April 2025
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THE Hospitalist®

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Thank You!

By Anika Kumar, MD, FAAP, FHM

As SHM Converge 2025 approaches I am feeling excited and a bit nostalgic. I look forward to learning from presenters, connecting with friends and colleagues from across the country, and making new connections. I am also very excited to meet *The Hospitalist's* new editorial board members at our annual meeting.

The April editorial board meeting at Converge will be my final meeting both as a member of the editorial board and as the pediatrics editor, a role I've been in since 2019. Through this role, I have met and learned from hospitalists across the country. I have participated in lively discussions about hospitalists' interests. I have also learned about caring for hospitalized adults, and I have applied some of that knowledge to caring for hospitalized children.

Thank you to SHM for creating a big tent that supports hospitalists from all backgrounds. I consider SHM to be my professional home and am grateful for all the friendships and collaborations that have stemmed from my SHM membership.

Thank you to the SHM Pediatrics Special Interest Group (SIG) members for entrusting me with the responsibility of representing pediatric hospital medicine and our SIG. I hope I have adequately highlighted the wonderful work of our pediatric hospital medicine colleagues.

Thank you to *The Hospitalist's* editorial board members from 2019 to 2025. We accomplished a lot, especially during the pandemic, and I am very proud of our collective products. I have enjoyed working and learning from all of you. I will take what I have learned and apply it to my work as a clinician, colleague, physician, and/or writer.

Thank you to Lisa Casinger, *The Hospitalist's* editor at Wiley, for always having an agenda and assuring we didn't stray too far off-topic. I appreciate you reminding us of the importance of our work and keeping us humble. Also, thanks to Lisa's cat, Chonk, for making cameos during our meetings.

Thank you to former and current SHM staff members Caitlin Cowan, Myles Daigneault, and Kristen Coar for teaching me about creating community and connections. I enjoyed collaborating with all of you.

Dr. Kumar

Dr. Kumar is a clinical assistant professor of pediatrics at the Cleveland Clinic Lerner College of Medicine at Case Western Reserve University and a pediatric hospitalist at Cleveland Clinic Children's, both in Cleveland.

Thanks to Brett Radler, SHM's director of communications, for welcoming me as a new pediatrics editor and fostering my growth in this role. Thank you for always reminding us of *The Hospitalist's* mission, to serve SHM's members, and for always encouraging us to have some fun with our content.

"My hope for the future of The Hospitalist is that you, our readers, continue to provide great content and feedback so that the publication continues to grow and flourish."

Thank you to Dr. Weijen Chang, my predecessor in the role of pediatrics editor and the current physician editor of *The Hospitalist*. Thank you for selecting me as your successor as pediatrics editor. I am grateful for the autonomy and guidance you provided me in this role. I am also appreciative of your mentorship and sponsorship.

Lastly, thank you to our readers. You have provided our editorial board with so much wonderful content and feedback. My hope for the future of *The Hospitalist* is that you, our readers, continue to provide great content and feedback so that the publication continues to grow and flourish. I look forward to joining you all in reading and sharing.

I am pleased to welcome and pass the baton to Dr. Patricia Tran as *The Hospitalist's* new pediatrics editor. I know she will warmly embrace this role and will share a new perspective. ■

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EDITORIAL STAFF

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

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

Editor
Lisa Casinger
lcasinger@wiley.com

Art Director
Christina Whissen

Copy Editor
Peri Dwyer Worrell

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Kate Wimberly, MD
Yuting Ye, MD

PUBLISHING STAFF

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Lisa Dionne Lento
ldionnelen@wiley.com

Associate Director, Advertising Sales
Tracey Davies
tdavies@wiley.com

ADVERTISING STAFF

Display Advertising
Senior Account Managers
Stephen Donohue
sdonohue@wiley.com
MJ Drewn
mdrewn@wiley.com

Classified Advertising
Associate Director of Sales
Allister Crowley
acrowley@wiley.com

THE SOCIETY OF HOSPITAL MEDICINE

Phone: 800-843-3360
Fax: 267-702-2690
Website: www.hospitalmedicine.org

Chief Executive Officer
Eric E. Howell, MD, MHM

Director of Communications
Brett Radler
bradler@hospitalmedicine.org

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

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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.

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Welcome New Editors and Editorial Board Members

The Hospitalist has appointed two new members to its editorial team: Arunab Mehta, MD, MEd, FHM, will assume the recently created role of associate editor, and Patricia Tran, MD, MS, will succeed Anika Kumar, MD, FHM, as pediatrics editor, at SHM Converge on April 23, 2025, in Las Vegas.

"We are delighted to welcome Drs. Mehta and Tran to their new editor roles," said Weijen Chang, MD, SFHM, physician editor of *The Hospitalist*. "Their extensive backgrounds in hospital medicine, coupled with their unique perspectives and volunteer pathways within SHM, make them ideal candidates to amplify the diverse voices within our hospital medicine community. I would also like to extend my sincere gratitude to Dr. Kumar for her years of dedicated service as pediatrics editor."

Dr. Mehta is a hospitalist, medical director, and assistant professor of medicine at the University of Cincinnati Medical Center. He has served in leadership roles in SHM's Northern Ohio/Lake Erie Chapter and was a member of SHM's Education Committee. More recently, Dr. Mehta served a two-year term on the editorial advisory board of *The Hospitalist* and has contributed regularly to its Coding Corner column. As associate editor, he will support the editorial strategy of the news magazine, working closely with fellow editors, SHM staff, and the editorial advisory board.

"With my strong background in program evaluation and improvement, as well as my leadership experience as a medical director, I have gained a deep understanding of the issues that can arise in hospital operations. Yet, more importantly, I have seen how powerful it can be to identify and disseminate solutions that work," Dr. Mehta said. "By highlighting successful strategies from various organizations and sharing them through *The Hospitalist*, I aim to contribute to a broader conversation that helps hospitalists solve common problems and improve care delivery nationwide."

Dr. Tran is an assistant professor of clinical pediatrics at the University of Illinois College of Medicine in Peoria, Ill., and a pediatric hospitalist at the Children's Hospital of Illinois. She is also a deputy editor of digital media for the *Journal of Hospital Medicine*. As pediatrics editor, she will lead strategy for pediatric hospital medicine-focused content, bringing this expertise to the editorial team and ensuring pediatric hospitalists' voices are represented.

"I am grateful to step into the role of pediatrics editor for *The Hospitalist* as it will allow me to contribute to shaping the content and direction of pediatric hospital medicine, while also supporting SHM's mission," Dr. Tran said. "The opportunity to collaborate with a multidisciplinary editorial team and engage with SHM's diverse audience excites me, and I am eager to help translate complex clinical topics into accessible and impactful content, building on the newsmagazine's already strong foundation."

New board members

The Hospitalist's editorial board is comprised of SHM members who volunteer their time and experience in hospital medicine to ensure the magazine remains relevant to readers.

Welcome new board members:

- Jennifer Caputo-Seidler, MD
- Kevin Donohue, DO, FHM
- Arnold W. Facklam, NP, FHM
- Neha Garg, MD
- Prerak Juthani, MD
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- Goutham Talari, MD, SFHM

Thank you to our outgoing members for their time and dedication to the magazine:

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In the Literature

University of California Davis Medical Research Reviews

By Adrienne Atencio, MD, Noelle Boctor, MD, Lauren Damon, MD, Sarah Herrman, MD, Ivonne E. Martinez, MD, Jessie Medina, MD, Lucy Shi, MD, Eric Signoff, MD, FACP, Huixia Wei, MD, Dennis Whang, MD, Theresa Duong, MD

University of California Davis School of Medicine, Sacramento, Calif.

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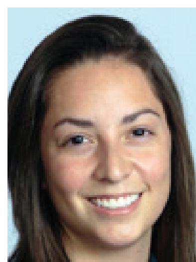
By Adrienne Atencio, MD

1 Effects of Semaglutide on CKD in Patients with Type 2 Diabetes: the FLOW Trial

CLINICAL QUESTION: Does treatment with semaglutide in patients with type 2 diabetes and chronic kidney disease (CKD) prevent the progression of CKD or death from kidney and cardiovascular events?


Dr. Atencio

BACKGROUND: Patients with CKD are at high risk for kidney failure and death from cardiovascular events. Semaglutide, a glucagon-like peptide 1 (GLP-1) receptor agonist, has been shown to reduce cardiovascular events in patients with type 2 diabetes but its effect on kidney outcomes is not fully understood.

STUDY DESIGN: Randomized, double-blinded, placebo-controlled trial

SETTING: 28 countries, 387 sites

SYNOPSIS: 3,533 patients with CKD and type 2 diabetes were randomly assigned to receive once-weekly semaglutide (1,767) or placebo (1,766). The trial had two primary endpoints, major kidney disease events (a composite of the onset of kidney failure with initiation of dialysis, kidney transplantation, eGFR of less than 15 mL/min/1.73 m_2, or eGFR reduction of 50% from baseline) or death from renal and cardiovascular events. The trial was stopped early at a median follow-up of 3.4 years. Patients in the semaglutide arm had a 24% lower relative risk of a primary outcome event (331 versus 410 events, HR, 0.76; *P*=0.0003), with an NNT of 20 patients over three years to prevent one major primary outcome event. Results for kidney-specific components of the primary outcome (HR, 0.79) and death from cardiovascular causes (HR, 0.71) were similar. Limitations include underrepresented Black and indigenous populations and the inability of the trial to assess combination therapy with sodium-glucose cotransporter 2 inhibitors and nonsteroidal mineralocorticoid receptor antagonists.

BOTTOM LINE: In patients with type 2 diabetes and CKD, semaglutide reduced the risk of CKD progression and death from renal and cardiovascular events.

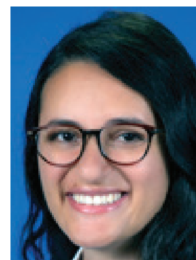
CITATION: Perkovic V, et al. Effects of semaglutide on chronic kidney disease in patients with type 2 diabetes. *N Engl J Med*. 2024;391(2):109-121. doi: 10.1056/NEJMoa2403347.

Dr. Atencio is an assistant professor of medicine and co-chair of hospital medicine clinical operations at the University of California Davis School of Medicine, and president of SHM's Sacramento chapter, both in Sacramento, Calif.

By Noelle Boctor, MD

2 High-Flow Nasal Cannula Versus Non-Invasive Ventilation for AECOPD

CLINICAL QUESTION: Is high-flow nasal cannula oxygen therapy (HFNC) non-inferior to non-invasive ventilation (NIV) for acute exacerbations of chronic obstructive pulmonary disease (AECOPD) in patients admitted to the medical intensive care unit?


Dr. Boctor

BACKGROUND: NIV is the recommended standard respiratory therapy for patients who present with AECOPD and moderate hypercapnic respiratory failure. Cumulative studies have shown benefits in using HFNC for stable COPD patients; however, randomized trials comparing HFNC with NIV for the initial treatment of AECOPD are limited.

STUDY DESIGN: Randomized, open-label, non-inferiority trial

SETTING: Two intensive care units at a large tertiary academic teaching hospital in China between March 2018 and December 2022

SYNOPSIS: 228 patients admitted to two intensive care units for AECOPD who had baseline arterial blood gas pH between 7.25 and 7.35 and $PaCO_2$ of at least 50 mmHg were randomized to receive initial respiratory support with HFNC or NIV. The primary endpoint was the failure rate of the initial intervention (either via intubation or a switch to the other study treatment modality). The failure rate of the HFNC group was higher (25.7%) than the NIV group (14.3%). The HFNC group also experienced higher intubation rates compared to the NIV group (14.2% versus 5.4%, *P*=0.026). The failure rate risk difference between both groups was 11.38% (95% CI, 0.25-21.20, *P*=0.033) which was higher than the 9% cutoff for non-inferiority. Some study limitations included generalizability, given it was a single-center study, and the inability to blind the attending physicians or patients to the intervention. The study demonstrated that HFNC resulted in more intubations or switches to the other study treatment modality, compared to NIV use, when used as initial respiratory support for patients with AECOPD and moderate hypercapnic respiratory failure.

BOTTOM LINE: Initial respiratory support with HFNC resulted in more frequent treatment failure and intubations compared to NIV in patients presenting with acute to moderate hypercapnic respiratory failure from AECOPD.

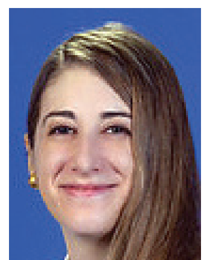
CITATION: Tan D, et al. High flow nasal cannula oxygen therapy versus non-invasive ventilation for acute exacerbations of chronic obstructive pulmonary disease with acute-moderate hypercapnic respiratory failure: a randomized controlled non-inferiority trial. *Crit Care*. 2024;28(1):250. doi:10.1186/s13054-024-05040-9.

Dr. Boctor is an academic hospitalist in the department of internal medicine and an assistant clinical professor at the University of California Davis School of Medicine, and an executive board member for SHM's Sacramento chapter, both in Sacramento, Calif.

