

THE Hospitalist

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At U.S. Ground Zero for coronavirus, a hospital is transformed

By Kari Oakes
MDedge News

David Baker, MD, a hospitalist at EvergreenHealth in Kirkland, Wash., had just come off a 7-day stretch of work and was early into his usual 7 days off. He'd helped care for some patients from a nearby assisted living facility who had been admitted with puzzlingly severe viral pneumonia that wasn't influenza.

Though COVID-19, the novel coronavirus that was sickening tens of thousands in the Chinese province of Hubei, was in the back of everyone's mind in late February, he said he wasn't really expecting the call notifying him that two of the patients with pneumonia had tested positive for COVID-19.

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First row from the bottom: Dr. Maria Lazareva. 2nd row: Dr. James Colquhoun. 3rd row: Dr. Nancy Marshall. 4th row (L): Dr. Johnson Loh. 4th row (R): Dr. Anna Dolgner. 5th row (L): Dr. Ryan Uselman. 5th row (R): Dr. Ronald Huang.

PHOTO COURTESY EVERGREENHEALTH, KIRKLAND, WASH.

PEDIATRICS

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FHM, FAAP**

p12 Managing infants born to mothers with COVID-19.

EDITOR'S DESK

**Weijen Chang, MD,
SFHM, FAAP**

p26 Moving beyond the hospital ward.

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Hospitalist Movers and Shakers

By Matt Pesyna

Pediatric hospitalists **Linda Bloom, MD, Corina Sandru, MD, and Ilana Price MD,** all from Reading Hospital – Tower Health (West Reading, Pa.) recently earned board certification in pediatric hospital medicine from the American Board of Pediatrics. This was the first certification of its kind given by the ABP.

Sitting for the board certification exam required ABP certification and meeting the training requirements set for pediatric hospital medicine, which was recognized as a subspecialty in 2016.

Felipe Castorena, MD, recently received the Humanitarian Award at the Northwell Health Hospital Medicine Academic Summit. Dr. Castorena was honored for the volunteer work he did with underserved communities in the Dominican Republic in October 2018.

Dr. Castorena worked with the Dr. Almanzar Foundation, providing medical care that included vaccine administration, surgery, and general checkups. A native of Mexico, Dr. Castorena is a hospitalist at Phelps Hospital in Sleepy Hollow, N.Y.

Alteon Health has named **Frank Kelley, MD,** as one of three 2019 Facility Medical Directors of the Year. Dr. Kelley serves as director of hospital medicine at University Hospitals Portage Medical Center (Ravenna, Ohio). Alteon began managing the Portage hospitalist program in 2006.

Dr. Kelley was recognized for exhibiting “exemplary leadership and professionalism ... mentoring their physicians and advance practice providers while improving department performance.” He is one of three winners among Alteon’s 125 clinical sites.

Amina Ahmed, MD, recently was named chief medical officer for CareOne, New Jersey’s largest family-owned and -operated senior-living/post-acute care operator.

A board-certified internist, Dr. Ahmed most recently was chief of hospitalist medicine and post-acute care at Summit Medical Group (Berkeley Heights, N.J.).

Ikenna Ibe, MD, has been promoted to vice president of medical affairs and chief medical officer at Virginia Commonwealth University Health Community Memorial

Hospital (Richmond, Va.). Dr. Ibe will be charged with creating a stronger connect between staff at VCU Health CMH and the clinical programs at VCU Medical Center’s main campus.

Dr. Ibe has been medical director of the hospitalist group since starting at VCU Health CMH in 2018. He will continue to care for patients and guide the hospitalist program while in his new role until his replacement is



Dr. Ibe

found. He previously directed the hospitalist program at Richmond’s St. Mary’s Hospital.

The medical staff at Saint Thomas Rutherford Hospital (Murfreesboro, Tenn.) has voted **David Sellers, MD,** to be chief of staff for a 2-year term that began in January 2020.

Dr. Sellers is the lead hospitalist at Ascension Saint Thomas Rutherford. Dr. Sellers, as chief of staff, will chair the hospital’s Medical Executive Committee, as well as serving as the staff’s advocate at overall board meetings. In addition, he will seek continuing education opportunities for staff, and safeguard that the staff aligns along board policies.

Angela Shippy, MD, FHM, has been promoted to senior vice president and chief medical officer at Memorial Hermann Health System (Houston). In addition, Dr. Shippy will continue to execute her duties as the system’s chief quality officer, a position she has held for the past 5 years.

Dr. Shippy has worked in management throughout her career, serving as chief medical officer at HCA Healthcare’s Gulf Coast Division and as vice president of medical affairs at St. Luke’s Episcopal Hospital, where she also was a hospitalist.

Munir Ahmed, MD, an internist with a quarter century’s worth of experience in Cape Cod, Mass., has been named chief transformation officer with Community Health Center of Cape Cod. Dr. Ahmed will be tasked with creating improvements in clinical outcomes and expanding the facility’s use of emerging technology.

Dr. Ahmed previously worked as a hospitalist and internist at Cape Cod Hospital (East Sandwich, Mass.).

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Coronavirus: Managing a resource crunch and ethical challenges

By Nitesh Kumar Jain, MD; Raghav Tirupathi, MD; and Venkataraman Palabindala, MD, FACP, SFHM

C OVID-19 has been a watershed event in medical history of epic proportions. With this fast-spreading pandemic stretching resources at health care institutions, practical considerations for management of a disease about which we are still learning has been a huge challenge.

Although many guidelines have been made available by medical societies and experts worldwide, there appear to be very few which throw light on management in a resource-poor setup. The hospitalist, as a frontline provider, is likely expected to lead the planning and management of resources in order to deliver appropriate care.

As per American Hospital Association data, there are 2,704 community hospitals that can deliver ICU care in the United States. There are 534,964 acute care beds with 96,596 ICU beds. Additionally, there are 25,157 step-down beds and 1,183 burn unit beds. Of the 2,704 hospitals, 74% are in metropolitan areas (>50,000 population), 17% (464) are in micropolitan areas (10,000-49,999 population), and the remaining 9% (244) are in rural areas. Only 7% (36,453) of hospital beds and 5% (4,715) of ICU beds are in micropolitan areas. Two percent of acute care hospital beds and 1% of ICU beds are in rural areas. Although the United States has the highest per capita number of ICU beds in the world, this may not be sufficient as these are concentrated in highly populated metropolitan areas.

Infrastructure and human power resource augmentation will be important. Infrastructure can be ramped up by:

- Canceling elective procedures
- Using the operating room and perioperative room ventilators and beds
- Servicing and using older functioning hospitals, medical wards, and ventilators.

As ventilators are expected to be in short supply, while far from ideal, other resources may include using ventilators from the Strategic National Stockpile, renting from vendors, and using

state-owned stockpiles. Use of noninvasive ventilators, such as CPAP (continuous positive airway pressure), BiPAP (bi-level positive airway pressure), and HFNC (high-flow nasal cannula) may be considered in addition to full-featured ventilators. Rapidly manufacturing new ventilators with government direction is also being undertaken.

Although estimates vary based on the model used, about 1 million people are expected to need ventilatory support. However, in addition to infrastructural shortcomings, trained persons to care for these patients are lacking. Approximately 48% of acute care hospitals have no intensivists, and there are only 28,808 intensivists as per 2015 AHA data. In order to increase the amount of skilled manpower needed to staff ICUs, a model from the Society of Critical Care Medicine's Fundamental Disaster Management Program can be adopted. This involves an intensivist overseeing four different teams, with each team caring for 24 patients. Each team is led by a non-ICU physician or an ICU advanced practice provider (APP) who in turn cares for the patient with respiratory therapists, pharmacists, ICU nurses, and other non-ICU health professionals.

It is essential that infrastructure and human power be augmented and optimized, as well as contingency plans, including triage based on ethical and legal considerations, put in place if demand overwhelms capacity.

Lack of PPE and fear among health care staff

There have been widespread reports in the media, and several anecdotal reports, about severe shortages of personal protective equipment (PPE), and as a result, an increase in fear and anxiety among frontline health care workers.

In addition, there also have been reports about hospital administrators disciplining medical and nursing staff for voicing their concerns about PPE shortages to the general public and the media. This likely stems from the narrow "optics" and public relations concerns of health care facilities.

It is evident that the size and magnitude of the COVID-19 pandemic was grossly underestimated, and preparations were inadequate. But according to past surveys of health care workers, a good number of them believe that medical and nursing staff have a duty to deliver care to sick people even if it exposes them to personal danger.

Given the special skills and privileges that health care professionals possess, they do have a moral and ethical responsibility to take care of sick patients even if a danger to themselves exists. However, society also has a responsibility to provide for the safety of these health care workers by



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Dr. Jain is senior associate consultant, hospital & critical care medicine, at Mayo Clinic in Mankato, Minn. He is a board-certified internal medicine, pulmonary, and critical care physician, and has special interests in rural medicine and ethical issues involving critical care medicine. Dr. Tirupathi is the medical director of Keystone Infectious Diseases/HIV in Chambersburg and is currently chair of infection prevention at Wellspan Chambersburg and Waynesboro Hospitals, all in Pennsylvania. Dr. Palabindala is hospital medicine division chief at the University of Mississippi Medical Center, Jackson, and a member of the editorial advisory board for The Hospitalist.

supplying them with appropriate safety gear. Given the unprecedented nature of this pandemic, it is obvious that federal and state governments, public health officials, and hospital administrators (along with health care professionals) are still learning how to appropriately respond to the challenge.

