pagali, MD, MPH, AGSF, FHM.

Dr. Pagali, an assistant

professor of medicine and a geriatrics hospitalist at Mayo Clinic in Rochester, Minn., says that COVID-19 rapidly accelerated the concerns about interhospital transfers, as bed space became a critical issue—as well as one on many nightly news shows.

"Prior to the pandemic, this was not a huge concern. Everyone was managing on their own bandwidth. Things were working okay. But with the pandemic coming in, and the significant shift in health care staffing resources, the gap of capacity became very prominent, and every single organization came up with its own ways to handle it.

"There are no textbooks about it. There are no triage guidelines about it. There is no published literature identifying how transfer centers are managed. But everybody looked up to hospitalists, because (we) are the key people in the hospital who know how things work in the hospital."

The SIG created the "right platform for all of us to brainstorm, exchange ideas, and troubleshoot," Dr. Pagali said.

"None of us had the magic answer but at least it was very comforting just hearing that I'm not the only one struggling," he said. "Sometimes that in itself gave us comfort and added validation to what we are doing. Even though there are no regulations around this, all we hoped for was safe patient transfers and how we can facilitate them. I am glad that SHM recognized the importance of it and facilitated the platform to create a SIG."

Dr. Dekhtyar, who works at Montefiore Medical Center in the Bronx, New York, echoed the pure value of having a support system for a field so new it didn't have a defined nomenclature.

"That's why I love it," she said. "Because I can feel like I'm alone, and then I realize that experienced and sophisticated health systems are having the same struggles. It validates the chal-

lenges and makes me feel like I'm not missing something obvious.

"It also is important because we kind of have to move fast. This is the way health systems are going. We saw during the pandemic that this is an immediate need, and we have to work together to advance this practice safely and quickly."

Dr. Dekhtyar says that before the pandemic, transfers always moved in a single direction, and usually at the beginning of a patient's hospitalization, from smaller hospitals to large, academic centers. During the COVID-19 surges, when capacity was a constant factor, "that singular unidirectional model had to be reimagined. To manage capacity across a health system we started transferring patients who were nearing discharge, from the main academic center to smaller, community facilities," she said.

So, what did they call that process?

"We have no name for it," Dr. Dekhtyar said. "Some people call that a reverse transfer, but it's one of the jobs of the SIG to come up with standardized nomenclature. We started transferring patients in different directions. Not always small hospitals to big hospitals. Maybe you go from a medium hospital to a medium hospital or a big hospital to a small hospital. And at different parts of a patient's hospitalization."

For Dr. Dekhtyar, the growth of the SIG is the birth of a new field of specialized thought on transfers.

"Forming the SIG, I did it out of desperation and then excitement when I realized there were people out there who had the same struggles," she said. "Some had answers, and some had good ideas. It was particularly crucial because there isn't much evidence-based anything out there when it comes to interhospital transfers."

That won't likely be the case when the SIG gets through with it. ■

Richard Quinn is a freelance writer in New Jersey.



Dr. Dekhtyar



Dr. Pagali





## Chapter Spotlight: San Diego

Engaging younger members in community and academic hospitals

By Richard Quinn

**A**li Farkhondehpour, MD, FACP, FHM, was a third-year medical student who got involved in SHM early in his career, so it likely wouldn't surprise anyone he's risen to president of its San Diego chapter.

"So really far back," he said. "Back then, I really become interested in just hospital medicine, the acuity of inpatient medicine, the breadth of knowledge it takes to care for patients...(now) by getting involved, I think it allows me to give back to the San Diego community while being at a major academic center."

Dr. Farkhondehpour, associate program director for the internal medicine residency program at the University of California, San Diego, says starting so young has taught him the value of having a chapter reach out to younger members.

"I do use our SHM platform to bring on trainees, to introduce them to hospital medicine, and to guide them," he said. "A lot of them are interested in doing it. And it is a little bit nebulous in how you pursue hospital medicine. For a lot of subspecialty fellowships, it's very systematic and guided.



Dr. Farkhondehpour

The interviews are pretty clear... but, when applying for hospital medicine, a lot of residents might not feel guided. What our chapter does, and in my role as a medical educator, we help the residents not only at our own institution but many of the residents in San Diego."

The results speak for themselves as the group won a silver 2022 Chapter Excellence Award. It has been an active participant in broader district-wide events, as well, and there are plans this summer to hold a Rapid Clinical Update.

"It's always nice to receive recognition, particularly for many of our chapter leaders, they're dedicating their free time to do this," Dr. Farkhondehpour said. "They truly are doing this out of a sense of volunteer work, and wanting to be part of the San Diego chapter, and SHM in general, because they see the value of it."