By Lauren Damon, MD

3 Sex Disparities in Opioid Prescription Practices on a Hospital Medicine Service

CLINICAL QUESTION: Does patient sex influence opioid prescription patterns during hospitalization and at discharge on general medicine services?


Dr. Damon

BACKGROUND: Clinicians may have sex- and gender-based biases in pain management, potentially leading to disparities in opioid prescriptions. Studies

have shown that clinicians tend to underestimate pain in female patients.

STUDY DESIGN: Retrospective cohort study

SETTING: Inpatient general medicine service at UCSF Helen Diller Medical Center in San Francisco

SYNOPSIS: This retrospective cohort study analyzed opioid prescription patterns for 48,745 hospitalizations involving 27,777 patients at a large academic medical center from 2013 to 2021. 50.1% of hospitalized patients were female. When adjusted for demographic, clinical, and hospitalization-related variables, female patients were less likely to receive inpatient opioids (adjusted OR 0.87, *P* <0.001) and received fewer morphine milligram equivalents (MMEs) on average (27.46 fewer MMEs/day; *P* <0.001) compared to male patients. No significant differences were found in discharge opioid prescriptions (OR, 0.98; *P*=0.594). Subgroup analysis of common pain-related diagnoses (abdominal pain, acute back pain, pancreatitis) revealed similar trends. These findings suggest that while female patients report higher pain scores, they are often under-prescribed opioids during hospitalization. Limitations include reliance on sex rather than gender identity, potential confounding due to disease severity, and unaccounted pharmacological factors such as weight, body mass index, and renal function. These results highlight the need to address gender biases in pain management.

BOTTOM LINE: Despite higher pain scores, female patients are less likely to receive opioids and when they do, receive fewer MMEs than male patients during hospitalization, suggesting potential sex-based disparities in pain management.

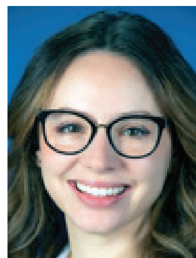
CITATION: Yang, N, et al. Sex disparities in opioid prescription and administration on a hospital medicine service. *J Gen Intern Med*. 2024;39(14):2679-2688. doi.org/10.1007/s11606-024-08814-7.

Dr. Damon is an academic hospitalist at the University of California Davis Medical Center, and internal medicine clerkship director and the hospital medicine track co-director for the internal medicine residency at the University of California Davis School of Medicine in Sacramento, Calif.

By Sarah Herrman, MD

4 The CONVINCE Trial: No Reduction in Recurrent Vascular Events with Long-Term Colchicine Use After Ischemic Stroke

CLINICAL QUESTION: Does long-term colchicine use plus guideline-based care after ischemic stroke prevent recurrent vascular events?


Dr. Herrman

BACKGROUND: According to the World Health Organization, stroke is the third leading cause of death worldwide. Prior studies in patients with coronary artery disease have shown that colchicine and other anti-inflammatory agents have helped to prevent recurrent events. Inflammation is known to be associated with initial and recurrent stroke events, but the use of colchicine has not yet been studied after stroke.

STUDY DESIGN: Prospective, randomized, open-label trial

SETTING: 144 hospital sites across 13 European countries and Canada between December 19, 2016 and November 21, 2022

SYNOPSIS: 3,154 patients above the age of 39 who had been diagnosed with non-severe ischemic stroke or high-risk transient ischemic attack (TIA) were randomized to receive colchicine 0.5 mg orally daily or no colchicine, plus guideline-based stroke care. Exclusion criteria included stroke or TIA due to atrial fibrillation or other cardioembolic cause, pre-existing diagnosis of moderate to severe renal, liver, or blood disorders, inflammatory bowel disease, and chronic diarrhea, among others. The primary composite endpoint was first, recurrent, fatal, or non-fatal ischemic stroke, myocardial infarction, cardiac arrest, or hospitalization for unstable angina or vascular death within 30 days. Patients were followed for a median of 33.6 months. The primary endpoint occurred in 153 patients (9.8%) in the colchicine group and 185 patients (11.7%) in the standard care group (*P*=0.12). The adjusted hazard ratio was 0.84 (95% CI, 0.68–1.05; *P*=0.12). Rates of serious adverse events were similar in both groups. Due to the COVID-19 pandemic, the trial prematurely ended, resulting in fewer than expected number of endpoints and a reduction in statistical power.

BOTTOM LINE: Administration of colchicine after non-severe ischemic stroke or high-risk TIA did not result in a statistically significant reduction in recurrent vascular events.

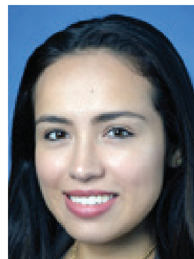
CITATION: Kelly P, et al. Long-term colchicine for the prevention of vascular recurrent events in non-cardioembolic stroke (CONVINCE): a randomized controlled trial. *Lancet*. 2024;404(10448):125-133. doi: 10.1016/S0140-6736(24)00968-1.

Dr. Herrman is an academic hospitalist at the University of California Davis Medical Center, and a pre-clerkship clinical skills discipline co-lead at the UC Davis School of Medicine, both in Sacramento, Calif.

By Ivonne E. Martinez, MD

5 Risk of Major GI Adverse Events with Use of Potassium Binders in the Hospital

CLINICAL QUESTION: Are the new potassium binders, patiromer and sodium zirconium cyclosilicate (SZC), safer than sodium polystyrene sulfonate (SPS)?


Dr. Martinez

BACKGROUND: Potassium binders were created to reduce the adverse gastrointestinal events, like intestinal necrosis, associated with SPS. However, analyses comparing the safety of SPS with the new binders remain limited.

STUDY DESIGN: Retrospective cohort study

SETTING: Veteran Affairs hospitals throughout the U.S.

SYNOPSIS: Using the VA Corporate Data Warehouse database, 3,144,960 admissions (1,461,933 adult patients, ≤30 days) were categorized by: potassium binder use, SPS (30,040; 1%), patiromer (3,750; 0.1%), or SZC (5,520; 0.2%); or no binder (3,105,650; 98.7%). Primary 30-day outcomes were intestinal ischemia or thrombosis and composite major GI adverse outcomes. Intestinal ischemia or thrombosis occurred in 106 (0.35%; aOR, 1.40 [CI, 1.16 to 1.69]) with SPS, 12 (0.32%; aOR, 1.36 [CI, 0.79 to 2.36]) with patiromer, and 24 (0.43%; aOR, 1.78 [CI, 1.21 to 2.63]) with SZC, versus 6,998 (0.23%) without binder. Composite gastrointestinal adverse outcomes occurred in 754 (2.51%; aOR, 1.00 [CI, 0.94 to 1.08]) with SPS, 96 (2.56%; aOR, 1.08 [CI, 0.89 to 1.32]) with patiromer, and 144 (2.61%; aOR, 1.08 [CI, 0.93 to 1.27]) with SZC, versus 75,488 (2.43%) without binder. SPS and SZC were associated with an increased risk of ischemia or thrombosis, but no statistical difference was found between the new binders and SPS. No association was found with composite GI outcomes. Limitations include the observational design (limited data), residual confounding, and limited generalizability.

BOTTOM LINE: The risk of intestinal ischemia or thrombosis or major GI adverse events is low among all three potassium binders studied and this may be a class effect of potassium binders rather than associated with any single medication.

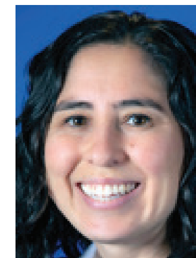
CITATION: Holleck JL, et al. Risk of serious adverse gastrointestinal events with potassium binders in hospitalized patients: A national study. *J Gen Intern Med*. 2024. doi:10.1007/s11606-024-08979-1.

Dr. Martinez is a hospitalist and co-chair of the QI committee in the division of hospital medicine at University of California Davis Health in Sacramento, Calif.

By Jessie Medina, MD

6 Racial and Ethnic Bias Through Language Application in Letters of Recommendation

CLINICAL QUESTION: Are there racial, ethnic, and underrepresented in medicine (UIM) differences in letters of recommendation and standardized letters of recommendation?


Dr. Medina

BACKGROUND: Letters of recommendation are becoming an increasingly important element in the evaluation of applicants at all stages of academic promotion. As traditional components of assessment such as Step 1 and clerkship grading move towards "pass/fail," narrative comments including letters of recommendation are becoming increasingly consequential. Studies have demonstrated gender bias in letters of recommendation specifically with adjectives to describe men and women in the domains of agentic (assertiveness), communal (interpersonal sensitivity), grindstone (dedication), and standout (outstanding) language. Standardized letters of recommendation are intended to be more objective, however they have also been found to demonstrate gender bias.

STUDY DESIGN: Systematic review with data abstraction

SETTING: Original, peer-reviewed, English-language publications assessing racial, ethnic, or UIM status differences in letters of recommendation from the following electronic databases: MEDLINE via PubMed, SCOPUS, Education Resources Information Center (ERIC), PsycInfo, Embase, and Cochrane Database of Systematic Review

SYNOPSIS: 23 studies were included which looked at 19,012 applications and 41,925 letters of recommendation with 82.6% of studies assessing the letters for residency and 17.4% assessing them for fellowship. 17 of 23 studies looked at linguistic differences with 15 (88.2%) reporting statistically

significant differences based on race or ethnicity. 7 of 17 studies showed fewer agentic terms used for Black and Latino applicants. One study noted more communal terms used in letters for Hispanic, Latino, and Black applicants which were often framed negatively. White applicants were more often described as "exceptional," "best," or "outstanding." 8.7% of all studies demonstrated UIM applicants were more likely to have doubt-raising language compared to non-UIM applicants. Standardized letters of recommendation were found to have fewer linguistic differences among applicants compared to narrative or unstructured letters of recommendation.

BOTTOM LINE: Bias exists in academic medicine letters of recommendation based on ethnic, race, and UIM status specifically in regard to language application. Use of standardized letters should be considered as they may decrease racial and ethnic bias compared to traditional letters of recommendation.

CITATION: Deshpande SR, et al. Racial and ethnic bias in letters of recommendation in academic medicine: a systematic review. *Acad Med*. 2024;99(9):1032-1037. doi:10.1097/ACM.0000000000005688.

Dr. Medina is an academic hospitalist and assistant clinical professor at the University of California Davis School of Medicine and the internal medicine clerkship director and vice president of SHM's Sacramento chapter, both in Sacramento, Calif.

By Lucy Shi, MD

7 Language Discordance Increases Risk of Hospital Readmissions

CLINICAL QUESTION: Does language discordance increase hospital readmissions or unplanned emergency department (ED) visits?

Dr. Shi

BACKGROUND: Studies have shown that language discordance impacts patient-clinician communication and patient ease of accessing care, but it is unclear whether language discordance impacts readmissions or ED revisits.

STUDY DESIGN: Systematic review and meta-analysis

SETTING: Hospitals and EDs in the U.S., Australia, Canada, and Switzerland

SYNOPSIS: This article sought to determine whether patient-clinician language discordance increases the risk of unplanned hospital readmission or ED revisits. A total of 49 studies were included and the majority were observational studies looking at hospitalized adult patients from the general medicine service. They found that adult patients with a non-dominant language preference had an increased odds of 28 or 30-day hospital readmissions (OR, 1.11 [95% CI, 1.04-1.18]) and 30-day ED revisits (OR, 1.07 [95% CI, 1-1.15]). For pediatric patients where the parent was identified as having a non-dominant language preference, they found a higher rate of 72-hour ED revisits (OR, 1.12 [95% CI, 1.05-1.19]) and seven-day ED revisits (OR, 1.02 [95% CI, 1.01-1.03]). Only two studies looked at the use of interpretation services and found no difference in readmission rates when interpreters were used. The studies were somewhat heterogenous in terms of study design, language discordance definition, inclusion criteria, and outcome timing. Additionally, there was limited literature looking at the impact of language access interventions such as interpretation services on clinical outcomes.

BOTTOM LINE: Language discordance between clinicians and patients is associated with higher odds of readmission or ED revisit and additional studies are needed to see if using interpretation services has an impact on clinical outcomes.

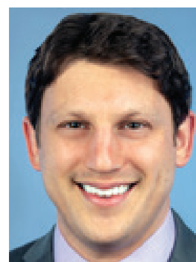
CITATION: Chu JN, et al. Association between language discordance and unplanned hospital readmissions or emergency department revisits: a systematic review and meta-analysis. *BMJ Qual Saf*. 2024;33(7):456-469. doi:10.1136/bmjqs-2023-016295.

Dr. Shi is an assistant clinical professor and the director of student-run clinics at the University of California Davis School of Medicine in Sacramento, Calif.

By Eric Signoff, MD, FACP

8 Ammonia Levels Do Not Reflect Severity of Hepatic Encephalopathy in Hospitalized Patients with Cirrhosis

CLINICAL QUESTION: Do serum ammonia levels correlate with the severity of overt hepatic encephalopathy (OHE) in hospitalized patients with cirrhosis?


Dr. Signoff

BACKGROUND: Guidelines recommend diagnosing OHE clinically rather than relying on ammonia levels. Nonetheless, clinicians frequently use serum ammonia levels as a marker of OHE severity in hospitalized patients with cirrhosis to guide treatment decisions. This practice leads to an estimated annual expenditure of more than $1 million dollars in the U.S. Thus, there remains significant opportunity to integrate evidence-based medicine and high-value care into clinical practice.