It would be reasonable and appropriate for everyone concerned to understand and acknowledge that there is a shortage of PPE, and while arranging for this to be replenished, undertake and implement measures that maximize the safety of all health care workers. An open forum, mutually agreed-upon policy and procedures, along with mechanisms to address concerns should be formulated.

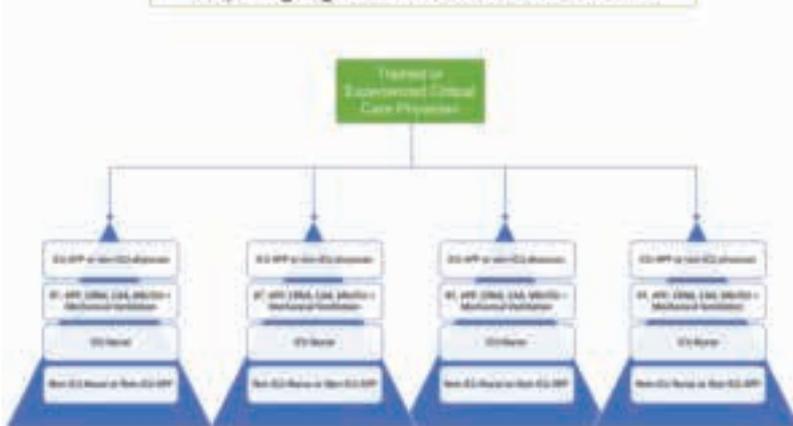
In addition, health care workers who test positive for COVID-19 can be a source of infection for other health care workers and noninfected patients. Therefore, health care workers have the responsibility of reporting their symptoms, they have the right to have themselves tested, and they must follow agreed-upon procedures that would limit their ability to infect other people, including mandated absenteeism from work. Every individual has a right to safety at the workplace and this right cannot be compromised, as otherwise this will lead to a suboptimal response to the pandemic. The government, hospital administrators, and health care workers will need to come together and work cohesively.

Ethical issues surrounding resource allocation

At the time of hospital admission, any suspected or confirmed COVID-19 patient should have his or her wishes recorded with the admitting team regarding the goals of care and code status. During

Continued on following page

Tiered Staffing Strategy for Pandemic Requiring Significant Mechanical Ventilation



Adapted from the American Society for Health Care Professionals (ASHP) Position Statement on Pandemic Preparedness

ABIM grants MOC extension in light of pandemic

More assessment dates to be added

By Gregory Twachtman
MDedge News

Physicians will not lose their certification if they are unable to complete maintenance of certification requirements in 2020, the American Board of Internal Medicine announced.

“Any physician who is currently certified and has a Maintenance of Certification requirement due in 2020 – including an assessment, point requirement or attestation – will now have until



Dr. Baron

the end of 2021 to complete it,” ABIM president Richard Baron, MD, said in a letter sent to all diplomates.

Additionally, physicians “currently in their grace year will also be afforded an additional grace year in 2021,” the letter continued.

ABIM noted that many assessments were planned for the fall of 2020 and the organization will continue to offer them as

planned for physicians who are able to take them. It added that more assessment dates for 2020 and 2021 will be sent out later this year.

“The next few weeks and months will challenge our health care system and country like never before,” Dr. Baron stated. “Our many internal medicine colleagues – and the clinical teams that support them – have been heroic in their response, often selflessly putting their own personal safety at risk while using their superb skills to provide care for others. They have inspired all of us.”

Continued from previous page

any critical illness, goals evolve depending on discussions, reflections of the patient with family, and clinical response to therapy. A patient who does not want any kind of life support obviously should not be offered an ICU level of care.

On the other hand, in the event of resources becoming overwhelmed by demand as can be expected during this pandemic, careful ethical considerations will need to be applied.

A carefully crafted transparent ethical framework, with a clear understanding of the decision-making process, that involves all stakeholders – including government entities, public health officials, health care workers, ethics specialists, and members of the community – is essential. Ideally, allocation of resources should be made according to a well-written plan, by a triage team that can include a nontreating physician, bioethicists, legal personnel, and religious representatives. It should not be left to the frontline treating physician, who is unlikely to be trained to make these decisions and who has an ethical responsibility to advocate for the patient under his care.

Ethical principles that deserve consideration

The “principle of utility” provides the maximum possible benefit to the maximum number of people. It should not only save the greatest number of lives but also maximize improvements in individuals’ post-treatment length of life.

The “principle of equity” requires that resources are allocated on a nondiscriminatory basis with a fair distribution of benefits and burdens. When conflicts arise between these two principles, a balanced approach likely will help when handled with a transparent decision-making process, with decisions

Ethical values to guide rationing of scarce health resources

Ethical values and guiding principles	Application to COVID-19 pandemic
Maximize benefits	
<ul style="list-style-type: none"> Save the most lives Save the most life-years – maximize prognosis 	<ul style="list-style-type: none"> Receives the highest priority Receives the highest priority
Treat people equally	
<ul style="list-style-type: none"> First-come, first-served Random selection 	<ul style="list-style-type: none"> Should not be used Used for selecting among patients with similar prognosis
Promote and reward instrumental value (benefit to others)	
<ul style="list-style-type: none"> Retrospective – priority to those who have made relevant contributions Prospective – priority to those who are likely to make relevant contributions 	<ul style="list-style-type: none"> Gives priority to research participants and health care workers when other factors such as maximizing benefits are equal Gives priority to health care workers
Give priority to the worst off	
<ul style="list-style-type: none"> Sickest first Youngest first 	<ul style="list-style-type: none"> Used if it aligns with maximizing benefits Used if it aligns with maximizing benefits such as preventing the spread of the virus

Source: N Engl J Med. 2020 Mar 23. doi: 10.1056/NEJMs2005114

to be applied consistently. Most experts would agree on not only saving more lives but also preserving more years of life.

The distribution of medical resources should not be based on age or disability. Frailty and functional status are important considerations; however, priority is to be given to sicker patients who have lesser comorbidities and are also likely to survive longer. This could entail that younger, healthier patients will access scarce resources based on the principle of maximizing benefits.

Another consideration is “preservation of functioning of the society.” Those individuals who are important for providing important public services, health care services, and the functioning of other key aspects of society can be considered for prioritization of resources. While this may not satisfy the classic utilitarian principle of doing maximum good to the maximum number of people, it will help to continue

augmenting the fight against the pandemic because of the critical role that such individuals play.

For patients with a similar prognosis, the principle of equality comes into play, and distribution should be done by way of random allocation, like a lottery. Distribution based on the principle of “first come, first served” is unlikely to be a fair process, as it would likely discriminate against patients based on their ability to access care.

Care should also be taken not to discriminate among people who have COVID-19 and non-COVID-19 health conditions that require medical care. Distribution should never be done based on an individual’s political influence, celebrity, or financial status, as occurred in the early days of the pandemic regarding access to testing.

Resuscitation dilemma

Should a COVID-19 positive patient be offered CPR in case of cardiac

arrest? The concern is that CPR is a high-level aerosolizing procedure and PPE is in short supply with the worsening of the pandemic. This will depend more on local policies and resource availability, along with goals of care that have to be determined at the time of admission and subsequent conversations.

The American Hospital Association has issued a general guideline and as more data become available, we can have more informed discussions with patients and families. At this point, all due precautions that prevent the infection of health care personnel are applicable.

Ethical considerations often do not have answers that are a universal fit, and the challenge is always to promote the best interest of the patient with a balance of judiciously utilizing scarce community resources.

Although many states have had discussions and some even have written policies, they have never been implemented. The organization and application of a judicious ethical “crisis level of care” is extremely challenging and likely to test the foundation and fabric of the society.

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Doing things right vs. doing the right things

A framework for a COVID-19 Person Under Investigation unit

By Padageshwar Sunkara, MD, MMCI, FACP, FHM; William C. Lippert, MD, MPH; Christopher Morris, MD; and Chi-Cheng Huang, MD, FACP, SFHM

The current coronavirus disease 2019 (COVID-19) pandemic shocked the world with its rapid spread despite stringent containment efforts, and it continues to wreak havoc. The surrounding uncertainty due to the novelty of this virus has prompted significant investigation to determine proper containment, treatment, and eradication efforts.^{1,2} In addition, health care facilities are facing surge capacity issues and a shortage of resources resulting in lower quality care

- Minimize cross contamination with healthy patients on other hospital units.
- Provide clear and direct communications with our HCWs.
- Efficiently use our personal protective equipment (PPE) supply.
- Minimize our HCW exposure risk.
- Educate HCWs on optimal PPE donning and doffing techniques.

Unit and team characteristics

We used a preexisting 24-bed hospital medicine medical-surgical unit with a dyad rounding model of an attending physician and advanced practice provider (APP). Other team members include a designated care coordinator (social worker/case manager), pharmacist, respiratory therapist, physical/occupational therapist, speech language pathologist, unit medical director, and nurse manager. A daily multidisciplinary huddle with all the team members was held to discuss the care of the PUI patients.

Administrative leadership

A COVID-19 task force composed of the medical director of clinical operations from the Section of Hospital Medicine,

admitted to this PUI unit directly from the emergency department (ED), or as transfers from outside institutions with assistance from our patient placement specialist team. Those patients admitted from our ED were tested for COVID-19 prior to arriving on the unit. Other suspected COVID-19 patients arriving as transfers from outside institutions were screened by the patient placement specialist team asking the following questions about the patient:

- “Has the patient had a fever or cough and been in contact with a laboratory-confirmed COVID-19 patient?”
- “Has the patient had a fever and cough?”