One big event for the chapter is its annual career panel, where hospitalists from community and academic centers are brought in to help residents learn about the hospitals they don't work in. The idea is to have roughly 10 hospitals from various medical centers to show attendees how broad the scope of the field is beyond the walls of a given hospital.

"Many of them don't know anything beyond their own institution," Dr. Farkhondehpour says.

"Do I need letters of recommendation? When do I send my resume? What should my CV even look like?"

Dr. Farkhondehpour says the value of that networking—whether early in your career or at other times—is paramount.

"The value is networking outside of your own institution," he said. "I always found it, even before I became involved as a chapter leader, it was nice to just go to events and network with hospitalists outside of our own place, and to talk to them. Get to learn, 'What does work look like for you? What's your patient population?'"

"Meeting other hospitalists outside your institution does help you understand what the challenges are because they might be facing very similar challenges. And maybe they solved that specific challenge we are facing. It's an exchange of ideas at many of these events."

Now that the young chapter—it was founded in 2019—is positioned for success, Dr. Farkhondehpour is already working to build a generation of future leaders.

One approach is to build a non-leadership board, that he hopes will engage more members from medical centers that may not already have a robust presence in the chapter.

"We are, for the first time, bringing in hospitalists from different

hospitals to our SHM-member board to help engage," he said. "If we don't have a representative from one of these hospitals, the likelihood of some of those hospitalists coming to these events is reduced. So, if they have someone who represents them, I feel like they can advertise it better, and tell them why it is worthwhile coming to these chapter events and being more engaged."

In addition, the chapter is expanding its leadership board and adding an advisory, all moves aimed at having more people get involved.

One hope for Dr. Farkhondehpour is that with SHM Converge in San Diego from April 12 to 15 this year, he can use the backyard aspect of the specialty's largest annual meeting as a motivator—particularly as one of the hurdles to attending a national conference is the travel.

Not for San Diego chapter members this year.

"We are definitely looking to, as a fairly young chapter, continue to increase our chapter membership," he said. "I'm hoping with Converge being here, we can kind of ride the coattails, that perk that when more people attend, they'll be more willing to attend and engage with our chapter more, too." ■

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



# Demystifying Performance Measures for Hospitalists: VTE Prophylaxis

By Matthew Cerasale, MD, MPH, SFHM, Christopher Bruti, MD, MPH, SFHM, and Atashi Mandal, MD

As venous thromboembolism (VTE) became an increasingly recognized cause of death in hospitalized patients, prevention became a high priority for the health care system.<sup>1,2</sup> Starting in 2005, the Joint Commission and the National Quality Forum collaborated to set the stage for the first iteration of VTE-specific measures.<sup>3</sup> Since then, numerous other organizations adopted requirements and practices to report VTE prevention measures and outcomes, including the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, and other domestic and international accreditation agencies. Today, VTE prophylaxis is a common metric used by many hospitals and hospitalist groups to measure quality and performance.

Case

Mrs. Jones is a 75-year-old woman admitted to the hospital with right lower extremity cellulitis and an abscess that has worsened despite taking oral antibiotics at home. She has a history of well-controlled diabetes, hypertension, and hyperlipidemia. The patient is admitted to the hospital for IV antibiotics and surgical evaluation for possible incision and drainage. She ambulates from the bathroom to the bed. As you decide whether to prescribe VTE prophylaxis, the following thoughts come to mind:

- How can I bypass the continuous electronic health record (EHR) alerts for mandatory VTE prophylaxis?
- Which practitioner is responsible for prophylaxis during the periprocedural period?
- Will I get my bonus if I don't order the "right" VTE prophylaxis for this patient?

Moving from universal prophylaxis to universal risk assessment

The expanded use of VTE prophylaxis as a quality metric may not have had the intended effects on practice and patient outcomes. Organizational and regulatory pressures to achieve compliance with VTE measures have resulted in blunt applications of these measures, possibly leading to both unnecessary use in some cases and undertreatment in others. Recently, there has been an effort to shift

the paradigm from the focus on VTE prophylaxis administration, as is exemplified by the VTE-1 measure, to VTE risk assessment, as is used in both British and Australian quality measures. In simplified terms, the standard is shifting from being an "opt-out" strategy for prophylaxis, to "opt-in" only for high-risk patients.

EHR integration

Across the country, hospitalists are familiar with the "hard stop" for VTE prophylaxis in most EHRs. These embedded clinical decision tools are built around the current, common paradigm of universal prophylaxis for patients, and they ensure regulatory measures are met. In patients for whom the clinical gestalt of the hospitalist says VTE prophylaxis is unnecessary or, worse, potentially harmful, these EHR prompts are cumbersome and disruptive of clinical workflows. Focusing on appropriate risk assessment will increase the likelihood of the right patients getting prophylaxis. However, this shift puts more work on the clinician.