STUDY DESIGN: Secondary review of randomized, double-blinded, placebo-controlled trial

SETTING: Multiple hospitals in the U.S. between September 2018 and March 2020

SYNOPSIS: The study investigates the relationship between serum ammonia levels and the severity of OHE in 44 hospitalized patients with cirrhosis who were receiving lactulose therapy. The study found no significant correlation between serum ammonia levels and the severity of OHE. Of note, only 60% of patients clinically diagnosed with OHE had elevated ammonia levels (>72 μmol/L) while patients with elevated ammonia levels did not have correspondingly more severe OHE. There was also no correlation between ammonia level and time to resolution of OHE. Further reducing the utility of serum ammonia levels to guide clinical decision-making, the study also noted substantial interlaboratory variability in ammonia measurements. This study ultimately puts any debate to rest regarding reliance on ammonia levels for guiding diagnosis and treatment decisions in patients with cirrhosis regarding OHE.

BOTTOM LINE: While ammonia plays a role in the pathophysiology of hepatic encephalopathy, it lacks clinical utility as a severity marker due to the absence of correlation with OHE in cirrhosis.

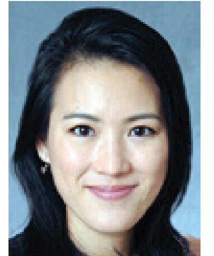
CITATION: Bajaj JS, et al. Serum ammonia levels do not correlate with overt hepatic encephalopathy severity in hospitalized patients with cirrhosis. *Clin Gastroenterol Hepatol*. 2024;22(9):1950-1952.e1. doi:10.1016/j.cgh.2024.02.015.

Dr. Signoff is an academic hospitalist in the department of internal medicine and an associate professor at the University of California Davis Medical School in Sacramento, Calif.

By Huixia Wei, MD

9 Can Salt Stir the Pot? Sodium's Effect on HF Clinical Outcomes

CLINICAL QUESTION: Is there an association between baseline dietary sodium intake and clinical outcomes in heart failure?


Dr. Wei

BACKGROUND: Dietary sodium restriction is common advice for patients with heart failure (HF) to prevent fluid overload and adverse outcomes. The recently published randomized clinical trial, namely SODIUM-HF (published in *Lancet* in 2022), showed that in ambulatory patients who have HF with either reduced or preserved ejection fraction, a dietary intervention to reduce sodium intake did not reduce cardiovascular (CV)-related hospitalization or all-cause mortality. This secondary analysis on the data collected from the SODIUM-HF trial explores the relationship between baseline dietary sodium intake and clinical outcomes in HF.

STUDY DESIGN: Post hoc exploratory analysis of an international, open-label, randomized, controlled trial, namely SODIUM-HF

SETTING: Ambulatory patients from 26 sites in six countries with varied diets over an intervention period of 12 months

SYNOPSIS: The SODIUM-HF trial was conducted between March 2014 and December 2020 and enrolled 806 patients from 26 sites in six countries (Australia, New Zealand, Canada, Chile, Colombia, and Mexico). The patients were randomized into either usual care or a low-sodium diet of less than 100 mmol (i.e., less than 1500 mg) a day over an intervention period of 12 months. The primary outcome was the composite of CV-related hospitalization, CV-related emergency department (ED) visits, and all-cause death measured at 12 and 24 months. Using the data from the SODIUM-HF trial, this secondary analysis focuses on assessing the association between baseline dietary sodium intake and the study outcome, and the relationship between change in dietary sodium intake at six months and the study outcomes at 12 and 24 months. In summary, the analysis found that HF patients with higher baseline sodium intake do not necessarily have higher incidence of all-cause mortality, CV-related hospitalization or ED visits over the monitored period of two years. Furthermore, there is no association between the magnitude of dietary sodium reduction and these HF clinical outcomes. Of note, this post hoc analysis is limited by the data collected in one single clinical randomized trial, in which baseline dietary information and adherence to dietary sodium restriction were self-reported by ambulatory patients.

BOTTOM LINE: Baseline dietary sodium intake has no significant impact on clinical outcomes over 24 months in patients with HF.

CITATION: Saldarriaga C, et al. Dietary sodium intake and outcomes: a secondary analysis from SODIUM-HF. *J Card Fail*. 2024;30(9):1073-1082. doi: 10.1016/j.cardfail.2024.04.031.

Dr. Wei is a hospitalist in the department of hospital medicine at the University of California Davis in Sacramento, Calif.

By Dennis Whang, MD

10 Moderate IV Fluid Resuscitation is the Goldilocks of Sepsis Mortality in ICU Patients

CLINICAL QUESTION: In patients presenting to the intensive care unit (ICU) for sepsis, which intravenous (IV) fluid resuscitation strategy (restrictive, liberal, or moderate) is optimal for lower mortality?

Dr. Whang

BACKGROUND: IV fluids are used to restore effective circulating volume and tissue perfusion for patients with sepsis. Early goal-directed therapy directed by the Rivers trial in 2001 has led to the swift adoption of high-volume IV fluid resuscitation. However, subsequent studies have shown varying benefits between restrictive and liberal IV fluid resuscitation strategies. Clinical uncertainty regarding either IV fluid resuscitation strategy for septic patients has led to large practice variation among physicians.

STUDY DESIGN: Retrospective analysis of the Premier Healthcare Database

SETTING: 612 U.S. hospitals from January 1, 2016 to December 31, 2019

SYNOPSIS: Inclusion criteria were patients with ICD-10-CM codes for sepsis, septic shock, or infection with acute organ dysfunction on admission, aged 18 years or older, admitted from the emergency department (ED) to the ICU on hospital day one, and who received IV antibiotics and IV fluids on hospital day one. Exclusion criteria were hospitals with less than 20 cases and poor IV fluid reporting, patients given less than 1 L of fluids, identified as do not resuscitate (DNR), who underwent surgery, or who transferred from another hospital. The primary outcome was hospital mortality. The study analyzed 190,682 patients with sepsis and septic shock among 24,445 attending physicians who were separated to five fluid groups: very low, low, moderate, high, and very high. Patients in the moderate fluid group were administered a median of 4.0 L of IV fluids on hospital day one and experienced a 2.5% reduction of risk-adjusted mortality compared with very low group (1.6 L) or very high group (6.1 L), *P* <0.01. Large variance of IV fluid resuscitation was observed (95% range, 1.7 to 7.4 L) despite similar patient characteristics. Limitations of the study are that the observational study design cannot establish causality between IV fluid resuscitation and sepsis mortality, the absence of data on timing of antibiotics administration and patient height and weight, and use of ICD-10 coding to identify patients.

BOTTOM LINE: A moderate IV fluid resuscitation approach (3.6 to 4.5 L) is associated with lower mortality in ICU patients presenting with sepsis, compared to restrictive and liberal fluid strategies. Further randomized controlled trials and guidelines are needed to determine optimal use of IV fluid resuscitation and to reduce physician variability.

CITATION: Corl KA, et al. Moderate IV fluid resuscitation is associated with decreased sepsis mortality. *Crit Care Med*. 2024;52(11):e557-e567. doi: 10.1097/CCM.0000000000006394.

Dr. Whang is hospitalist in the division of hospital medicine at the University of California Davis Medical Center in Sacramento, Calif.

SHORT TAKES

LACK OF PREDICTIVE RISK STRATIFICATION MODELS FOR STROKE IN NEW-ONSET ATRIAL FIBRILLATION SECONDARY TO SEPSIS

By Theresa Duong, MD

A retrospective cohort study shows that the CHA2DS2VASc score and a novel prediction model that includes presepsis and intrasepsis variables are not predictive of one-year stroke risk in new-onset atrial fibrillation secondary to sepsis.

CITATION: Myers LC, et al. Predicting stroke risk after sepsis hospitalization with new-onset atrial fibrillation. *J Hosp Med*. 2024;19(7):565-571. doi:https://doi.org/10.1002/jhm.13343.

Dr. Duong is a hospitalist in the division of hospital medicine, department of internal medicine, at the University of California Davis Medical Center, and an associate clinical professor of medicine at University of California Davis School of Medicine, both in Sacramento, Calif.

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The Balancing Act

How hospitalists juggle clinical care and teaching responsibilities

By Ruth Jessen Hickman, MD

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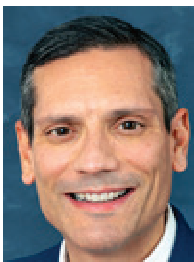
Among their many responsibilities, hospitalists typically rank patient care as their number one priority and the education of medical students, residents, and fellows as a critical number two. As hospitalists have grown as a field, they have taken on increasing roles in educational activities, including leading medical student clerkships and residency fellowship programs, designing curricula, and participating in procedural training, coaching, and mentoring.[1]

Although patient care is the key focal point, the traditional structure of daily hospital rounds with a team over a longitudinal period provides opportunities for student observation, goal setting, feedback, and impressive student learning. Hospitalists can strategically intersperse teaching and more direct clinical care throughout the day, providing learners with opportunities for growth while still maintaining excellent clinical care.[2]

However, the challenges of direct patient care responsibilities and other required tasks may sometimes infringe upon an optimal medical education. Thus, practitioners must learn how to appropriately balance and prioritize competing demands on their time.

Based on their positions, hospitalists have greater or less educational responsibilities. Some community hospitalists may sometimes play supervisory roles for medical students, residents, or fellows without being direct members of a trainee service. Others may oversee teaching services, in which some combination of trainees with varying levels of experience work together to oversee care. In many cases, hospitalists also need to cover some additional patients not on the teaching service, which requires thoughtfulness in terms of timing and prioritization. Given the scope of these demands, it can be challenging to get everything done.

"Preparation and organization are both key for maintaining that balance between clinical care and teaching responsibilities," said Dustin T. Smith, MD, SFHM, section chief for inpatient medicine at the Atlanta Veterans Affairs Medical Center, associate program director for the J. Willis Hurst Internal Medicine Residency Program, and an associate professor of medicine at Emory University School of Medicine in Atlanta.



Dr. Smith

Kathleen Lane, MD, director for the Inpatient Process of Care Clerkship and an assistant professor of medicine at the University of Minnesota Medical School in Minneapolis, added, "I really appreciate the value of setting expectations, having structure, and trying to develop trust between the team and me."

Dr. Lane

Academic hospitalists have additional teaching responsibilities, such as mentorship and formal lectures for medical students, residents, or colleagues. Academic medicine also comes with additional responsibilities not directly related to either clinical care or education, such as administrative and research tasks, which may also be essential in advancing one's career.

The Hospitalist talked with Drs. Smith, Lane, and other hospitalists about how they balance and prioritize clinical care and teaching while working directly with trainees on the wards. They also addressed some of the challenges of balancing clinical care, teaching, and other duties within the broader context of a career in academic hospital medicine.

Balancing clinical care and teaching on the wards

The optimal way to balance teaching while on the wards may vary somewhat depending on one's specific appointment and responsibilities, individual organizational approach, and personal style and preferences, and on local institutional culture, but some general overarching principles may apply.

Creating a positive environment, getting to know your team, and setting expectations

Several of the hospitalists pointed out the importance of setting the right tone for the teaching team to help ensure a positive, collaborative approach essential for both trainee learning and optimal clinical care.

"I want to get to know them and show that I am invested in them as a human being, invested in them becoming an excellent physician," said Dr. Lane. "When that is there, the team becomes more engaged in sharing their thoughts and ideas about patient care, even if it's not their direct patient."

Dr. Smith emphasized the importance of maintaining the right team atmosphere, one which emphasizes psychological safety and approachability, an environment in which asking questions and soliciting real-time feedback is welcomed. He added, "I want our healthcare professional trainees to know that we're here on service working together as a team to try to provide excellent patient care—we need one another to succeed at this."

An important part of getting to know the team is getting a sense of trainees' skill levels and strengths, to help inform the degree of supervision and the kind of education needed. Not enough supervision of a trainee who needs more instruction and support might negatively impact patient care and not give trainees the education they need.

Yet Jenny Y. Shen, MD, FHM, an academic hospitalist and an associate professor of medicine and clinical nursing at the University of Rochester Medical Center, noted that in some cases it can inhibit trainee growth if one doesn't grant them enough autonomy and responsibility. Input from the senior resident can be insightful in gauging this, as can context from the previous hospitalist on the service.

Dr. Shen

Getting a sense of learners' goals can be another helpful part of getting to know the team. Dr. Lane has all her trainees set a goal for the time they will be together on service using a SMART (specific, measurable, achievable, relevant, and time-bound) goals format. This helps guide trainee growth and

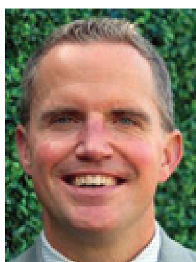
can inform evaluation as well.

In general, being clear about setting expectations with trainees can help with both clinical efficiency and learner growth. Dr. Lane shares a list of expectations with her trainees at the beginning of service, tailored to individuals at different levels of training, and she also provides expectations they should have for her.