If the answer to either screening question was “yes,” then the patient was accepted to the PUI unit and tested upon arrival. Lastly, patients who were found to be COVID-19 positive at the outside institution, but who required transfer for other clinical reasons, were placed on this PUI unit as well.

Mechanisms to efficiently utilize PPE and mitigate HCW exposure risk

Our objectives are reducing the number of HCWs encountering PUI patients, reducing the number of encounters the HCWs have with PUI patients, and reducing the amount of time HCWs spent with PUI patients.

First, we maintained a log outside each patient’s room to track the details of staff encounters. Second, there was only one medical provider (either the attending physician or APP) assigned to each patient to limit personnel exposure. Third, we removed all learners (e.g., residents and students) from this unit. Fourth, we limited the number of entries into patient rooms to only critical staff involved in patient care (e.g., dietary and other ancillary staff were not allowed to enter the rooms) and provided updates to the patients by calling into the rooms. In addition, care coordination, pharmacy, and other staff members also utilized the same approach of calling into the room to speak with the patient regarding updates to minimize the duration of time spent in the room. Furthermore, our medical providers – with the help of the pharmacist and nursing – timed a patient’s medica-



Dr. Sunkara



Dr. Lippert

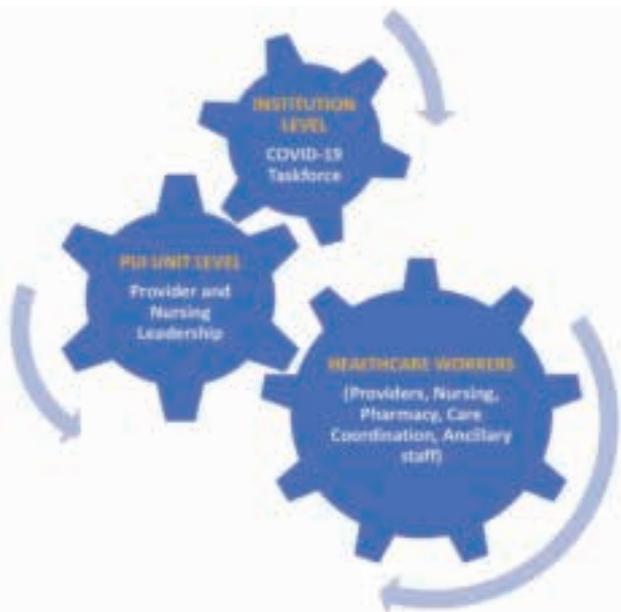


Dr. Morris



Dr. Huang

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COURTESY DR. SUNKARA, DR. LIPPERT, DR. MORRIS, AND DR. HUANG

Figure 1. COVID-19 Person Under Investigation unit communication and feedback loop

for patients and putting health care workers (HCWs) at risk for infection.^{3,4}

While there is a lot of emerging clinical and basic science research in this area, there has been inconsistent guidance in regard to the containment and prevention of spread in health care systems. An initiative to minimize HCW exposure risk and to provide the highest quality care to patients was implemented by the Section of Hospital Medicine at our large academic medical center. We used a hospital medicine medical-surgical unit and converted it into a Person Under Investigation (PUI) unit for patients suspected of COVID-19.

Unit goals

- Deliver dedicated, comprehensive, and high-quality care to our PUI patients suspected of COVID-19.

infectious disease, infection prevention, and several other important stakeholders conducted a daily conference call. This call allowed for the dissemination of information, including any treatment updates based on literature review or care processes. This information was then relayed to the HCWs following the meeting through the PUI unit medical director and nurse manager, who also facilitated feedback from the HCWs to the COVID-19 task force during the daily conference call. (See Figure 1.)

Patient flow

Hospital medicine was designated as the default service for all PUI patients suspected of COVID-19 and confirmed COVID-19 cases requiring hospitalization. These patients were

tions to help reduce the number of entries into the room.

The medical providers also eliminated any unnecessary blood draws, imaging, and other procedures to minimize the number of encounters our HCWs had with the PUI. Lastly, the medical providers also avoided using any nebulizer treatments and noninvasive positive pressure ventilation to reduce any aerosol transmission of the virus. These measures not only helped to minimize our HCWs exposures, but also helped with the preservation of PPE.

Other efforts involved collaboration with infection prevention. They assisted with the training of our HCWs on proper PPE donning and doffing skills. This included watching a video and having an infection prevention specialist guide the HCWs throughout

Continued on following page

Social distancing comes to the medicine wards

By Ian Jenkins, MD, SFHM; Greg Seymann, MD, SFHM; Sarah Horman, MD; and John Bell, MD, FHM

As the coronavirus pandemic has swept across America, so have advisories for social distancing. As of April 2, stay-at-home orders had been given in 38 states and parts of 7 more, affecting about 300 million people. Most of these people have been asked to maintain 6 feet of separation to anyone outside their immediate family and to avoid contact whenever possible.

Typical hospital medicine patients at an academic hospital, however, receive visits from their hospitalist, an intern, a resident, and sometimes several medical students, pharmacists, and case managers. At University of California, San Diego, many of these visits would occur during Focused Interdisciplinary Team rounds, with providers moving together in close proximity.

Asymptomatic and presymptomatic spread of coronavirus has been documented, which means distancing is a good idea for everyone. The risks of traditional patient visits during the coronavirus pandemic include spread to both patients (at high risk of complications) and staff (taken out of the workforce during surge times). Even if coronavirus were not a risk, visits to isolation rooms consume personal protective equipment (PPE), which is in short supply.

In response to the pandemic, UCSD Hospital Medicine drafted guidelines for the reduction of patient contacts. Our slide presentations and written guidelines were then distributed to physicians, nurses, pharmacists, and other staff by our pandemic response command center. Key points include the following:

- Target one in-person MD visit per day for stable patients. This means that attending reexaminations of patients seen by residents, nurse practitioners, physician assistants, and so on would

not be done for billing or teaching purposes, only when clinically necessary.

- Use phone or video conferencing for follow-up discussions unless direct contact is needed.
- Consider skipping daily exams on patients who do not require them, such as patients awaiting placement or stably receiving long courses of antibiotics. Interview them remotely or from the door instead.
- Conduct team rounds, patient discussions, and handoffs with all members 6 feet apart or by telephone or video. Avoid shared work rooms. Substitute video conferences for in-person meetings, and use EMR embedded messaging.
- Check if a patient is ready for a visit before donning PPE to avoid waste.
- Explain to patients that distancing is being conducted to protect them. In our experience, when patients are asked about distancing, they welcome the changes.

We have also considered that most patient visits are generated by nurses and assistants. To increase distancing and reduce PPE waste, we have encouraged nurses and pharmacists to maximize their use of remote communication with patients and to suggest changes to care plans and come up with creative solutions to reduce traffic. We suggested the following changes to routine care:

- Reduce frequency of taking vital signs, such as just daily or as needed, in stable patients (for example, those awaiting placement).
- Reduce checks for alcohol withdrawal and neurologic status as soon as possible, and stop fingersticks in patients with well-controlled diabetes not receiving insulin.
- Substitute less frequently administered medications where appropriate if doing so would reduce room traffic (such as enoxaparin for heparin, ceftriaxone for cefazolin, naproxen for ibuprofen, or patient-controlled analgesia for as-needed morphine).



Dr. Jenkins

Dr. Seymann

Dr. Horman

Dr. Jenkins is professor and chair of the Patient Safety Committee in the Division of Hospital Medicine at UCSD. Dr. Seymann is clinical professor and vice chief for academic affairs, UCSD Division of Hospital Medicine. Dr. Horman and Dr. Bell are hospitalists and associate professors of medicine at UC San Diego Health.

- Place intravenous pumps in halls if needed – luckily, our situation has not required these measures in San Diego.
- Explore the possibility of increased patient self-management (self-dosed insulin or inhalers) where medically appropriate.
- Eliminate food service and janitorial trips to isolation rooms unless requested by RN.

There are clear downsides to medical distancing for hospital medicine patients. Patients might have delayed diagnosis of new conditions or inadequate management of conditions requiring frequent assessment. Opportunities for miscommunication (either patient-provider or provider-provider) may be increased with distancing. Isolation also comes with emotional costs such as stress and feelings of abandonment. Given the dynamic nature of the pandemic response, we are continually reevaluating our distancing guidelines to administer the safest and most effective hospital care possible as we approach California's expected peak coronavirus infection period.

Continued from previous page

the entire process. We felt this was vital given the high amount of active failures with PPE use (up to 87%) reported in the literature.⁵ Furthermore, to ensure adequate mastery of these skills, infection prevention performed daily direct observation checks and provided real-time feedback to our HCWs.

Other things to consider for your PUI unit

There are several ideas that were not implemented in our PUI unit, but something to consider for your PUI unit, including:

- Use elongated intravenous tubing, such that the IV poles and pumps are stationed outside the patient's room, as a means of reducing the amount of PPE required as well as HCW exposure to the patient.
- Have designated chest radiog-

raphy, computed tomography, and magnetic resonance imaging scanners for these PUI patients to help minimize contamination with non-PUI patients and to standardize the cleaning process.

- Supply HCWs with designated scrubs at the beginning of their shifts, such that they can discard them at the end of their shifts for decontamination/sterilization purposes. This would help reduce HCWs fear of potentially exposing their families at home.
- Supply HCWs with a designated place to stay, such as a hotel or other living quarters, to reduce HCWs fear of potentially exposing their families at home.
- Use sophisticated audiovisual equipment. Although we encouraged providers and staff to utilize designated phones to conduct patient history and review of

systems information-gathering to decrease the time spent in the room, the availability of better equipment could also improve the quality of the interview.