The decision for VTE prophylaxis is no longer a simple review of contraindications, but often requires a nuanced understanding of complex risk-assessment tools. This increased mental load could be offset through the optimization of support within the EHR. While varying levels of support and customization can be a limitation with all EHRs, they can still be used as a tool in VTE risk assessment. This can be as simple as displaying the risk-assessment tool and annotating potential orders with the related score ranges, to much more complex systems that can integrate information from the EHR, such as weight and renal function, and present the optimal prophylaxis choice. The feasibility of this approach has been clearly demonstrated.<sup>4-6</sup> More work is required to reach this optimal state in most EHRs and will depend on the preferred risk-stratification tool and comfort levels with complete automatization of the process.

Implications of co-management

The role of the hospitalist in surgical co-management and perioperative optimization creates another challenge for measuring VTE prophylaxis. The importance of VTE prevention in the surgical population is emphasized by Patient Safety Indicator (PSI) 12: Perioperative PE or DVT Rate and the impact it has on multiple quality metrics and reimbursement. Unlike



Dr. Cerasale



Dr. Bruti



Dr. Mandal

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those for medical patients, VTE prophylaxis recommendations and supportive literature range widely for surgical patients, depending on the procedure.

As hospitalists work with surgeons to weigh the risk of clotting

against bleeding, there may be situations where the two recommendations do not align. When hospitalists serve as consultants, they offer just a recommendation to the primary team, but in co-management arrangements, both parties





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have a strong responsibility for the patient, and conflicting care plans may emerge. This emphasizes the importance of directed and standardized communication with the surgical team regarding VTE prophylaxis to ensure the appropriate information is being consistently conveyed.

### Attribution

These concerns circle back to the initial quandary of using VTE prophylaxis as a quality metric to evaluate hospitalists. The opportunities to measure the process and outcomes of VTE prophylaxis, from risk assessment to actually developing a clinical VTE, present a wide range of attributions, which can be strongly or weakly associated with hospitalists, along with a potential for misattribution.

Some countries use risk assessment as a quality measure, which could minimize attribution bias. However, if measurement is based on the completion of the risk assessment or its accuracy, this would require secondary reviews

and could introduce other biases. As another example, the actual administration of appropriate VTE prophylaxis depends not only on the ordering clinician, but also on the bedside nurse delivering the medication and the patient's consent to treatment.

Co-management arrangements also add complexity to attributing performance to a single practitioner. Therefore, the assessment of VTE prophylaxis and even the ultimate outcome measure of clinically significant in-hospital VTE depend on numerous clinical and non-clinical factors, only a few of which fall under the hospitalists' direct control, making them difficult to apply at the provider level.

### Guidance for hospitalist groups

In VTE prophylaxis, there is likely not one single right answer for what process or outcome measure(s) to use for hospitalists, but it is important to understand a measure's strengths, limitations, and what other factors affect it. As

an organization and/or hospitalist group aims to use VTE prophylaxis as a quality process measure, it is also important to understand the new paradigm shift toward risk assessment and to recognize where in the wide continuum of VTE prophylaxis hospitalists can be best attributed and demonstrate the highest impact. Decisions around VTE prophylaxis can be further complicated for hospitalists as their roles expand in the surgical co-management and perioperative optimization settings. To support this process, optimizing the EHR to assist providers in making accurate decisions is key. All these components confound how and if to use VTE prophylaxis as a meaningful quality metric. Overall, if this specific metric is deemed to be a meaningful measure of performance, resources from the organization should be allocated toward optimizing the EHR to assist providers in making accurate decisions. The generation of co-management agreements or rules of engagement among consulting services may also prove helpful. While in-hospi-

tal VTEs are clinically significant events for the patient, a cautious and thoughtful approach should be utilized with VTE prophylaxis as a measure for hospitalists. ■

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Interested applicants should apply via the URL below:  
[www.hmfphysicians.org/careers](http://www.hmfphysicians.org/careers) • Job Requisition No: 171443

Cover letters should be addressed to:

**Richard M. Schwartzstein, M.D.**  
Division of Pulmonary, Critical Care &  
Sleep Medicine  
Beth Israel Deaconess Medical Center  
330 Brookline Avenue, GZ409A  
Boston, Massachusetts 02215

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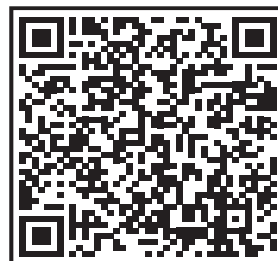
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**Joseph Li, MD - Chief of Hospital Medicine**  
[JLi2@bidmc.harvard.edu](mailto:JLi2@bidmc.harvard.edu)

and

**Rusty Phillips, MD - Director of Recruitment**  
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