Preparation, organization, and prioritization

Part of setting clear expectations is being clear, thoughtful, and consistent about scheduling and the team plan, setting a consistent time for rounds and checking back in later in the day. This helps both the supervising hospitalist and the trainees be most efficient with their time, leaving more opportunities for student education and other tasks.

Bradley A. Sharpe, MD, SFHM, is a professor of clinical medicine and a clinician-educator in the division of hospital medicine at University of California San Francisco Health in San Francisco. He pointed out that when setting times to meet, it's important to keep in mind relevant aspects of the schedule, such as when medical students will be unavailable due to afternoon conferences.


Dr. Sharpe

The schedule and timeline for rounds can vary somewhat based on institutional structures and personal preference. But for clinical and workflow efficiency, it's important not to let them extend for too long, said Dr. Shen.

Pre-rounding by the hospitalist, when possible, can be an important part of making the most out of rounds both clinically and for educational aspects. Dr. Smith always pre-rounds on his patients and starts his notes and task lists before meeting with his team, who have already done their own initial assessments. This helps streamline the later discussion with the team on patient plans.

"If you have all the information at hand that you need to be able to move through the aspects of clinical care, you create efficiency," said Dr. Smith. "Then you can talk more about what's actually going on with the patients, focus time on clinical reasoning, and make point-of-care teaching points."

Dr. Lane also uses that pre-rounding time to pick out a few teaching topics that apply to the current patient load, pulling out teaching resources (e.g., recent guidelines) that might be applicable. "I don't want to fall into the trap of trying to teach every single little thing," she said. "I want to make sure that that burst of team rounding time is high-yield for our patients and learners. Sometimes other educational things can come later, like in the afternoon, when you have more time."

Figure 1. The Eisenhower Matrix.

Dr. Shen also noted that sometimes she must get clinically oriented with the patient before adding in the educational element. "If I'm really comfortable with the clinical scenario then I clear out my bandwidth to actually be assessing the interactions between the students and the residents."

Another key aspect of prioritization is simply recognizing which elements are urgent and important and must be done immediately. Other tasks, like aspects of trainee education, might need to be scheduled, as they are important but not urgently needed at a specific moment. Tasks that are time-sensitive but not important might best be delegated, and those that are neither urgent nor important might best be deleted (see Figure 1).

Role-modeling and multitasking versus time blocking

A paradox of time management on the wards is that both multitasking and time-block compartmentalization can be essential for balancing clinical responsibilities, educational goals, and other tasks.

For example, Dr. Smith compartmentalizes certain necessary tasks that don't directly pertain to clinical care that he might be able to take care of before or after rounds. "You can separate those tasks, so your overarching to-do list is not too long at the end of the day. This allows you to focus on the patient care that you're providing and not be distracted by pending tasks outside of the clinical context."

It may be helpful to block time in the afternoon for additional tasks like seeing additional patients not on the teaching team or performing tasks related to academic medicine, and knowing the schedule can help one find appropriate times for this. However, Dr. Sharpe noted that it's important not to overbook this time, as it can decrease one's availability to the team and impair educational opportunities.

Finding time for didactics in the afternoon can be beneficial, noted Dr. Sharpe, but it's often best to keep this relatively short (probably no more than 15 to 20 minutes). However, such didactic sessions are not the only approach to education, as education can be built into each clinical encounter.

Dr. Shen shared, "I believe that, to balance the teaching and the clinical work, you have to combine them both." As much as possible, she multitasks and interweaves the education aspect with patient care. Instead of quizzing or lecturing, she focuses on guiding trainees through practical applications of their medical knowledge, troubleshooting more challenging cases with them, and referring them to additional resources as needed.

Positive role modeling is also a critical part of education while on service. Sometimes Dr. Lane purposefully takes over an element from her senior resident, because she wants to demonstrate how she would do it for the benefit of the trainees.

"It's really the best to role model what you are trying to teach," said Dr. Smith. "But you must be particularly mindful of that because you can unintentionally role model bad behaviors as well. Approaching patients and learners similarly with an outward mindset can protect us as hospitalists from making that error."

Balancing academic medicine responsibilities

More broadly, it's incredibly challenging to balance the responsibilities of academic medicine with the clinical responsibilities of being a hospitalist. While on clinical service, hospitalists face long intense clinical days.

"Yet you are also expected to be working on that abstract, going to meetings, teaching, and performing other tasks. So how do you balance that?" asked Dr. Sharpe. "It's almost like two full-time jobs you're supposed to be doing at the same time."

For those who truly desire a successful career as an academic hospitalist, Dr. Sharpe noted that it's important to anticipate the time that one will be on service and allocate time appropriately. It's helpful to complete as many academic tasks as possible while off service. To be successful as an academic, it's simply not possible to take as much time off between hospital service periods as one might as a community hospitalist.

Although this may vary based on institutional culture and personal preference, it may also be helpful to put an "out of office" message on one's email while on service, so that people know response times may be delayed. Dr. Sharpe added that it's also important to know one's personal rhythms and commitments and schedule around that, e.g., find an hour to answer emails in the early mornings or late evenings.

To help keep projects moving, sometimes it's possible to sneak in a meeting with one's collaborators while one is on service, Dr. Lane shared, although it's important not to overbook. It's key to prioritize one's tasks in the limited time that is available and not get bogged down in less urgent tasks like answering the email at the top of one's inbox. Even more broadly, it's key to learn how to say no when needed and be intentional about the broader commitments one accepts.

Dr. Sharpe also urges self-forgiveness and sincere apologies if you miss a deadline or don't get back to someone. The patients must come first and the trainees second, and so sometimes things are going to be missed. ■

Ruth Jessen Hickman, MD, is a graduate of the Indiana University School of Medicine in Bloomington, Ind. and a freelance medical writer.

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2. Larsen T, et al. The role of the hospitalist in the clinical education of medical students. *J Brown Hosp Med.* 2023;2(4). doi:10.56305/001c.87819

5 Best Practices and Resources for Interhospital Transfers

Helping better manage the increasing patient transfer demand and ensuring optimal outcomes

By John R. Vazquez, MD, James Clements, MD, FACP, Michael Hendricks, MD, and Sandeep R. Pagali, MD, MPH, CLHM, SFHM

Transfer of patients between hospitals has long been a part of hospitalist life, and most hospitalists can recall any number of challenging situations. Driven by a desire to improve these situations and help patients in need of transfer, hospitals are actively examining their practices and making changes for the better. SHM has a special interest group (SIG) for interhospital transfers and has included more transfer medicine-related content in national meetings. This article summarizes a high-yield session from Converge 2024 related to interhospital transfer best practices.

Patient transfers between healthcare facilities or hospitals occur for several reasons, including the need for specialized capabilities unavailable at the referring facility, and temporary lack of bed or staff capacity. Owing to increased procedural specialization as well as inpatient capacity challenges nationwide, the need for patient transfers across healthcare facilities has increased, and with it the need for established best practices and more efficient transfer models. As the demand for interhospital transfers rises, we highlight the need for a new sub-branch of medicine coined "transfer medicine" by the SHM Interhospital Transfer SIG. Transfer medicine includes the study of inpatient transfer processes and infrastructure, with a focus on standardization, quality improvement, and outcomes. Widespread implementation of best practices can significantly improve efficiency, resource utilization, quality of interhospital transfers, and patient safety.

We focus on structured processes, dedicated workforce roles, and patient-centered care pathways, so that healthcare systems can better manage the increasing patient transfer demand and ensure optimal patient outcomes. Continuous evaluation and adaptation of these practices are essential to meet the changing needs of healthcare systems. Based on our experiences in triage roles, we highlight five best practices related to patient transfers.

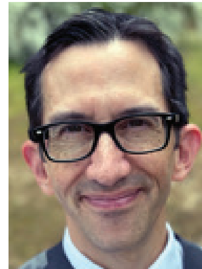
1 Transfer intake

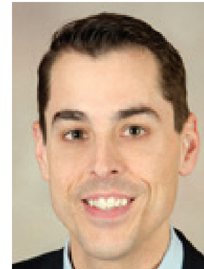
Transfer calls are frequently chaotic or conducted under temporal duress, creating high-stress situations where the risk of human error is elevated. A well-designed transfer intake documentation template acts as a checklist, ensuring that no critical information is overlooked.

A. **Standardized intake (form or template or questionnaire)**—a standardized template is essential to identify the need for transfer, assess patient stability, and ensure a smooth handoff. Different health systems may have roles besides physicians to capture some of the standardized information, but important information includes:
   - Demographics, referring location, callback number and name
   - Reason for transfer
   - If the transfer is for a procedure or specialist consultation, confirmation if and when the service is available can be helpful, to avoid unnecessary transfers and arrange transfers to align with specialist or procedure availability
   - Health information (medical history, labs, imaging)
   - Most appropriate receiving system facility, care level, and bed level
   - Transportation plans and timing

B. **Medical information**—one of the key roles for the hospitalist during times of transfer is to quickly ascertain and summarize the important facts of the patient's condition so that receiving teams have concrete information to initiate care upon arrival. This is particularly important when records from the referring hospital do not accompany the patient. While a detailed history may not be practical, targeted medical information helps to minimize errors and promote safety. This should include code status, medical interventions performed at the referring facility, ongoing anticipated medical needs, medical stability, and transportation plans. If there is a change in clinical status while awaiting patient transfer following acceptance, communication from the referring facility is encouraged. Finally, clear communication helps hospitalists ensure patient transfers benefit the patient, while also supporting colleagues at other hospitals.

C. **Recorded phone lines**—due to the potential for risk management and regulatory concerns, recorded phone lines should be a standard feature in facilities that regularly accept transfers. Recorded lines establish an accurate record of conversations made during the transfer process, which can later be used for feedback, case review, quality improvement, and orientation. Additionally, they offer a layer of protection in case of disputes or misunderstandings, ensuring that all parties have access to a clear record of what was discussed and agreed upon while regulatory or professionalism concerns are adjudicated.


Dr. Vazquez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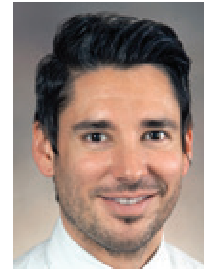
Dr. Hendricks

Dr. Pagali

Dr. Vazquez is an assistant professor of medicine at Emory University in Atlanta and a hospitalist with Emory Healthcare in Atlanta, where he is also the medical director of its transfer and access service. Dr. Clements is an associate professor of medicine at Oregon Health & Science University (OHSU) and medical director of its episodes of care program and mission control transfer center in Portland, Ore. Dr. Hendricks is an assistant professor of medicine at OHSU and the assistant medical director of the division of hospital medicine and medical director of the Intake Hospital group in Portland, Ore. Dr. Pagali is a geriatrician, hospitalist, and assistant professor of medicine at Mayo Clinic in Rochester, Minn.

2 EMTALA and patient transfers

The Emergency Medical Treatment and Labor Act (EMTALA) applies to all patient transfer requests originating from an emergency department, however, it is not applicable if the patient is located elsewhere (e.g., admitted in the hospital, from a nursing home, or clinic). EMTALA is also not applicable when there is no capacity (bed or service) available at the accepting facility during the time of intake. Understanding the nuances of EMTALA is crucial for healthcare providers to remain compliant and avoid legal repercussions or penalties.

When the accepting facility has both the capability and capacity to care for the potential transfer patient, EMTALA guidelines must be followed. Importantly, insurance should not be discussed for EMTALA-related transfers as insurance type should not be factored into medical decision making. In contrast, insurance may be reviewed for non-EMTALA transfers. This distinction is vital, to ensure that patient care is not delayed or compromised due to administrative issues. It also highlights the importance of having clear protocols in place to manage capacity issues efficiently.

3 Triage clinicians

Triage clinicians are a group of clinicians (either physicians or advanced practice practitioners) who serve in roles that process patient transfer-related calls and perform triage. Establishing a trained cohort of triage clinicians facilitates standard work and higher transfer quality.

A. **Roles and responsibilities**—triage clinician responsibilities may vary among institutions and should be based on workload and triage call volumes. If volumes are high, the triage function can't be done well by a person with other obligations (i.e., during rounding or direct patient care) By clearly defining roles and responsibilities, healthcare facilities can ensure that triage clinicians are well-equipped to handle the demands of their job efficiently.

B. **Triage lists**—serve as helpful tools for patient review and can streamline the transfer process when multiple patients are accepted and awaiting transfer. These lists, along with standardized triage algorithms, reduce variability in decision-making, ensuring that all patients are prioritized according to medical needs and receive equitable, timely care. Regular reviews and updates of these protocols are necessary to adapt to changing healthcare resources and dynamics in each organization. A time-stamped handoff column or text box

ensures that medical information for waitlisted patients is updated and on hand for triage decisions.

C. **Core group—**a dedicated group of triage clinicians can maximize the safety and efficiency of transfers. The characteristics of successful triage clinicians include strong clinical acumen, excellent communication skills, high emotional intelligence, organizational skills, and the ability to make decisions regarding ambiguous clinical scenarios. Selection of a smaller cohort results in greater transfer medicine exposure and, in turn, more systems knowledge. Many transfer requests are managed through creative solutions, which are easier to execute with experience and facility with hospital and clinic infrastructure.