Conclusions

The increasing incidence in suspected COVID-19 patients has led to significant strain on health care systems of the world along with the associated economic and social crisis. Some health care facilities are facing surge capacity issues and inadequate resources, while others are facing a humanitarian crisis. Overall, we are all being affected by this pandemic, but are most concerned about its effects on our HCWs and our patients.

To address the concerns of low-quality care to our patients and anxiety levels among HCWs, we created this dedicated PUI unit in an

effort to provide high-quality care for these suspected (and confirmed) COVID-19 patients and to maintain clear direct and constant communication with our HCWs.

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EvergreenHealth

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Michael Chu, MD, was coming onto EvergreenHealth's hospitalist service at about the time Dr. Baker was rotating off. He recalled learning of the first two positive COVID-19 tests



Dr. Chu

“So many of these patients had risk factors for severe disease and only had mild illness. Many were really quite stable.”

on the evening of Feb. 28 – a Friday. He and his colleagues took in this information, coming to the realization that they were seeing other patients from the same facility who had viral pneumonia and negative influenza tests. “The first cohort of coronavirus patients all came from Life Care,” the Kirkland assisted living facility that was the epicenter of the first identified U.S. outbreak of community-transmitted coronavirus, said Dr. Chu. “They all fit a clinical syndrome” and many of them were critically ill or failing fast, since they were aged and with multiple risk factors, he said during the interviews he and his colleagues participated in.

As he processed the news of the positive tests and his inadvertent exposure to COVID-19, Dr. Baker realized that his duty schedule worked in his favor, since he wasn't expected back for several more days. When he did come back to work after remaining asymptomatic, he found a much-changed environment as the coronavirus cases poured in and continual adaptations were made to accommodate these patients – and to keep staff and other patients safe.

The hospital adapts to a new normal

The usual protocol in EvergreenHealth's ICU is for the nocturnist hospitalists, such as Dr. Baker, to staff that unit, with intensivists readily available for phone consultation. However, as the numbers of critically ill, ventilated COVID-19 pa-

tients climbed, the facility switched to 24/7 staffing with intensivists to augment the hospitalist team, said Nancy Marshall, MD, the director of EvergreenHealth's hospitalist service.

Dr. Marshall related how the entire hospital rallied to create appropriate – but flexible – staffing and environmental adaptations to the influx of coronavirus patients. “Early on, we established a separate portion of the emergency department to evaluate and test persons under investigation,” for COVID-19, she said. When they realized that they were seeing the nation's first cluster of community coronavirus transmission, they used “appropriate isolation precautions” when indicated. Triggers for clinical suspicion included not just fever or cough, but also a new requirement for supplemental oxygen and new abnormal findings on chest radiographs.

Patients with confirmed or suspected coronavirus, once admitted, were placed in negative-pressure rooms, and droplet precautions were used with these patients. In the absence of aerosol-generating procedures, those caring for these patients used a standard surgical mask, goggles or face shield, an isolation gown, and gloves. For intubations, bronchoscopies, and other aerosol-generating procedures, N95 masks were used; the facility also has some powered and controlled air-purifying respirators.

In short order, once the size of the outbreak was appreciated, said Dr. Marshall, the entire ICU and half of another general medical floor in the hospital were converted to negative-pressure rooms.

Dr. Marshall said that having daily team debriefings has been essential. The hospitalist team room has a big whiteboard where essential information can be put up and shared. Frequent video conferencing has allowed physicians and advanced practice clinicians on the hospitalist team to ask questions, share concerns, and develop a shared knowledge base and vocabulary as they confronted this novel illness.

The rapid adaptations that EvergreenHealth successfully made depended on a responsive administration, good communication among physician services and with nursing staff, and the active participation of engineering and environmental services teams in adjusting to shifting patient needs, said Dr. Marshall.

“Preparedness is key,” Dr. Chu noted. “Managing this has required a unified effort” that addresses everything from the supply chain for personal protective equipment, to cleaning procedures, to engineering fixes that quickly added negative-pressure rooms.

“I can't emphasize enough that this is a team sport,” said Dr. Marshall.

COVID-19 has unpredictable clinical course

The chimeric clinical course of COVID-19 means clinicians need to keep an open mind and be ready to act nimbly, said the EvergreenHealth hospitalists. Pattern recognition is a key to competent clinical management of hospitalized patients, but the course of coronavirus thus far defies any convenient application of heuristics.

Those first two patients had some characteristics in common, aside from their arrival from the same long-term care facility. They each had unexplained acute respiratory



Dr. Marshall

“Early on, we established a separate portion of the emergency department to evaluate and test persons under investigation.”

distress syndrome and ground-glass opacities seen on chest CT, said Dr. Marshall. But all agreed it is still not clear who will fare well, and who will do poorly once they are admitted with coronavirus.

“We have noticed that these patients tend to have a rough course,” said Dr. Marshall. The “brisk inflammatory response” seen in some patients manifests in persistent fevers, and big C-reactive protein (CRP) elevations, and likely is part of the picture of yet-unknown host factors that contribute to a worse disease course for some, she said. “These patients look toxic for a long time.”

Dr. Chu said that he's seen even younger, healthier-looking patients admitted from the emergency department who are already quite dyspneic and may be headed for ventilation. These patients may have a low procalcitonin, and will often turn out to have an “impressive-looking” chest x-ray or CT that will show prominent bilateral infiltrates.

On the other hand, said Dr. Marshall, she and her colleagues have admitted frail-appearing nonagenarians who “just kind of sleep it off,” with little more than a cough and intermittent fevers.

Dr. Chu concurred: “So many of these patients had risk factors for severe disease and only had mild illness. Many were really quite stable.”

In terms of managing respiratory status, Dr. Baker said that the time to start planning for intubation is when the supplemental oxygen demands of COVID-19 patients start to go up. Unlike with patients who may be in some respiratory distress from other causes, once these patients have increased FiO₂ needs, bridging “doesn't work. ... They need to be intubated. Early intubation is important.” Clinicians' level of concern should spike when they see increased work of breathing in a coronavirus patient, regardless of what the numbers are saying, he added.

For coronavirus patients with acute respiratory distress syndrome (ARDS), early proning also seems to provide some benefit, he said. At EvergreenHealth, standard ARDS ventilation protocols are being followed, including low tidal volume ventilation and positive end-expiratory pressure (PEEP) ladders. Coronavirus ventilation management has thus far been “pretty similar to standard practice with ARDS patients,” he said.

The hospitalist team was able to tap into the building knowledge base in China: Two of the EvergreenHealth hospitalists spoke fluent Mandarin, and one had contacts in China that allowed her to connect with Chinese physicians who had been treating COVID-19 patients since that outbreak had started. They established regular communication on WeChat, checking in frequently for updates on therapies and diagnostics being used in China as well.

One benefit of being in communication with colleagues in China, said Dr. Baker, was that they were able to get anecdotal evidence that elevated

D-dimer levels and highly elevated CRP levels can portend a worse illness course. These findings seem to have held generally true for EvergreenHealth patients, he said. Dr. Marshall also spoke to the value of early communication with Chinese teams, who confirmed that the picture of a febrile illness with elevated CRP and leukopenia should raise the index of suspicion for coronavirus.

"Patients might improve over a few days, and then in the final 24 hours of their lives, we see changes in hemodynamics," including reduced ejection fraction consistent with cardiogenic shock, as well as arrhythmias, said Dr. Baker. Some of the early patient deaths at Ever-



Dr. Baker

"[Once these patients have increased FiO₂ needs, bridging] doesn't work. ... They need to be intubated. Early ... is important."

greenHealth followed this pattern, he said, noting that others have called for investigation into whether viral myocarditis is at play in some coronavirus deaths.

Moderately and severely ill coronavirus patients at EvergreenHealth currently receive a course of hydroxychloroquine of approximately 4-5 days' duration. The hospital obtained remdesivir from Gilead through its compassionate-use program early on, and now is participating in a clinical trial for COVID-19 patients in the ICU.

By March 23, the facility had seen 162 confirmed COVID-19 cases, and 30 patients had died. Twenty-two inpatients had been discharged, and an additional 58 who were seen in the emergency department had been discharged home without admission.

Be suspicious – and prepared

When asked what he'd like his colleagues around the country to know as they diagnose and admit their first patients who are ill with coronavirus, Dr. Baker advised maintaining

a high index of suspicion and a low threshold for testing. "I've given some thought to this," he said. "From our reading and what information is out there, we are geared to pick up on the classic symptoms of coronavirus – cough, fever, some gastrointestinal symptoms." However, many elderly patients "are not good historians. Some may have advanced dementia.

... When patients arrive with no history, we do our best to gather information," but sometimes a case can still take clinicians by surprise, he said.

Dr. Baker told a cautionary tale of one of his patients, a woman who was admitted for a hip fracture after a fall at an assisted living facility. The patient was mildly hypoxic, but had an unremarkable physical exam, no fever, and a clear chest x-ray. She went to surgery and then to a postoperative floor with no isolation measures. When her respiratory status unexpectedly deteriorated, she was tested for COVID-19 – and was positive.

"When in doubt, isolate," said Dr. Baker.

Dr. Chu concurred: "As soon as you suspect, move them, rather than testing first."

Dr. Baker acknowledged, though, that, when testing criteria and availability of personal protective equipment and test materials may vary by region, "it's a challenge, especially with limited resources."