D. **Regular touchpoints—**ensure continuous improvement and address any system or process-related issues. These touchpoints should include case reviews, discussion of new workflows, and group feedback sessions that preserve and promote group triage expertise.

E. **Quality review—**regular review of patient-related outcomes, professionalism, and EMTALA compliance is essential to safe and appropriate patient transfers. It fosters a culture of accountability and transparency, encouraging healthcare providers to adhere to best practices and strive for excellence in patient care. A developing skill is the identification of transfers that could have been avoided with extra communication and coordination. This involves recognizing that interhospital transfer comes with significant risks, and when able, finding patient-centric alternatives to transfer, like expedited outpatient follow-up or procedure-only transfers, which can be safer and more efficient options.

4 Transfer center versus command center

Based on the specific needs of the organization, and its resources available to allocate towards efficient patient transfers, a transfer center or command center can be set up. Transfer centers typically focus on coordinating patient transfers, while command centers have a broader scope, including staffing allocation, hospital throughput, and discharge processes. Usually, transfer centers are embedded within the command centers. Each model has its own purposes, advantages, and resource needs, and the choice should be based on the facility's goals and capabilities. For further reading regarding the command-center concept, please see the excellent reviews recently published regarding command centers.[1,2]

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A. **Regional transfer center coordinators or state capacity coordinators—**play a crucial role in facilitating patient placement within the region or state. They function as liaisons between referring and accepting facilities, to place patients in the most appropriate setting for their care needs. Many of these started during the COVID-19 pandemic, but only a few states have ongoing regional transfer centers. Others activate these centers during emergencies or crises. This flexibility allows for a rapid and coordinated response to surges in patient volume, ensuring that resources are allocated efficiently, and patient care is not compromised. These functions are typically only possible with the help of local or state governmental involvement—given the nature of the American healthcare system—but offer tremendous potential for patients when placement in an appropriate hospital is challenging due to region-wide capacity challenges.

5 Innovative pathways for capacity optimization

A. **Procedure-only transfers—**procedure-only transfers involve the transfer of a patient from the referring facility to an accepting facility for a specific, time-sensitive procedure that is unavailable at the referring facility, without the use of an inpatient bed at the procedural hospital. After the procedure, the patient returns to the referring facility, where they remain in inpatient status throughout the entire process. This model allows for expedited access to specialized care without the need for prolonged stays at the accepting facility. To accomplish this effort successfully, a multi-disciplinary approach, including triage clinicians, proceduralists, anesthetists, and case management, is essential.

Thorough assessments and clear communication between the referring and accepting facilities are critical to ensure the patient is optimized for the procedure, and stable for transfer. An established contractual agreement between the two facilities is required for each to receive equitable reimbursement when the hospital-based DRG payments are processed. These agreements also outline the responsibilities of each facility, ensuring both parties are aligned and committed to providing high-quality care.

B. **Transfer back—**involves the transfer of a patient from the accepting facility back to the referring facility once the specialized care need that prompted the transfer has been resolved. This practice preserves bed capacity at the tertiary-care accepting facility, but also benefits patients by returning them closer to home and family support.[3] Transfer back can optimize resource utilization without impacting patient safety.[4] A patient-centered approach, with internal and external partnerships, is key to the success of transfer-back programs. This includes obtaining patient and family consent, ensuring the need for ongoing acute care, and fostering multidisciplinary collaboration.

Transfer-back processes require substantial coordination with established workflows and agreements between facilities that consider finances and transportation costs. Effective coordination ensures that patients receive continuous care without unnecessary delays or disruptions. Implementing transfer back is a change in health care delivery and current clinical practice, which needs to be supported by collaborative partnerships and legal review. Changing established traditional practices can be challenging, but with the right support and commitment, it is possible to overcome these cultural and logistical barriers.

Conclusion

Transfer medicine includes the study of inpatient transfer processes and infrastructure, with a focus on standardization, quality improvement, and outcomes. Following best practices can significantly improve care delivery efficiency, patient safety, and the quality of these transfers. Structured transfer intake, awareness about regulatory requirements as EMTALA, establishing dedicated triage clinicians, the evolution of transfer centers and command centers, and innovative pathways for capacity optimization help better manage the increasing patient transfer demand and ensure optimal outcomes are achieved for patients and the healthcare system. ■

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Empowering Growth: The Impact of Mentorship, Sponsorship, and Coaching on Career Development

Cultivate these relationships to enhance your professional journey

By Ann Perrin, MD, MPH, Laura Paletta-Hobbs, MD, and Teela Crecelius, MD

"A sponsor talks about you, a mentor talks to you, and a coach talks with you."[1]

As a new hospitalist embarking on a career in academic medicine and with aspirations to become an effective educator, Rosa is struggling to determine if she needs a mentor, a sponsor, or a coach to hone her skills.

Having a mentor increases career satisfaction, improves retention, enhances career goals, and augments academic productivity.[2,3,4] This usually consists of a collaborative, reciprocal relationship focused on the mentee's learning and career growth. Equally important, but often overlooked, are a sponsor and a coach. The terms sponsor and coach are often used interchangeably with mentor; however, they function in slightly different roles and use different tools to shape one's career.

A sponsor highlights your accomplishments for others and uses influence to provide you with opportunities. A coach helps develop a specific skill or improve performance for tasks already underway. With the youth and vigor of hospital medicine and the constantly expanding scope of hospitalists, there is a great need for mentors, sponsors, and coaches both within hospital medicine and beyond. One person could serve in these three roles. However, more often than not several people will fill these various parts throughout your career.

Advise—mentorship

Usually a few steps ahead in their career journey, a mentor shares knowledge and experiences to aid in navigating career opportunities. A mentor-mentee relationship is often mutually beneficial: the mentee receives advice and guidance from someone more senior, while the mentor develops enhanced leadership skills and professional growth. Mentors can be found within your institution or more broadly within professional organizations.

Finding a quality mentor can prove challenging, as you want to cultivate a relationship with a peer who not only is committed to your success but who also has the time available to invest in the relationship. Evaluate compatibility by searching for someone with similar values, a career trajectory that aligns with your goals, and expertise in the field you desire to further explore. Develop rapport before establishing the mentorship relationship. Effective mentees prepare ahead for each meeting with their mentor, demonstrate curiosity and ask insightful questions, take notes and develop action plans, seek feedback, and drive the relationship forward by demonstrating a hunger to learn and improve. Seeking feedback is the most important aspect of this relationship as this is what allows mentees to recognize strengths and weaknesses, which are crucial for growth. While there is no set constraint on the duration of a mentor-mentee relationship, most last for at least one year.

For Rosa, a mentor might suggest attending a conference to further develop her teaching skills and to collect feedback surrounding weaknesses so she can make an action plan.

Advocate—sponsorship

A sponsor is usually someone more established in their field who uses their influence and experience to advise and advocate for opportunities that might lead to career benefits. In this active, visible role, sponsors help create opportunities and influence people's perceptions of you.

Sponsors can be especially hard to find for women.[5] Seek out those locally or nationally who have similar interests and have had opportunities you seek. Before meeting with a sponsor, self-identify specific sponsorship asks. Avoid being too general or specific with whom you are seeking, otherwise it is difficult to find a sponsor. Opportunities could include being an invited speaker on a topic you are well versed in, having someone nominate you for an award, or making introductions for networking.

While the characteristics of a mentor and a sponsor overlap, research shows that those who have sponsors are promoted faster and have more career-advancing opportunities.[5] A sponsor helps get you a seat at the table, but remember: you are a reflection of your sponsor. They facilitate introductions, promote your visibility, and recommend you for opportunities with local or national visibility. A pure sponsor is often a time-limited or episodic relationship.

For Rosa, a sponsor might approach a clerkship or program director, vouch for her skills as an effective educator on the wards, and encourage involving Rosa in the next curriculum development summit.

Dr. Perrin

Dr. Paletta-Hobbs

Dr. Crecelius

Dr. Perrin is an academic hospitalist, a clinical associate professor of medicine, the director of the hospitalist certificate program, and co-director of the generalist track at the University of Pittsburgh Medical Center in Pittsburgh. Dr. Paletta-Hobbs is an academic hospitalist, an associate professor of internal medicine, an associate program director for the internal medicine residency program and the hospitalist pathway director at Virginia Commonwealth University in Richmond, Va. Dr. Crecelius is an academic hospitalist and assistant professor of medicine at Indiana University School of Medicine in Indianapolis.

Empower—coach

Since Dr. Atul Gawande wrote about his experience with having a coach in the operating room in 2011, the concept of coaching in medicine has slowly increased in popularity.[6] A coach is someone who partners with their clients to co-create solutions to problems and gain skills to maximize the client's personal and professional potential. Using appreciative inquiry, coaches ask powerful questions that allow clients to create meaningful goals *and* to achieve them.

While executive coaching has become very popular in the business world, many healthcare systems are employing coaches for their physicians and leaders. Having a coach is most useful when there is a specific challenge to overcome or a goal to achieve. Coaching often involves direct observation and feedback on skills, such as observing and then delivering feedback on how you conduct your teaching rounds. Before meeting with a coach, it can be helpful to think about what is currently going well and what needs to be improved upon in your life or career. Your coach will guide you through that challenge, reflecting your thoughts and actions to you in a way that you can identify possible solutions. Coaching relationships typically last several months, although they can continue longer if new areas for growth are identified.

For Rosa, a coach might say, "I understand you want to expand your skills as an educator, especially surrounding building frameworks for key clinical teaching moments. Let's find a time where I can observe and give feedback on hospital medicine wards."

Conclusion

Mentors, sponsors, and coaches are vital to career success. As a trusted, experienced individual who imparts experiential knowledge, mentors are key drivers of career success by helping you define your goals and identify strengths and weaknesses. Sponsors leverage their positions of authority or influence to advocate for you and support your involvement in new projects or in new roles. Lastly, coaches partner with you and encourage self-discovery and growth to inspire you to maximize your potential in the workplace. By cultivating these relationships, individuals can enhance their professional journeys, foster personal development, and achieve a more dynamic and successful career trajectory. ■

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Reducing Avoidable Readmissions is an Important Focus for Hospitalists

How do other institutions manage?

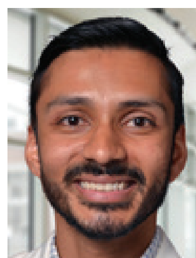
By Larry Beresford

Now in its 13th year, Medicare's Hospital Readmissions Reduction Program (HRRP) continues to incentivize hospitals to do a better job of coordinating the care of patients they are discharging to prevent unplanned readmissions. Medicare calls it a "value-based purchasing program," linking payment to the quality of hospital care by penalizing hospitals with a higher-than-predicted rate of readmissions to any acute hospital within 30 days after discharge.

At least 93% of nearly 3,000 participating hospitals have incurred financial penalties on their Medicare reimbursement for readmissions for six specified conditions or procedures (see also sidebar on page X).[1] Penalties can be as high as 3% of their Medicare reimbursement but the average penalty is 0.64%.

Hospitals have tried a variety of measures to discourage avoidable readmissions, with greater success in reducing their rates in the early days of HRRP. Much of the focus has been on communication, care coordination, and discharge planning as primary strategies. But by now the low-hanging fruit has mostly been plucked, and further reductions have become harder to achieve.

Quality experts emphasize that hospitals and their hospitalists should aim not only to avoid HRRP penalties but also to enhance the quality of care for patients, who likely prefer to avoid rehospitalization when possible. Transparency is a cornerstone of this quality approach, said Vijay Duggirala, MD, a hospitalist and director of quality and patient safety in the division of hospital medicine at The Ohio State University Wexner Medical Center in Columbus, Ohio.



Dr. Duggirala

Owning one's readmission experience

"Transparency means saying, 'This is our readmissions experience.'," Dr. Duggirala said. "We share that information with our partners." If the vast majority of hospitals have been penalized for excessive readmissions, he added, then it follows that they needn't feel ashamed over it, he said.

"Does your institution push that information forward to your frontline providers and say to them: 'Partner with us on improving the patient experience and ensuring that we have appropriate processes in place to prevent readmissions'? It's important to understand what the baseline is. Let's own it, let's admit it, and let's work together to make it better," he said. "We don't have the answers, but there are interventions that people across the country are doing. What we are doing here is based on what we've identified as best practices."

Much of the readmissions focus at The Ohio State University Wexner Medical Center is on inpatient huddles, so everyone on the inpatient team understands what the plan is before the patient leaves. Discharge huddles for every patient on the general medical service are held daily in 15-minute increments and include nursing, case management, social work, rehabilitation and therapy, and the clinician team.

"We talk about barriers, for example: insurance limitations and social determinants of health," Dr. Duggirala said. The focus on social determinants of health can offer a realization of what can or cannot be mitigated. For example, if the patient can't get an appointment with a primary care physician, can they be connected with other medical services in the community?

The hospital team has also embedded phone calls to its patients after discharge. "We as an institution haven't gotten as good as we'd like at reconnecting our patients back to their primary care physician within seven to 10 days of discharge, as recommended," he said. In the meantime there are navigators, such as the hospital's heart failure navigator, who can call or schedule a visit to the heart failure navigation clinic.