Dr. Chu said that stringent isolation, though necessary, creates great hardship for patients and families. "It's really important for us to check in with family members," he said; patients are alone and afraid, and family members feel cut off – and also afraid on behalf of their ill loved ones. Workflow planning should acknowledge this and allocate extra time for patient connection and a little more time on the phone with families.

Dr. Chu offered a sobering final word. Make sure family members know their ill loved one's wishes for care, he said: "There's never been a better time to clarify code status on admission."

Physicians at EvergreenHealth have created a document that contains consolidated information on what to anticipate and how to prepare for the arrival of COVID-19+ patients, recommendations on maximizing safety in the hospital environment, and key clinical management considerations. You can download the document at www.evergreenhealth.com/covid-19-lessons. The document will be updated as new information arises.



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'The kids will be all right,' won't they?

Pediatric patients and COVID-19

By Andrea Hadley, MD

The coronavirus disease 2019 (COVID-19) pandemic affects us in many ways. Pediatric patients, interestingly, are largely unaffected clinically by this disease. Less than 1% of documented infections occur in children under 10 years old, according to a review of over 72,000 cases from China.¹ In that review, most children were asymptomatic or had mild illness, only three required intensive care, and only one death had been reported as of March 10, 2020. This is in stark contrast to the shocking morbidity and mortality statistics we are becoming all too familiar with on the adult side.

From a social standpoint, however, our pediatric patients' lives have been turned upside down. Their schedules and routines upended, their education and friendships interrupted, and many are likely experiencing real anxiety and fear.² For countless children, school is a major source of social, emotional, and nutritional support that has been cut off. Some will lose parents, grandparents, or other loved ones to this disease. Parents will lose jobs and will be unable to afford necessities. Pediatric patients will experience delays of procedures or treatments because of the pandemic. Some have projected that rates of child abuse will increase as has been reported during natural disasters.³

Pediatricians around the country are coming together to tackle these issues in creative ways, including the rapid expansion of virtual/telehealth programs. The school systems are developing strategies to deliver online content, and even food, to their students' homes. Hopefully these tactics will mitigate some of the potential effects on the mental and physical well-being of these patients.

How about my kids? Will they be all right? I am lucky that my husband and I will have jobs throughout this ordeal. Unfortunately, given my role as a hospitalist and my husband's as a pulmonary/critical care physician, these same jobs that will keep our kids nourished and supported

pose the greatest threat to them. As health care workers, we are worried about protecting our families, which may include vulnerable members. The Spanish health ministry announced that medical professionals account for approximately one in eight documented COVID-19 infections in Spain.⁴ With inadequate supplies of personal protective equipment (PPE) in our own nation, we are concerned that our statistics could be similar.

There are multiple strategies to protect ourselves and our families during this difficult time. First, appropriate PPE is essential and integrity with the process must be maintained always. Hospital leaders can protect us by tirelessly working to acquire PPE. In Grand Rapids, Mich., our health system has partnered with multiple local manufacturing companies, including Steelcase, who are producing PPE for our workforce.⁵ Leaders can diligently update their system's PPE recommendations to be in line with the latest Centers for Disease Control and Prevention recommendations and disseminate the information regularly. Hospitalists should frequently check with their Infection Prevention department to make sure they understand if there have been any changes to the recommendations. Innovative solutions for sterilization of PPE, stethoscopes, badges, and other equipment, such as with the use of UV boxes or hydrogen peroxide vapor,⁶ should be explored to minimize contamination. Hospitalists should bring a set of clothes and shoes to change into upon arrival to work and to change out of prior to leaving the hospital.

We must also keep our heads strong. Currently the anxiety amongst physicians is palpable but there is solidarity. Hospital leaders must ensure that hospitalists have easy access to free mental health resources, such as virtual counseling. Wellness teams must rise to the occasion with innovative tactics to support us. For example, Spectrum Health's wellness team is sponsoring a blog where physicians can discuss COVID-19-related challenges openly. Hospitalist leaders should ensure that there is a structure for debriefing



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after critical incidents, which are sure to increase in frequency. Email lists and discussion boards sponsored by professional societies also provide a collaborative venue for some of these discussions. We must take advantage of these resources and communicate with each other.

For me, in the end it comes back to the kids. My kids and most pediatric patients are not likely to be hospitalized from COVID-19, but they are also not immune to the toll that fighting this pandemic will take on our families. We took an oath to protect our patients, but what do we owe to our own children? At a minimum we can optimize how we protect ourselves every day, both physically and mentally. As we come together as a strong community to fight this pandemic, in addition to saving lives, we are working to ensure that, in the end, the kids will be all right.

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Switching gears at high speed

Michigan hospitalists prepare for COVID-19 care

By Kara Gavin

When March began, Valerie Vaughn, MD, split her time between caring for general inpatients at the University of Michigan's hospitals in Ann Arbor and doing research on how to reduce overuse of antibiotics in hospitals nationwide.

By the time the month was over, she had helped create a new kind of hospital team focused on caring for patients with COVID-19, learned how to provide an intensive level of care for the sickest among them, trained hundreds of physicians in how to do the same, and created free online learning tools for physicians nationwide.

Call it switching gears while driving a race car. Changing horses in the middle of a raging river. Or going to medical boot camp. Whatever the metaphor, Dr. Vaughn and her colleagues did it.

And now they're hoping that sharing what they learned will help others if their hospitals go through the same thing.

Near the epicenter

Michigan Medicine, the University of Michigan's academic medical center, is a few dozen miles west of the Detroit hospitals that have become a national epicenter for COVID-19 cases. It's gotten plenty of direct and transferred COVID-19 patients since mid-March.

When Dr. Vaughn's boss, division of hospital medicine chief Vineet Chopra, MD, was tapped to lead the creation of an all-COVID unit, he asked Dr. Vaughn to work with him and the team of hospitalists, nurse practitioners, physician assistants, nurses, respiratory therapists, and other staff that had volunteered for the team.

They had 3 days to prepare.

The "SWAT team," as Dr. Vaughn calls it, opened the RICU, or Regional Infectious Containment Unit, on March 16. They doubled the number of beds 2 weeks later.

By the end of March, the team had handed over the reins to a team of experienced intensive care profes-

sionals so the unit could focus on the sickest patients. And the RICU team had moved on to transforming other areas of the hospital, and training their staff, in the same way.

By early April, more than 200 beds across the University of Michigan's hospitals were devoted to COVID-19 care. General medicine physicians who hadn't practiced inside a hospital since their residency days were pulled into inpatient duty. Hospitalists were pulled into caring for patients who would normally have been in the care of an intensive care team.

"What's amazed me most is how much people have stepped up to the challenge," says Dr. Vaughn. "As hard and uncomfortable as it is to do something you're not typically doing, it can also be therapeutic to say how can I help, let me do something. Yes, they're anxious, but they want to know how they can be as prepared as they can be."

Dr. Chopra agrees. "The silver lining in all of this is that I have personally seen the best in us come to the surface. Nurses, physicians, pharmacists, and therapists have come together and have shown selflessness, kindness, empathy, and resilience in profound ways."

One giant leap

Even though they didn't choose hospital medicine, or ICU medicine,

"You're no good to anyone else if you're not healthy. Your mental and physical health have to come first because they enable you to help others."

as their specialty, physicians may greatly underestimate how useful they can be with a little just-in-time training and the help of residents, fellows, advanced practice providers, and experienced nurses and respiratory therapists.

That training is now available for free through Michigan Medicine's new online COVID-19 CME portal. The session in "Inpatient Manage-

ment of COVID-19 patients" provides an important overview for those who have never cared for a case, especially if they haven't been on inpatient duty in a while. The ICU Bootcamp is for those who will be caring for sicker COVID-19 patients but haven't practiced in an ICU for a while.

One of the most important roles

"Nurses, physicians, pharmacists, and therapists have come together and have shown selflessness, kindness, empathy, and resilience."

of a COVID-19 inpatient physician, Dr. Vaughn notes, doesn't involve new skills. Rather, it draws on the doctoring skills that physicians have already honed: the ability to assess and treat the entire patient, to talk with families who can't be with their loved ones, to humanize the experience for patients and their loved ones as much as possible, and to bring messages of love from the family back to the bedside.

By pairing a general medicine physician newly placed on inpatient duty with a resident, nurse practitioner, or physician assistant who can handle inpatient charting duties, the team can make the most of each kind of provider's time. Administrators, too, can reduce the burden on the entire team by simplifying processes for what must be charted and recorded in the EMR.

"Hospitals facing a COVID-19 crunch need to make it easier for teams to focus on medicine and the human connection" and to shorten the learning curve for those shifting into unfamiliar duties, she advises.

Other lessons learned

Placing COVID-19 patients on the same unit, and keeping non-COVID-19 patients in another area of the hospital, isn't just a good idea for protecting uninfected patients, Dr. Vaughn notes. It's also good for providers who are getting used to treating COVID-19 because they don't have to shift between the needs of different types of patients as they go from room to room.

"The learning curve is steep, but after a couple of days taking care

of these patients, you have a good feeling about how to care for them and a great sense of camaraderie with the rest of the team," she says. "Everyone jumps in to help because they know we're in this as a team and that it's OK for respiratory therapists to step up to help a physician who doesn't know as much about ventilator care or for nurses to suggest medications based on what other physicians have used."

The flattening of professional hierarchies long ingrained in hospitals may be a side effect of the tremendous and urgent sense of mission that has developed around responding to COVID-19, Dr. Vaughn notes.

Those stepping into new roles should invite their colleagues to alert them when they see them about to slip up on protective practices that might be new to them. Similarly, they should help each other resist the urge to rush into a COVID-19 patient's room unprotected in order to help with an urgent situation. The safety of providers – to preserve their ability to care for the many more patients who will need them – must be paramount.

"To handle this, we need to be all-in, working toward a common goal, without competing priorities," she says. "We need to use everyone's skill sets to the fullest, without creating burnout. We're going to be different when this is done."

Avoiding provider burnout is harder than ever because team members caring for COVID-19 must stay apart from family at home and avoid in-person visits. Those who are switching to inpatient or ICU-level care should make a point of focusing on exercise, sleep, virtual connections with loved ones, and healthy eating in between shifts.

"You're no good to anyone else if you're not healthy," Dr. Vaughn says. "Your mental and physical health have to come first because they enable you to help others."

Paying attention to the appreciation that the community is showing health care workers can also brighten the day of a stressed COVID-19 inpatient clinician, she notes.

"All the little signs of love from the community – the thank you signs, sidewalk chalk drawings, hearts in people's windows – really do help."

This article is published courtesy of the University of Michigan Health Lab, where it appeared originally.



Dr. Chopra



Dr. Vaughn

Managing infants born to mothers with COVID-19

Initial guidance for pediatric hospitalists

By Anika Kumar, MD, FHM, FAAP

CLINICAL QUESTION: How should we care for newborns born to mothers with COVID-19?

BACKGROUND: Around the United States, the SARS-CoV-2 virus is infecting pregnant mothers and causing COVID-19. Current limited data demonstrate that children under the age of 1 year are at risk for severe disease. Clinicians are caring for infants born to mothers with COVID-19 during the pandemic with minimal guidance.

STUDY DESIGN: Clinical practice guidelines.

SYNOPSIS: The American Academy of Pediatrics' Committee on Fetus and Newborn, Section on Neonatal and Perinatal Medicine and Committee of Infectious Diseases developed guidelines of care for infants born to COVID-19 mothers to help clinicians care for newborns using limited data published before March 30, 2020.

- Neonates should be considered persons under investigation (PUIs) if they are born to mothers with diagnosed COVID-19 or with COVID-19 tests pending at the time of delivery.
- Neonatal clinicians should attend deliveries based on their center's policies. If clinicians are required to perform stabilization they should use airborne, droplet, and contact personal protective equipment (PPE). This includes, gown, gloves, eye protection (goggles or face shield), and N95 respirator mask or an air-purifying respirator.
- Mother and newborn should be separated to minimize the infant's risk of postnatal infection.
- Well newborns born at or near term may be admitted to areas physically separated from newborns unaffected by maternal COVID-19. Alternatively, a mother may room-in with her infant with 6 feet of separation between mother and infant. Newborn PUIs should be bathed as soon as possible.
- Newborns requiring intensive care should be admitted to a single negative-pressure room. Alternatively, COVID-19–exposed infants should be grouped with a minimum of 6 feet of separation, or placed in air temperature-controlled isolettes.
- Until the newborn PUI's virologic status is known, clinical staff caring for the infant should use droplet and contact PPE. This includes gown, gloves, eye protection (goggles or face shield), and a standard surgical mask. Airborne, droplet, and contact precautions should be used for infants requiring CPAP or any form of mechanical ventilation.
- COVID-19–positive mothers who want to breastfeed may feed expressed breast milk using proper breast and hand hygiene or directly breastfeed their infants wearing a mask while practicing proper breast and hand hygiene.
- If testing is available, newborns should be tested for SARS-CoV-2 using molecular arrays. If testing is unavailable, clinicians may monitor newborns clinically. Infants should be tested if they require prolonged intensive care.
- Optimal timing and extent of testing is unknown. Tests should be performed around 24 hours of life and 48 hours of life. If discharge is planned for a well-appearing infant before 48 hours of life, the clinician may choose not to do the 48-hour test. A single swab should be taken from the throat followed by the nasopharynx to perform the test.
- Newborns should receive all newborn care, including circumcision if requested.
- Infants who are asymptomatic with positive or pending SARS-CoV-2 tests may be discharged home with plans for frequent outpatient follow-up through 14 days after birth. Infants with negative SARS-CoV-2 testing should be discharged to the care of a non-infected caregiver. If the mother lives in the same household, she must keep a distance of 6 feet as often as possible. When not possible, the mother should wear a mask and practice hand hygiene. The mother may resume caring for her infant normally when she has been afebrile for more than 72 hours (without antipyretics) and has been asymptomatic for



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7 days. Alternatively, the mother may resume care if she has two consecutive negative SARS-CoV-2 nasopharyngeal swabs taken more than 24 hours apart.

- Visitation to infants requiring intensive care should be limited for mothers with COVID-19 until her fever has resolved for more than 72 hours *and* has improvement of respiratory symptoms *and* has had two consecutive negative SARS-CoV-2 nasopharyngeal swabs taken more than 24 hours apart.

BOTTOM LINE: Clinicians should protect themselves with contact and droplet PPE at all times until the infant's viral status is known. Clinicians should use airborne, contact, and droplet PPE when resuscitating the infant and/or when using continuous positive airway pressure/mechanical ventilation. Mothers should be encouraged to feed their infants expressed breast milk while practicing proper hygiene or directly breastfeed while wearing a mask and practicing proper hygiene. Viral testing of every infant born to a mother with COVID-19 should be performed after the infant is 24 hours old. Mothers should resume caring for their infants normally after they have met criteria suggesting they are no longer actively infected.

ARTICLE CITATION: Puopolo KM et al. Initial guidance: Management of infants born to mothers with COVID-19. 2020 Apr 2. <https://downloads.aap.org/AAP/PDF/COVID%2019%20Initial%20Newborn%20Guidance.pdf>. Accessed 2020 Apr 2.



shm
Society of Hospital Medicine

To the entire hospital medicine care team: **THANK YOU.**

We are grateful for your courage, expertise and commitment to patient care during this COVID-19 pandemic.

Find resources for hospitalists at:
hospitalmedicine.org/coronavirus

Presenting the 2020 SHM Award of Excellence winners

Outstanding Service in Hospital Medicine

Efren Manjarrez, MD, SFHM, FACP, is an associate professor of clinical medicine at the University of Miami Miller School of Medicine, where he also serves as a hospitalist in the division of hospital medicine. His high-impact work at his home institution and through SHM has been extensive.



Dr. Manjarrez

He founded the division of hospital medicine at the University of Miami in 2000 and later served as the division chief and patient safety officer. Dr. Manjarrez served in the prestigious role of course director for HM15 and as co-course director for the Adult Hospital Medicine Boot Camp.

One of his most enduring contributions is as an author of the white paper on hospitalist handoffs, published in the *Journal of Hospital Medicine* in 2009, which continues to be cited and validated. He was an assistant editor for the *Journal of Hospital Medicine* and continues to review articles for JHM. Dr. Manjarrez is also a senior fellow in hospital medicine.

Excellence in Research

Shoshana J. Herzig, MD, MPH, is the director of hospital medicine research at Beth Israel Deaconess Medical Center in Boston, where she also serves as a hospitalist. She is also an associate professor of medicine at Harvard Medical School, also in Boston.

She has published nearly 50 original peer-reviewed manuscripts in some of medicine's top journals. Her impressive research, which primarily focuses on patterns of medication utilization and associated outcomes in hospitalized adults, has been cited more than 1,500 times in the medical literature.



Dr. Herzig

In addition to her work on medication safety, she is also a site principal investigator for the Hospital Medicine Research Network (HOMERuN), a nationwide collaborative of hospital medicine researchers.

Dr. Herzig has been a member of SHM since 2008 and has attended the annual conference every year since. She has served as an RIV abstract judge, was instrumental in developing SHM's consensus statement on safe opioid prescribing, and has served as an editor for the *Journal of Hospital Medicine* since 2012 and has been a senior deputy editor since 2015.

Clinical Leadership for Physicians

Karen Smith, MD, MEd, SFHM, is the chief of the division of hospitalist medicine and past president of the medical staff at Children's National

Medical Center in Washington. She also serves as associate professor of pediatrics at the George Washington University School of Medicine. She has consistently worked to create a supportive environment in which to promote wellness among her staff and colleagues.



Dr. Smith

She was one of three founding faculty members of the division of hospital medicine at Children's National, and under her leadership, the division has seen substantial growth. It has evolved from a single site to a comprehensive model of services, spanning six community hospitals and a specialty hospital for rehabilitation and subacute care.

To increase morale, Dr. Smith spearheaded the development of a virtual physician lounge. She reserved a conference room once a month and provided free lunch to medical staff members of different specialties. Its success led to the construction of a full-time lounge – all because of Dr. Smith's perseverance and forward thinking.

She is a past member of SHM's Pediatrics Committee and Hospital Quality and Patient Safety Committee and is a senior fellow in hospital medicine.

Excellence in Teaching

Kathleen M. Finn, MD, MPhil, SFHM, is the senior associate program director for resident and faculty development in the Massachusetts General Hospital internal medicine residency program



Dr. Finn

at Harvard Medical School, both in Boston, where she also is an assistant professor of medicine. She has excelled at teaching at all levels and in all kinds of settings, from clinical teaching on inpatient rounds, educating faculty through workshops to serving as course director for Hospital Medicine 2018 in Orlando. She constantly strives to think creatively and to teach in new ways and considers her career to be a synergy of all three domains in medical education: clinical teaching, leadership, and research.