Medication reconciliation is another, key, evidence-based intervention in managing readmissions, Dr. Duggirala said. "We've identified that for most discharged patients it's better if they leave the hospital with all their medications in hand."

The literature has shown that a significant proportion of readmissions can be attributed to medications, either errors on admission or omissions at the time of discharge from the hospital, while educating patients about their medications has been shown to make a difference in readmissions.[2] SHM's MARQUIS 14-month medical reconciliation collaborative is an important tool for improving medication reconciliation, Dr. Duggirala said.[3]

Venkat Gundareddy, MBBS, MPH, FACP, SFHM, associate director in the division of hospital medicine at Johns Hopkins Bayview Medical Center in Baltimore and a member of *The Hospitalist's* editorial board, said he believes an understanding of readmissions has improved over the years of HRRP. "It is a metric that continues to be used by hospitals." But there is also an appreciation by hospitalists and hospitals that not all readmissions are preventable.

Dr. Gundareddy

Whose responsibility?

Historically, the healthcare system has attributed readmissions to the discharging practitioner, Dr. Gundareddy said. "But with the complexity of patients that we have today, it's very difficult to say that one clinician is responsible. It's the team that now needs to take ownership for readmissions."

Johns Hopkins case managers and social workers have been using newer predictive tools to assess readmission risk. "In the future, we will be using AI," he said. "But the question is, 'Okay if you can predict the readmission, what are you doing to prevent it? What does that gap or transition from the hospital to the primary care team look like?' That is a field that needs to be explored more," he said.

"There are models that are available for certain disease conditions, but we need to find new solutions to address the larger population. Do we really fully understand the psycho-social causes of readmissions, which may need to be addressed much further upstream and at the policy level?"

Among the things being done at Johns Hopkins is a health-system-level, congestive heart failure, clinical community through the Arm-

strong Institute for Patient Safety and Quality, which has developed a road map for heart failure patients across the continuum of care. "They've come up with metrics for everybody to own. We've set up transition clinics at our academic medical centers, and at the community hospitals we partner with cardiologists to ensure that when patients are discharged, they will have a cardiology follow-up appointment within seven days," Dr. Gundareddy said.

Length of stay versus readmission rate

Arunab Mehta, MD, MEd, FHM, is a hospitalist, medical director, and vice chair of inpatient clinical affairs at the University of Cincinnati Medical Center in Cincinatti. He is also a member of *The Hospitalist's* editorial board. Since reimbursement is the same regardless of length of stay, hospitals have a financial incentive to keep patients for shorter periods of time.

Dr. Mehta

"The value of focusing on readmissions is to say, 'Don't just keep patients in the hospital for such a short amount of time that they will need to be readmitted within 30 days.' I think this principle is sound, and hospitals have to weigh the length of stay and readmissions as a kind of balancing act," he said.

"I think when you talk about what a hospital needs to do about readmissions, first get some baseline data. Do a needs assessment," Dr. Mehta added. "Some gold standards are starting to emerge in the industry. They are important, but you really need to know what your own system is not doing well."

The University of Cincinnati has a "meds to beds program because we don't always know the patient's medication purchase plan upon discharge. That's one thing we do really well here. Another is follow-up care after discharge, which is emerging as another gold standard for the hospital industry. You want to be sure to make a primary care appointment within two weeks, which can be hard because of barriers to access to care," he said.

Last July the University of Cincinnati Health started an after-discharge clinic, which is a collaboration between hospital medicine and primary care. Located across the street from the hospital for patients who need it, the clinic assures inpatient clinicians that patients will get the follow-up they need. Another thing a lot of institutions are doing, with the help of their electronic health records, is looking more closely at high utilizers and flagging those patients most likely to be readmitted, who need to get more resources, more social work support, or more focus on medication reconciliation, Dr. Mehta said.

A readmissions committee

"Where I work, at a large inner-city hospital with all the issues that entails, when I look at our system, the highest rates of readmissions involve alcohol and substance abuse," said Thejaswi Poonacha, MD, MBA, FACP, SFHM, a staff adult hospitalist, clinical associate professor of medicine and medical director for utilization management and clinical documentation integrity at the University of Minnesota Medical Center in Minneapolis, and a member of *The Hospitalist's* editorial board.

Dr. Poonacha

What the HRRP Is: Basic Facts

The Hospital Readmissions Reduction Program (HRRP) was created by the Affordable Care Act of 2010 and implemented starting October 1, 2012. It tallies 30-day, risk-standardized unplanned readmissions for hospitalized patients in the following six categories:

1. Acute myocardial infarction
2. Chronic obstructive pulmonary disease
3. Heart failure
4. Pneumonia
5. Coronary artery bypass graft surgery
6. Elective primary total hip arthroplasty and/or total knee arthroplasty

Participating hospitals get an annual, confidential, hospital-specific report, which they can review and comment on. Hospitals exempt from the penalties are those that focus on children, psychiatric patients, veterans, rehabilitation, or long-term care, or those that are the only hospital serving their area. Penalties of up to 3% of Medicare reimbursement (effectively a payment adjustment factor of 0.97) added up to an estimated $521 million in one recent year.[5]

HRRP, which assesses a hospital's performance relative to similar hospitals, groups them for comparison based on the proportion of patients who are dually Medicare and Medicaid eligible. Other peer-grouping methodologies that lead to cohorting of similar hospitals include demographic factors like age and illness severity. Exceptions are made for planned readmissions such as a scheduled angioplasty. ■

"What we need to do is to see what can be done prior to discharge for these patients. We've tried to implement root cause analysis for frequent users at the time of discharge, to see if that root cause was something that could have been preventable." At Dr. Poonacha's institution, a licensed drug and alcohol counselor on staff works with the care management team.

"We use a software called Power BI, a Microsoft product, one of the major tools for looking at readmissions, along with data generated from the emergency departments and direct admissions. We have a readmissions committee that meets quarterly and sets goals for the year, led by a physician who generally has an administrative role in medicine in the hospital, and a nursing designate from administration." This committee works with the multidisciplinary team, subject matter experts, and the care management team to put together an institution-wide plan, Dr. Poonacha said.

Pediatric issues are different

Issues surrounding readmissions are different for pediatric patients and for the hospitalists who manage their hospital care, said Anika Kumar, MD, FAAP, FHM, staff physician in the division of pediatric hospital medicine at Cleveland Clinic Children's Hospital in Cleveland and *The Hospitalist's* pediatric editor. Only a small percentage of these patients are covered by Medicare and its readmissions program, although private insurers are also concerned about covering preventable readmissions.

Dr. Kumar

The vast majority of hospitalized children are discharged home with their parents, rather than to a rehabilitation facility, she said. "Our goal is to assure that when they are discharged home, the family is comfortable and fully trained in caring for them and has all the needed resources. Sometimes that requires a day of education in the hospital," she said. For example, learning how to manage a nasogastric tube, or teaching with the actual medications on hand.

"We are seeing more children with medical complexity, and I would say the patients who get readmitted are likely to be those with medical complexity, technology dependence, and/or comorbid chronic conditions," Dr. Kumar said. "So our focus generally in peds is to address the children with medical complexity and ensure the resources for them to be safely cared for at home are accessible, such as home care."

The majority of pediatric 30-day readmissions are not preventable, she said. An example is a child discharged with pneumonia who comes back in 29 days with a broken arm. And the data say that focusing on hospital readmissions in pediatrics does not produce measurable results.

What's next?

"I will say that this problem of readmissions is not going away," Dr. Duggirala concluded. "We're improving our ability to treat patients, to reduce avoidable readmissions. The institutions that are doing it the best aren't just focused on the six diagnoses included in HRRP. They're creating pathways and processes that can be used for any discharged patient across the board."

He is excited about the ways telemedicine has been shown to reduce readmissions, confirmed in a 2021 study in the *Journal of General Internal Medicine*, and how it's being integrated into transitional care via virtual visits.[4] "As hospitalists, we haven't yet entered the space of virtual transition clinics." But that could be really important for a hospital like Wexner, where Dr. Duggirala practices, which serves a large catchment area two or three hours or more from the hospital.

"I'm excited for hospitalists and the opportunities for reducing readmissions in the future by leveraging our ability to step outside of our four walls and start focusing on how we can follow our patients [virtually] until we are able to give their primary care physician a warm handoff." ■

Larry Beresford is an Oakland, Calif.-based freelance medical journalist.

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Trends in Benefits for Hospitalists, and How They Help With Recruitment and Retention

Continuing medical education and paid time off are highly valued

By Karen Appold

Every incentive counts when it comes to recruiting and retaining top talent. In particular, today's hospitalists view funding for continuing medical education (CME) and getting paid time off (PTO) as some of the most important benefits.

"I've seen a growing trend in younger candidates asking about CME and PTO during their initial recruitment screening call," said Vineet Gupta, MD, FACP, CHCQM, SFHM, chair of the recruitment and retention committee and a clinical professor in the department of hospital medicine at the University of California San Diego in San Diego, an academic hospital system with around 800 beds.

Dr. Gupta

Charles LoPresti, MD, SFHM, chief of hospital medicine at University Hospitals in Cleveland, which has 13 adult medical centers including an academic center and community-based centers, agreed that CME and PTO are extremely important to hospitalists today. "A shift in how hospitalists value work-life balance has occurred," he said.

According to Thomas Haugh, MBA, FACMPE, executive service line director in the department of adult and pediatric hospital medicine at WakeMed Health & Hospitals in Raleigh, N.C., a not-for-profit community health system with 973 licensed beds, any significant gap in a recruitment package will impact recruitment success. "A comprehensive benefits package along with a competitive salary is vital to recruiting and retaining quality hospitalists," he said. "If you're competing against other local hospital systems for talent, your recruitment package must be in line with the competition."

Dr. LoPresti

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Funding for CME

Many medical institutions give a stipend or provide reimbursement for CME. WakeMed Health & Hospitals, for example, gives an annual CME stipend to hospitalists, who are then responsible for remaining compliant with their CME and licensure requirements. Physicians from .75 to 1.0 full-time equivalents receive the full amount in a taxed, lump sum payment, which avoids the hassles of having to track receipts and provide reimbursements, Mr. Haugh said. The allowance is prorated for physicians from .5 to .74 full-time equivalents.

University Hospitals encourages hospitalists to pursue any CME that benefits their knowledge and career. Hospitalists can be reimbursed up to a certain amount for expenses related to society membership fees, travel, online courses, and books.

"Not only do hospitalists benefit by either continuing their medical education or professional development, but our organization also benefits by having hospitalists stay current on changing best practices or gain knowledge that will help them prepare for leadership roles," Dr. LoPresti said.

Hospitalists at UCSD receive complimentary institutional access to UpToDate, a resource which provides healthcare professionals with clinical and drug information, as well as access to a multitude of CME courses offered by the institution for free or at deeply discounted rates, Dr. Gupta said.

UCSD also covers expenses related to external professional conferences and encourages members to speak at these events as well. Although the university doesn't offer individual discretionary funds, this may change in the future based on prevailing national trends, Dr. Gupta said.

Amanda Green, MD, chief medical officer in the department of hospital medicine at Paris Regional Health in Paris, Texas, a 152-bed rural community hospital, said hospitalists can submit for reimbursement for CME-related activities and expenses, such as in-person course tuition, books, travel expenses related to taking out-of-town courses, online courses, and memberships to professional organizations. The only requirement is that the expense must be designated as an appropriate education reimbursement expense according to the Internal Revenue Service.

Dr. Green

PTO ranks highly

Hospitalists often work in high-stress environments with long shifts, making PTO a critical factor in preventing burnout. Institutions offering more generous PTO policies are therefore more attractive, particularly to younger physicians who prioritize flexibility and mental well-being, Dr. Gupta said.

UCSD gives hospitalists PTO for various reasons, such as childbirth and extended illness, for up to six weeks. PTO is also given for bereavement, jury duty, and family care.

Some may argue that if a hospitalist gets seven days off every other week, they don't need PTO. "But it's not necessarily about need," Dr. LoPresti said. "Hospitalists compress their work into a single work week, so it's only fair that they're allowed to have some PTO like their colleagues who work more traditional workweeks." PTO can be used for vacation and sick days. A separate allowance of days can be used for bereavement, short-term leave, and maternity and paternity leave.

Despite the appeal of PTO, WakeMed Health & Hospitals doesn't offer it in the traditional way. Full-time hospitalists work an average of 16, 10-hour shifts per month (prorated for part-time), equating to 1,920 annual hours. A traditional full-time employee works 2,080 annual hours and accrues PTO. "In essence, PTO is built into their monthly-annual hours' requirement," Mr. Haugh said. "Scheduling flexibility allows physicians to block periods of time to allow for extended time off."

For example, shifts can be front-loaded for one month and back-loaded the next month to provide an extended gap of no-shift requirements. "Scheduling flexibility is a huge satisfier for our hospitalist team," Mr. Haugh said. Hospitalists receive three paid sick days annually, which are only to be used for personal sickness—not family care.