Her interest in improving the art of inpatient teaching has also taken Dr. Finn into the medical education research space, where she has conducted and published several significant studies.

She was the codirector of the Boston chapter of SHM for 18 years and is well known for her dedication to SHM's annual conference. She gained a reputation on the Annual Conference Committee for coming up with creative topics, including the Great Debate series.

Dr. Finn has previously served on the editorial board for the *Journal of Hospital Medicine*, where she continues to be a reviewer. She is a senior fellow in hospital medicine.

Excellence in Teaching

Juan Nicolás Lessing, MD, is an assistant professor of medicine within the division of hospital medicine at the Medical School at the University of Colorado at Denver, Aurora. He has dedicated himself to the teaching and study of clinical reasoning processes and has cocreated a resident clinical reasoning curriculum, which has been expended to all residency classes.

Dr. Lessing's dedication to mentorship has been extraordinary. In fewer than 5 years, he has mentored more than 50 learners, resulting in 54 competitive abstracts, posters, and presentations.



Dr. Lessing

He has led more than 24 workshops and consistently sponsors junior colleagues to join him. In summary, he teaches learners how to learn rather than what to learn. Additionally, Dr. Lessing created and facilitated several impactful department-wide sessions on how we can learn from our mistakes to openly discuss missed diagnoses. He served as a co-PI on the LOOP study, a multicenter endeavor to provide real-time feedback to admitting residents on a patient's clinical course, which was published in the *Journal of Hospital Medicine*.

Dr. Lessing has been actively involved with SHM since medical school, is a graduate of SHM's Academic Hospitalist Academy, and serves on the executive board for the Rocky Mountain chapter of SHM.

Clinical Leadership for NPs/PAs

Ilaria Gadalla, DMSc, PA-C, is a hospitalist at Treasure Coast Hospitalists in Port St. Lucie, Fla., and also serves as the physician assistant department chair/program director at South University, where she supervises more than 40 PAs, medical directors, and administrative staff.



Dr. Gadalla

She continuously drives innovative projects for NPs and PAs to demonstrate excellence in collaboration by working closely with C-suite administration to expand QI (quality improvement) and education efforts. A prime example is the optimal communication system that she developed within her first week as a hospitalist in the Port St. Lucie area. Nursing, ED, and pharmacy staff had difficulty contacting hospitalists since the EMR would not reflect the assigned hospitalist, so she developed a simple contact sheet that included the hospitalist team each day. This method is still in use today.

Dr. Gadalla is the chair of SHM's NP/PA special interest group who was integral in drafting the recent white paper on NP/PA integration and optimization.

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Excellence in Humanitarian Services

Khaalisha Ajala, MD, MBA, is a hospitalist and associate site director for education at Grady Memorial Hospital in Atlanta. She cares for patients of diverse backgrounds directly and also has a deep-seeded passion for public health and patient education, always demonstrating how to bring this passion to trainee education.

Using her knowledge as an MBA, Dr. Ajala has designed, developed, and now maintains her own nonprofit agency, Heart Beats & Hip-Hop. Through this organization, she has hosted public health fairs to conduct health screenings in less-traditional local settings, where community members who may not have access to care can gain exposure to a health care provider.



Dr. Ajala

More broadly, in the last year, she has made two journeys – one to Thailand and another to Ethiopia – to work with Emory University trainees in educational and clinical efforts to help them engage the global community in health improvement. In Thailand, she taught students how to care for patients at risk for trafficking and sexual exploitation. While in Ethiopia, she served as an educator and clinical preceptor to Emory residents in the global health pathway, teaching them to care for high-risk patients at a local hospital.

With her active and unrelenting humanitarian efforts in mind, she was also chosen as a member of the executive council for SHM's Care for Vulnerable Populations special interest group.

Diversity Leadership

Kimberly D. Manning, MD, FACP, FAAP, is a professor of medicine and the associate vice chair of diversity, equity, and inclusion at the Emory University School of Medicine in Atlanta, where she also is a hospitalist at Grady Memorial Hospital.



Dr. Manning

She demonstrates a strong passion for building and strengthening diverse clinical learning environments. This inspired her to promote cultural competency via lectures, curriculum development, and more.

Dr. Manning has designed a new educational modality – Bite-Sized Teaching (abbreviated “BST” and read as “BEAST”-Mode Teaching). This engages trainees as the teachers of their peers. As part of those sessions, Dr. Manning intentionally encourages and engages trainees from all backgrounds, including women, minorities, and trainees with varied ethnic and cultural perspectives.

Her leadership on the Emory Task Force on Diversity, Equity, and Inclusion led her to be named the department of medicine's first associate vice chair of diversity, equity, and inclusion. In large part because of her engagement, the medical school just admitted its largest class of underrepresented minorities.

She has received the 2018 AGCME Parker J. Palmer Courage to Teach Award and the 2019 Lifetime Achievement Award by the Association of Black Women Physicians.

Excellence in Management of Hospital Medicine

Douglas G. Philpot, MHA, MBA, MHR, FACHE, currently the hospitalist program director at Intermountain Healthcare in Salt Lake City, epitomizes excellence in practice management.

In mid-2018, Intermountain Healthcare transitioned to a new organizational structure that brought all medical and surgical operations under one leadership team. Prior to this reorganization, hospitalist groups were largely divided by the geographies they served, each operating independently.

After the reorganization, it was apparent that staffing structures among groups varied greatly. Mr. Philpot pored over the workload and billing data and determined the most efficient use of how to staff hospitalist providers. He recently created a program that allows all stakeholders to meet and discuss in an unbiased manner how and when to add resources to a given group. As a result, the team is better able to make smart decisions that translate into improved quality, better patient experience, a more engaged hospitalist group and improved financial decisions.

Team Award in Quality Improvement

The Michigan Hospital Medicine Safety Consortium has been in place for a decade and has worked together to improve quality and safety for patients across Michigan and the nation. It has been led since its inception by Scott Flanders, MD, a hospitalist at the University of Michigan, Ann Arbor.

At each participating hospital, teams include hospitalists, infectious disease clinicians, interventional radiologists, nephrologists, nurses, pharmacists, administrators, and more. This integration ensures that the team's work is highly relevant and generalizable for hospitals around the country.

Their initiatives have informed regulatory and guideline writing authorities in the United States and beyond. For example, findings from their venous thromboembolism project demonstrated that the majority of hospitalized patients do not benefit from VTE prophylaxis, but rather, targeted strategies to define those at high risk. In 2016, their work helped to prevent 852 VTEs in Michigan alone.

Their antimicrobial use initiative has led to a robust partnership between hospitalists, hospitals, and national partners. Early work has informed a key gap in stewardship – discharge antibiotic prescribing – which has been a focus for SHM, the Centers for Disease Control and Prevention, and many others. Efforts have already led to a reduction in thousands of unnecessary antibiotic prescriptions in Michigan.

Additional Awards

Junior Investigator Award

SHM's Research Committee presents the Junior Investigator Award to recognize early-career hospitalist researchers who are leading the way in their field. We are pleased to present the HM20 Junior Investigator Award to **Valerie Vaughn, MD, MSc**.

Dr. Vaughn is an assistant professor and research scientist in the division of hospital medicine at the University of Michigan and Veterans Affairs Ann Arbor Healthcare System.

Her research is focused on engaging hospital-

ists in antibiotic prescribing, especially at discharge. She is the hospitalist lead for an initiative to improve antibiotic prescribing in 46 hospitals across Michigan. She has already made a national contribution to the field – two manuscripts that have received high praise and have been cited by



Dr. Vaughn

the Joint Commission and the CDC in their updated recommendations for antibiotic stewardship. She has a grant from the Gordon and Betty Moore Foundation to study the role of diagnostic error in antibiotic overuse and just received a K08 career development award from the Agency for Healthcare Research and Quality to study methods to improve antibiotic prescribing at hospital discharge.

One of Dr. Vaughn's career goals is to advance hospital medicine through mentoring the next generation of hospitalists. In 2017, she authored a manuscript titled “Mentee Missteps” in JAMA, which has been viewed nearly 40,000 times since publication. She continues to give talks on this topic and mentors clinical hospitalists on research projects to improve quality and safety.

Dr. Vaughn represents SHM at the CDC's Healthcare Infection Control Practices Advisory Committee quarterly meetings.

Certificate of Leadership in Hospital Medicine

The Certificate of Leadership in Hospital Medicine (CLHM) cultivates leadership skills in the context of specific hospital medicine challenges. This designation informs employers – or potential employers – with confidence that a candidate is equipped and ready to lead teams and grow an organization.

Charmaine Lewis, MD, MPH, FHM, CLHM, is the quality director for New Hanover Hospitalists in Wilmington, N.C., a role she has held for 7 years. She is clinical assistant professor, department of medicine, University of North Carolina, Chapel Hill, serving as a mentor for internal medicine, surgery, and obstetrics residents completing projects in quality improvement.

While sitting on the CHF and readmissions committees at her institution, Dr. Lewis was asked why patients with heart failure came back to the hospital. This question launched an in-depth search for real-time and accurate data on heart failure patients in her institution. She worked with the Heart Failure Steering Committee to develop a process to close care gaps and document compliance to the American College of Cardiology/American Heart Association Get with the Guidelines: Heart Failure recommendations. She facilitated order set revisions, smartphrase documentation in EPIC, and scripted bedside interdisciplinary rounding to facilitate compliance prior to patient discharge. She also created an end-user friendly dashboard to report compliance with medical leaders, and this project was selected by the department of medicine as their annual quality goal. The project has led to the improvement of CHF GWTG Composite Bundle compliance from 76% to 93%, and compliance with use of aldosterone antagonists from 22% to 85%.