Paris Regional Health doesn't offer PTO, either. Hospitalists are paid by the shift, at an hourly rate, with a quality bonus at the end of the year based on five metrics (i.e., discharge before noon, response to queries, medical record completion, using stroke order sets, and

computerized provider order entry use), Dr. Green said.

Unlike others, Dr. Green doesn't think that CME and PTO sway recruiting decisions significantly. "The base pay rate and scheduling flexibility seem to be the main drivers for decision making beyond location and family needs," she said. Flexible scheduling works by having everyone provide their desired shifts. Hospitalists can request certain days off rather than having a required pattern, such as seven days on and seven off. A coordinator arranges the schedule around this with a few needed adjustments.

Working 12, 12-hour shifts a month is the minimum to maintain full-time benefits. Hospitalists can either choose to work that minimum, or they can work much more (which several hospitalists do), Dr. Green said.

Increased demand for maternity and paternity leave

A growing trend is a desire for extended paid leave for childbirth. In response to employees' needs, University Hospitals recently began offering up to 12 weeks of fully paid maternity leave. The institution also offers one week of paid paternity leave. An adoption assistance program reimburses certain costs of the adoption process.

In general, Dr. LoPresti has seen more medical institutions offering extended paid maternity and paternity leave. "The job market is starting to demand that these are standard benefits for physicians," he said. In fact, according to the 2023 SHM State of Hospital Medicine Report, more than 60% of hospitalist groups reported giving paid maternity leave, and more than 50% reported offering some kind of paid paternity leave.

UCSD gives hospitalists PTO for childbirth for up to 12 weeks and parental bonding for up to six weeks. "Early-career physicians may want to start a family soon after obtaining their first job," Dr. Gupta said. "Providing protected time for parental bonding underscores UCSD's commitment to creating a family environment around their employees."

Although Mr. Haugh said paternity care is a hot topic for younger male hospitalists, WakeMed Health & Hospitals doesn't offer paid paternity leave. Male physicians can apply for a leave of absence via the Family and Medical Leave Act (FMLA) due to the birth of a child, but it would be unpaid. "Some male physician candidates have inquired about paid paternity leave, but no one has declined a job with us because we don't offer it," he said.

Unlike others, Dr. Green hasn't heard requests for paid paternity leave, most likely because the hospital has had a stable group of hospitalists for many years and most have already had children. Currently, the institution complies with FMLA, which allows employees to take off as much time as needed if they have a child, illness, or unforeseen event, but it would be unpaid.

Other "non-mainstream" benefits

Medical institutions have found that a variety of other non-traditional benefits appeal to employees as well. UCSD's division of hospital medicine makes conscious efforts to help members maintain work-life balance by offering a variety of perks. "Most of our faculty members have families that include kids; respecting their personal time is very pertinent," Dr. Gupta said. "Offering non-mainstream benefits not only contributes to work-life balance but also professional development and supportive work environments, which play significant roles in recruitment and retention strategies."

Wellness programs, for example, can help reduce burnout and improve mental and physical health, Dr. Gupta said. They demonstrate UCSD's commitment to members' overall wellness.

UCSD also promotes well-being through various initiatives, such as a check-in program called the Healer Education Assessment and Referral Program which offers education, anonymous stress and depression screening, and short-term, no-cost, confidential counseling and individual check-in meetings.

Further, employees can use their UCSD email address to use Headspace Care (formerly Ginger), a mental health app that puts behavioral coaches, self-care resources, and video-based therapy and psychiatry services at users' fingertips.

When a wellness survey found that the majority of medicine faculty, including hospital medicine members, didn't have a primary care physician (PCP), UCSD set up a PCP hotline for physicians to establish PCPs emergently, Dr. Gupta said.

A dedicated wellness committee curates programs, such as yoga sessions, day-out socials, and holiday events to promote cohesion among colleagues. Monthly professionalism awards and recognition presentations boost morale.

UCSD has an onsite daycare facility for employees to use. "It provides an option near the workplace which fosters peace of mind, ultimately increasing productivity by reducing absenteeism and childcare-related disruptions," Dr. Gupta said.

For hospitalists, UCSD provides a generous relocation allowance for new hires. "This eases the financial and logistical burden of moving, especially for those residing out of state," Dr. Gupta said.

WakeMed Health & Hospitals also offers a comprehensive benefits package, including: health and wellness programs (e.g., health coaching, counseling, wellness rewards, maternity management, and tobacco cessation); flexible spending accounts for health and dependent care; disability and life insurance; critical illness insurance; Legalshield insurance, which provides 24/7 access to legal advice; 529 college savings plans, a tax-advantaged savings account that helps save for college; discounts from local businesses; and pet insurance. Employees can all choose to participate in these voluntary programs at discounted rates, and some via payroll deductions, Mr. Haugh said.

University Hospitals offers health and wellness programs as well as incentives via online modules and discounts at fitness centers. A free counseling program is available to employees, although it's mostly to help caregivers get connected to trusted agencies and providers for support, Dr. LoPresti said. The institution also offers a standard relocation benefit.

As employees, Paris Regional Health's hospitalists receive the same benefits as other team members. One exception is that hospitalists can participate in a non-deferred retirement program, which is a way to contribute up to 50% of their salary to an investment retirement account in which the distribution and tax burden happens within one to two years after separating from the company, Dr. Green explained. The institution also offers wellness programs and free counseling. Relocation allowances and student loan reimbursement are negotiable benefits. ■

The bottom line

Although base compensation continues to be the most important component in the eyes of new recruits, CME, PTO, and other non-mainstream benefits can be the deciding factor when choosing between two offers, Dr. LoPresti said. Because salary trends and fair-market-value compensation are widely published, the base salary between two similar jobs is often fairly close. ■

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

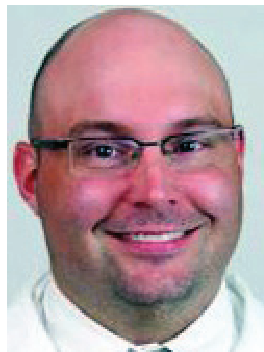
Key Operational Question

What Impact Do Affinity Groups Have on the Inclusivity of Hiring Practices for Hospital Medicine?

By William Lippert, MD, MPH, FHM, Brianna Haller, PA-C, Leah Snipe, MD, Y. Montez Lane-Brown, MPH, CDE, Dona Bolick, and Raghava Nagaraj, MBBS, MPH, SFHM

Case

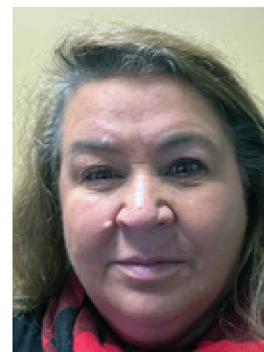
Dr. HM is a third-year internal medicine resident physician preparing to apply for a hospitalist position after completing residency. As an underrepresented physician in medicine, she seeks to join a hospitalist group that values inclusivity and diversity. She is particularly interested in learning about initiatives within the institution that foster a sense of belonging.


Dr. Lippert

Ms. Haller

Dr. Snipe

Ms. Lane-Brown


Ms. Bolick

Dr. Nagaraj

Dr. Lippert is an adult hospitalist at Atrium Health Wake Forest Baptist, a former member of the JEDI Committee in the section of hospital medicine, an assistant professor of internal medicine, and an associate program director for the Wake Forest University School of Medicine internal medicine residency program in Winston-Salem, N.C. Ms. Haller is a hospitalist at Atrium Health Wake Forest Baptist. She established the section of hospital medicine Wellness Committee and leads the Atrium Health Hospital Medicine Justice-Equity-Diversity-Inclusivity (JEDI) Committee in Winston-Salem, N.C. Dr. Snipe is an adult hospitalist at Atrium Health Wake Forest Baptist, co-leader for the Justice, Equity, Diversity, and Inclusion (JEDI) Committee for the section of hospital medicine, and clinical assistant professor at the Wake Forest University School of Medicine in Winston-Salem, N.C. Ms. Lane-Brown is a manager/operations lead in the Office of Diversity, Equity, and Inclusion at Atrium Health Wake Forest Baptist in Winston-Salem, N.C. Ms. Bolick is an administrative assistant in the section on hospital medicine at Atrium Health Wake Forest Baptist supporting the section chief for hospital medicine, the section APP for hospital medicine, the medical directors for Atrium Health Wake Forest Baptist, hospitalist at home, and the JEDI Committee in Winston-Salem, N.C. Dr. Nagaraj is a clinical associate professor of internal medicine at the Wake Forest School of Medicine, interim section chief of hospital medicine, and specialty medical director for hospital medicine at Atrium Health Wake Forest Baptist in Winston-Salem, N.C.

Brief overview of the issue

For decades, recruiting a diverse and inclusive workforce has been a priority across industries.[1] Such teams drive innovation and creativity by uniting varied perspectives and problem-solving approaches, as well as fostering effective solutions.[2,3] A culture of belonging and mutual respect further enhances collaboration, morale, and overall productivity.[4] Diverse teams excel in decision-making by anticipating and addressing the needs of varied stakeholders, leading to more adaptable and sustainable strategies.[5] Finally, diversity and inclusivity can enhance an organization's reputation, attracting top talent and fostering a supportive, dynamic workplace culture.[6]

Healthcare institutions nationwide have implemented initiatives to promote diversity and inclusivity in the physician workforce in a myriad of ways, including within our institutions and sections of hospital medicine.[7-9] Bringing diverse perspectives and experiences can lead to more culturally sensitive approaches to patient care and patient concordance, ultimately resulting in improved patient outcomes.[10-12] Inclusivity also fosters a collaborative and innovative environment, as healthcare teams feel valued and empowered to contribute.[2-3] A diverse workforce improves racial and ethnic concordance between the patient and clinician, which has been shown to improve healthcare delivery and outcomes.[12-14] Finally, inclusive practices contribute to higher morale and job satisfaction, reducing burnout, and improving retention among healthcare professionals.[15] Given our important role in healthcare, we believe that a diverse group and an inclusive environment are crucial to providing the best care to our patients and value to our institution.

Key Points

- Collaborating with our ODEI and human resources helped our JEDI committee to enhance our hospital medicine-inclusive hiring practice.
- Engaging our diverse SRGs enhanced hospital medicine applicant experiences as they provided applicants with an understanding of the institution's commitment to diversity and inclusivity, leading to a more welcoming and supportive hiring process for all applicants.
- Expanding SRG involvement to other departments can foster a culture of inclusivity across the health system, encouraging diverse perspectives and further improving patient care.

Within the section of hospital medicine at Atrium Health Wake Forest Baptist, we have a Justice-Equity-Diversity-Inclusivity (JEDI) Committee comprised of hospital medicine staff focused on promoting and achieving diversity in all respects to create a just, equitable, and inclusive working environment.[9] Several of the JEDI committee members sought to improve the inclusive hiring practices of both our physicians and advanced practice practitioners (APPs) within our section of hospital medicine to increase the pool of diverse interviewees. Therefore, a partnership between the JEDI committee and the Recruitment Committee within the section of hospital medicine, the Office of Diversity, Equity and Inclusion (ODEI), and human resources at Atrium Health Wake Forest Baptist was formed to develop a process that would offer hospital medicine applicants an opportunity to meet with a representative from any of the system resource groups (SRGs), formerly known as "Affinity Groups." The goal is to provide the applicant with an opportunity to meet with a current employee who would be able to share their perspective about our organization and the local community from their cultural background and experiences.

At our institution, SRGs are volunteer-led groups committed to embracing the diversity of staff, clinicians, providers, faculty, and learners, and to creating an environment of inclusion. They offer an opportunity for individuals with a common identity and experience to connect, to support workforce engagement and retention through mentorship efforts and professional development, and to represent our institution in our communities. They are open for all employees to participate, thereby advancing allyship and fostering

intersectionality. SRGs support our institution's mission and commitment to diversity, equity, and inclusion. We currently have the following SRGs at our institution and have plans to expand them throughout the larger Advocate Health Enterprise:

- Accessibility FOR ALL (A4A)
- African American Women Exemplifying Commitment to Equity and Leadership (A2 WeXcel)
- Asian Heritage and Allies (AHA)
- UNIDOS (Hispanic/Latinx)
- Indigenous People and Allies
- Shalom Jewish
- EQualityOne for LGBTQ+
- Muslim
- Veterans Society: One Team One Mission
- Atrium Health White Allies for Racial Equity

Figure 1. Workflow for extending applicant an interview and connecting with an SRG representative

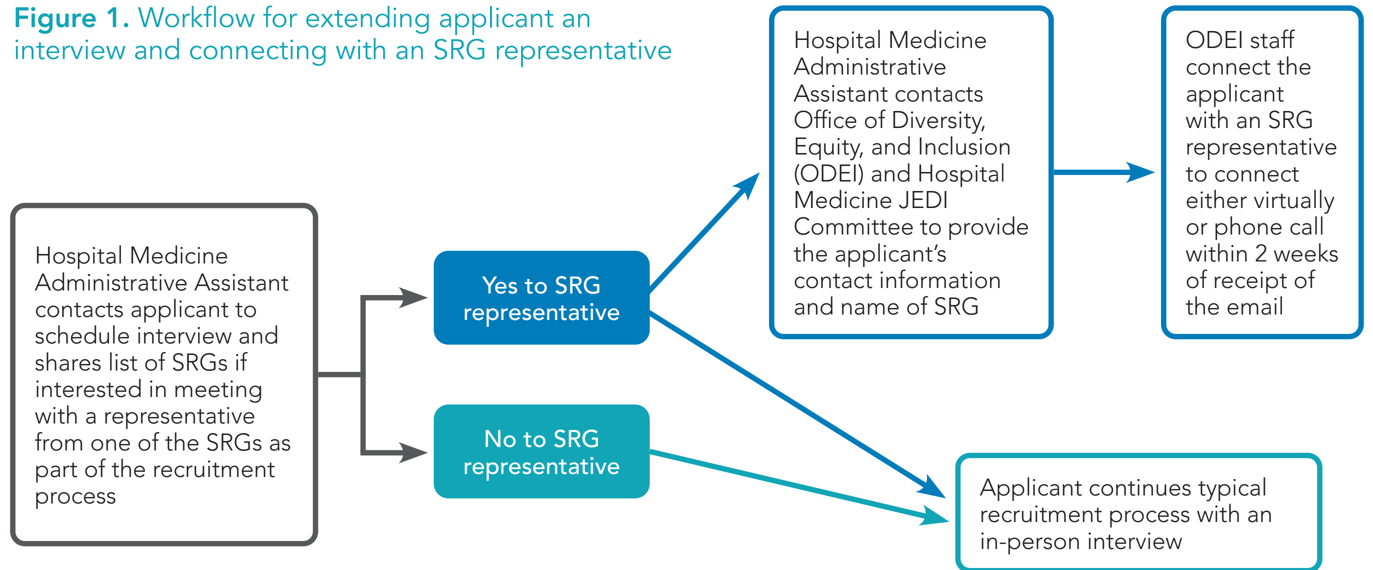


Figure 2. Applicant process for meeting with an SRG representative and post-SRG meeting feedback

*Please note that the SRG representative is not involved in the final decision in the hiring process

Creating a process to meet with an SRG representative

The first step was for the partners to establish a process to ensure applicants were informed of the various SRGs at our institution and offer an opportunity to meet with an SRG representative. If the Hospital Medicine Recruitment Committee decides to extend an interview to an applicant, an administrative assistant from hospital medicine contacts the applicant via email to schedule an in-person interview. This email also includes details about SRGs and offers an option for the applicant to connect with one or more SRG representative(s) either virtually or by phone during the recruitment process. If an applicant declines to meet with an SRG representative, the applicant will then proceed with the standard recruitment process. It should be noted that connecting with an SRG representative during the recruitment process has no impact on an applicant's eligibility for a position or interview. If an applicant wishes to connect with an SRG representative, then an administrative assistant from hospital medicine provides the ODEI staff and JEDI Committee member with the applicant's contact information and the name of the SRG with whom they wish to speak. The ODEI staff then connects the applicant with the SRG representative via email. The SRG representative is expected to meet virtually or over the phone with the applicant within two weeks of the connection email being sent out (Figure 1).

Once the meeting date and time have been arranged, the SRG representative communicates back to the Hospital Medicine JEDI Committee, the ODEI, and one of the administrative assistants from hospital medicine. Following the meeting, a JEDI Committee member contacts the applicant for feedback on their experience. It should also be noted that the SRG representative does not participate in the final hiring decision of the applicant (Figure 2).

Outcomes and future directions

In our case, Dr. HM received an interview offer and was informed about the option to meet with an SRG representative. Dr. HM requested to connect with an SRG representative from A2 WeXcel during their recruitment process. A meeting date and time were arranged and Dr. HM met with a representative from A2 WeXcel (Dr. WF) 10 days after the request. Dr. HM also had an interview with hospital medicine and was ultimately offered a position. Dr. HM's post-SRG meeting comments were indicative that the meeting with the SRG representative was helpful during the recruitment process and vital to the inclusive hiring process:

"I had a great experience with Dr. WF during the recruitment process. She had reached out to me via email, making it easy to get in touch with her. She had a lot of availability in which to speak and offered different platforms, which was convenient. She was prompt in calling at our scheduled time and we had a good conversation about the A2 WeXcel group and how it fits within the institution. It's empowering to know as an applicant that there were groups such as these within the system. It shows the sense of community at this hospital and helps to envision yourself as a part of it. This played a major role in my decision to accept the hospitalist job position to work at the institution."

Since the implementation of this process in July 2021, 60% of our hospital medicine physicians and APPs who met with an SRG representative went on to join our section of hospital medicine. Below are additional select comments from applicants who accepted an offer to join our section on hospital medicine:

- "My meeting with the AHA representative was awesome! I enjoyed my time speaking with her. I believe the mission and the ideas she has for the SRG will have an enormous impact on the providers. We discussed various ideas and suggestions for the future that I felt were well received! Overall, I'm so glad I got to speak with her and learn not only about the 'JEDI' and this SRG but also about all the other ones as well! This was a big reason I chose to come to this institution because it showed that inclusion is a priority."
- "I had a wonderful conversation with a representative from the Indigenous People and Allies SRG and am looking forward to being a part of the group once the meetings begin. I am hoping to learn more and in turn, contribute from my side toward its growth. This truly influenced my decision to join this institution!"

As with any process, there were challenges noted that should be shared. First, since some of the SRG representatives are clinicians, they often had to meet outside regular hours, such as at nights or on weekends, to ensure the process continued smoothly. Second, there were a few instances where the SRG representative was not able to meet the applicant within the two-week window due to various circumstances that often related to coordinating a mutually convenient time. Despite these challenges, they were still able to meet even though it was not within that two-week timeframe.

For future directions of incorporating SRGs in the recruitment process, we plan to continue collaborating with ODEI and human resources to expand this program to other departments, sections, and markets within our health system.

If this program proves success-

ful on a larger scale within the institution, we are considering implementing "open house" dates for each SRG. This approach would allow applicants to meet with SRGs collectively, reducing the time commitment for SRG representatives by minimizing the need for individual meetings with each applicant. Additionally, future expansion efforts will incorporate feedback on both the applicants and SRG representatives to improve the process and ensure the applicant remains connected and engaged with their SRG once hired. Providing orientation and training for SRG representatives and ensuring they have the capacity to participate effectively as the program expands will also be crucial.

Bottom line

Creating a diverse workforce in hospital medicine is imperative, and it starts with inclusivity in the hiring process. The integration of SRGs in the hiring process within our Section of Hospital Medicine at our institution has enhanced diversity and inclusivity, providing candidates with a welcoming community that positively influences recruitment and retention outcomes. ■

Acknowledgements

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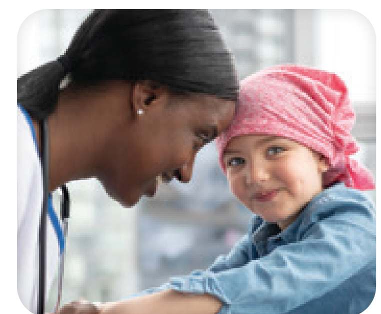

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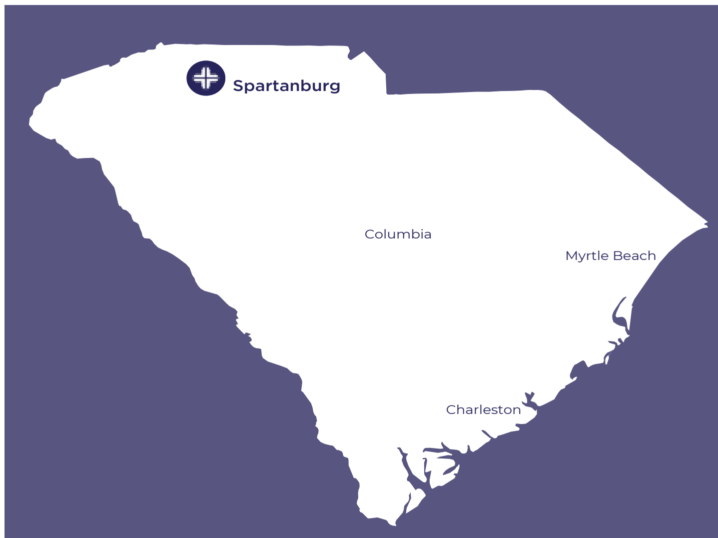

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- Nurse practitioner and physician assistant support
- A comprehensive two-week orientation
- Strong ancillary staff for discharge planning
- Seven on, seven off scheduling
- Comprehensive specialist support and user-friendly Epic EMR
- Days only; nights covered by our nocturnist team

Enjoy an exceptional compensation package that includes:

- Up to $100,000 in recruitment incentives, including sign-on bonus, relocation assistance, and student loan forgiveness
- Attractive retirement options
- Paid malpractice with tail coverage
- PSLF-approved institution
- $6,000 annually for CME

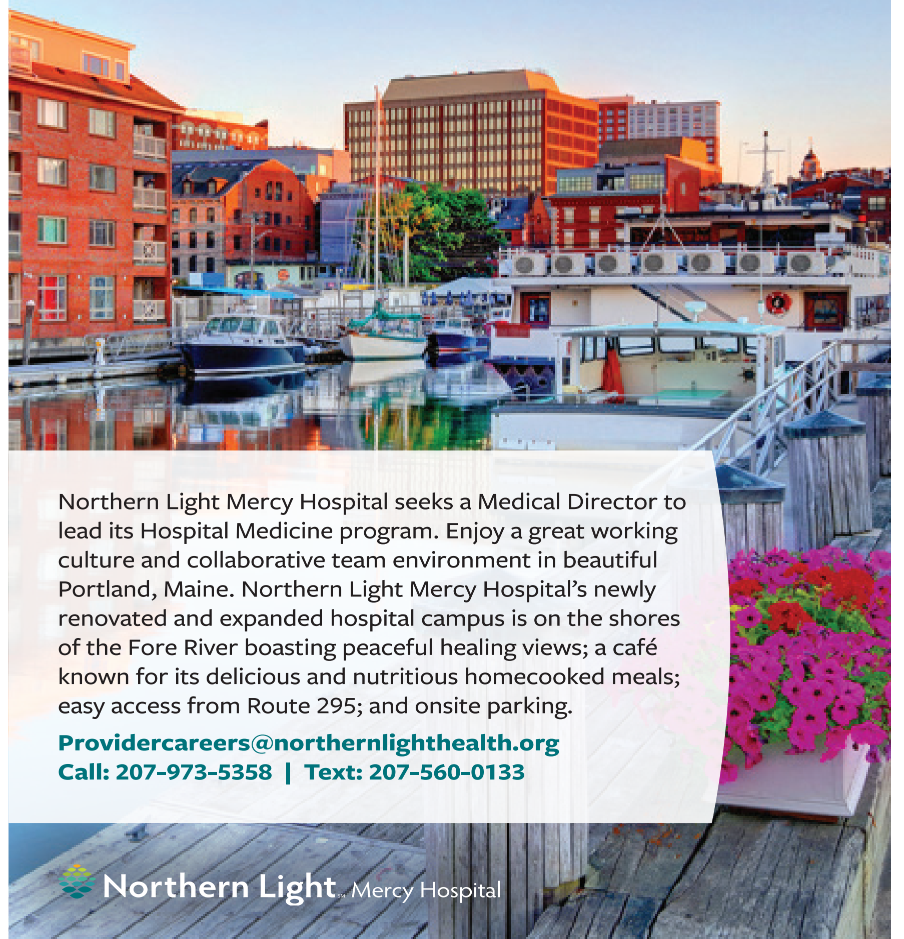
shm CAREER CENTER

Recruit candidates on the only career center exclusively for hospitalists

Combine the power of SHM's membership network with the reach of the Wiley Online Library – post a job ad on the SHM Career Center today

SCAN TO LEARN MORE

MAINE: THE WAY LIFE AND WORK SHOULD BE



Northern Light Mercy Hospital seeks a Medical Director to lead its Hospital Medicine program. Enjoy a great working culture and collaborative team environment in beautiful Portland, Maine. Northern Light Mercy Hospital's newly renovated and expanded hospital campus is on the shores of the Fore River boasting peaceful healing views; a café known for its delicious and nutritious homecooked meals; easy access from Route 295; and onsite parking.

Providercareers@northernlighthealth.org
Call: 207-973-5358 | Text: 207-560-0133

shm
Society of Hospital Medicine

Stay at the Forefront of Hospital Medicine

SHM invites you to continue your professional and personal growth and network with hospitalists nationwide at our upcoming selection of events.

Happening This Month

SHM Converge 2025 – Time is Running Out to Guarantee Your Spot!
April 22-25, 2025
Las Vegas, NV

Upcoming Events

Pediatric Hospital Medicine
July 24 -27, 2025
Anaheim, CA

Quality and Safety Educators Academy
September 10-12, 2025
Philadelphia, PA

Academic Hospitalist Academy
September 15-18, 2025
Philadelphia, PA

Multisite Leaders in Hospital Medicine Summit
September 25 -26, 2025
Philadelphia, PA

Leadership Academy
October 20-23, 2025
Scottsdale, AZ