The 'Three Rs' of email effectiveness

Resist, Reorganize, and Respond

By Ryan Nelson, MD;
Ernie Esquivel, MD; and
Alan M. Hall, MD

PING – you look down at your phone and the words “URGENT – Meeting Today” stare back at you. The elevator door opens, and you step inside – 1 minute, the seemingly perfect amount of time for a quick inbox check.

As a hospitalist, chances are you have experienced this scenario, likely more than once. Email has become a double-edged sword, both a valuable communication tool and a source of stress and frustration.¹ A 2012 McKinsey analysis found that the average professional spends 28% of the day reading and answering emails.²

Smartphone technology with email alerts and push notifications constantly diverts hospitalists' attention away from important and nonurgent responsibilities such as manuscript writing, family time, and personal well-being.³

How can we break this cycle of compulsive connectivity? To keep email from controlling your life, we suggest the “Three Rs” (Resist, Reorganize, and Respond) of email effectiveness.

Resist

The first key to take control of your inbox is to resist the urge to impulsively check and respond to emails. Consider these three solutions to bolster your ability to resist.

- **Disable email push notifications.** This will reduce the urge to continuously refresh your inbox on the wards.⁴ Excessively checking email can waste as much as 21 minutes per day.²
- **Set an email budget.**⁵ Schedule one to two appointments each day to handle email.⁶ Consider blocking 30 minutes after rounds and 30 minutes at the end of each day to address emails.
- **Correspond at a computer.** Limit email correspondence to your laptop or desktop. Access to a full keyboard and larger screen will maximize the efficiency of each email appointment.

Reorganize

After implementing these strategies to resist email temptations, reorganize your inbox with the fol-

lowing two-pronged approach.

- **Focus your inbox:** There are many options for reducing the volume of emails that flood your inbox. Try collaborative tools like Google Docs, Dropbox, Doodle polls, and Slack to shift communication away from email onto platforms optimized to your project's specific needs. Additionally, email management tools like SaneBox and OtherInbox triage less important messages directly to folders, leaving only must-read-now messages in your inbox.² Lastly, activate spam filters and unsubscribe from mailing lists to eliminate email clutter.
- **Commit to concise filing and finding:** Archiving emails into a complex array of folders wastes as much as 14 minutes each day. Instead, limit your filing system to two folders: “Action” for email requiring further action and “Reading” for messages to reference at a later date.² Activating “Communication View” on Microsoft Outlook allows rapid review of messages that share the same subject heading.

Respond

Finally, once your inbox is reorganized, use the Four Ds for Decision Making model to optimize the way you respond to email.⁶ When you sit down for an email appointment, use the Four Ds, detailed below to avoid reading the same message repeatedly without taking action.

- **Delete:** Quickly delete any emails that do not directly require your attention or follow-up. Many emails can be immediately deleted without further thought.
- **Do:** If a task or response to an email will take less than 2 minutes, do it immediately. It will take at least the same amount to retrieve and reread an email as it will to handle it in real time.⁷ Often, this can be accomplished with a quick phone call or email reply.
- **Defer:** If an email response will take more than 2 minutes, use a system to take action at a later time. Move actionable items from your inbox to a to-do list or calendar appointment and file appropriate emails into the Action or Reading folders, detailed above. This method allows completion of important tasks in

a timely manner outside of your fixed email budget. Delaying an email reply can also be advantageous by letting a problem mature, given that some of these issues will resolve without your specific intervention.

- **Delegate:** This can be difficult for many hospitalists who are accustomed to finishing each task themselves. If someone else can do the task as good as or better than you can, it is wise to delegate whenever possible.

Over the next few weeks, challenge yourself to resist email temptations, reorganize your inbox, and methodically respond to emails. This practice will help structure your day, maximize your efficiency, manage colleagues' expectations, and create new time windows throughout your on-service weeks.

References

For a complete list of references for this article, visit *The Hospitalist* website at www.the-hospitalist.org.



Dr. Nelson



Dr. Esquivel



Dr. Hall

Dr. Nelson is a hospitalist at Ochsner Medical Center in New Orleans. Dr. Esquivel is a hospitalist and assistant professor at Weill Cornell Medicine, New York. Dr. Hall is a med-peds hospitalist and assistant professor at the University of Kentucky, Lexington.



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The SHM 2019 Chapter Excellence Awards

The Society of Hospital Medicine is proud to recognize its chapters for their hard work and dedication in 2019 through Chapter Excellence Awards. Each year, chapters strive to demonstrate growth, sustenance, and innovation within their chapter activities, which are then applauded for their successes throughout the subsequent year. In 2019, a new Bronze category was established, for a total of four Status Awards that chapters can earn. Please join SHM in congratulating the following chapters on their year of success in 2019!

Outstanding Chapter of the Year

The Outstanding Chapter of the Year Award goes to one chapter who exemplifies high performance, going above and beyond the basic chapter requirements. The recipient of the Outstanding Chapter of the Year Award for 2019 is the Wiregrass Chapter of SHM. The chapter has a strong and engaged leadership which includes representation at all levels of the hospital medicine team, including physician hospitalists, advanced care provider hospitalists, practice administrators, nurses, residents, and medical students.

In the last year, the Wiregrass leadership team has organized programs and events to cater to and engage all the chapter's members. This includes a variety of innovative ideas that catered toward medical education, health care provider well-being, engagement, mentorship, and community involvement.

The SHM Wiregrass Chapter's biggest accomplishment in 2019 was the creation of an exchange program for physician and advanced practice provider hospitalists between the SHM New Mexico Chapter and the SHM Wiregrass Chapter. This idea first arose at HM19, where the chapter leaders had met during a networking event and debated the role of clinician well-being, quality of medical education, and faculty development to individual hospital medicine group (HMG) practice styles.

Clinician well-being is the prerequisite to the triple aim of improving the health of populations, enhancing the patient experience, and reducing the cost of care. Each HMG faces similar challenges but approaches to solving them vary. Professional challenges can affect the well-being of the individual clinicians. Having interinstitutional exchange programs provides a platform to exchange ideas and

Platinum Chapters		
BAAHM	Maryland	Pacific Northwest
Blue Ridge	Michigan	Piedmont Triad
Hampton Roads	Minnesota	Pittsburgh
Houston	Nashville	San Francisco Bay Area
Iowa	New Mexico	Western Mass
Knoxville	North Carolina Triangle	Wiregrass
Gold Chapters		
Boston/Eastern Mass	NYC/Westchester	St. Louis
Kentucky	Rocky Mountain	
North Florida	San Diego	
Silver Chapters		
Charlotte Metro Area	Indiana	Upstate South Carolina
Delaware	Maine	Wisconsin
Greater Philadelphia Area	South Central PA	
Hawaii	Southwest Florida	
Bronze Chapters		
Connecticut	North Central Texas	North Dakota
Memphis		

establish mentors. Also, the quality of medical education is directly linked to the quality of faculty development. Improving the quality of medical education requires a multifaceted approach by highly developed faculty. The complex factors affecting medical education and faculty development are further complicated by geographic location, patient characteristics, and professional growth opportunities. Overcoming these obstacles requires an innovative and collaborative approach. Although faculty exchanges are common in academic medicine, they are not commonly attempted with HMGs.

Hospitalists are responsible for a significant part of inpatient training for residents, medical students, and nurse practitioners/physician assistants (NPs/PAs), but their faculty training can vary based on location. Being a young specialty, only 2 decades old, hospital medicine is still evolving and incorporating NP/PA and physician hospitalists in varied practice models. Each HMG addresses common obstacles differently based on their culture and practice styles. The chapter leaders determined an exchange program would afford the opportunity for visiting faculty members to experience these differences. This emphasized the role and importance of exchanging ideas and contemplated a solution to benefit more practicing hospitalists.

The chapter leaders researched the characteristics of individual academic HMGs and structured a tailored faculty exchange involving physicians and NPs/PAs. During the exchange program planning, the visiting faculty itinerary was tailored to a well-planned agenda for 1 week,

with separate tracks for physicians and NPs/PAs giving increased access to their individual peer practice styles. Additionally, the visiting faculty had meetings and discussions with HMG and hospital leadership, to specifically address each visiting faculty institution's challenges. The overall goal of this exchange program was to promote cross-institutional collaboration, increase engagement, improve medical education through faculty development, and improve the quality of care. The focus of the exchange program was to share ideas and innovation and learn the approaches to unique challenges at each institution. Out of this also came collaboration and mentoring opportunities.

The evaluation process of the exchange involved interviews, a survey, and the establishment of shared quality improvement projects in mutual areas of challenge. The survey provided feedback, lessons learned from the exchange, and areas to be improved. Collaborative QI projects currently underway as a result of the exchange include paging etiquette, quality of sleep for hospitalized patients, and onboarding of NPs/PAs in HMGs.

This innovation addressed faculty development and medical education via clinician well-being. The physician and NP/PA Faculty Exchange was an essential and meaningful innovation that resulted in increased SHM member engagement, cross-institutional collaboration, networking, and mentorship.

Additional projects that the SHM Wiregrass Chapter successfully implemented in 2019 include a "Women in Medicine" event that recognized women physician and advanced practice provider hospitalist leaders,

a poster competition that expanded its research, clinical vignettes, and quality categories to include a fourth category of innovation, featuring 75 posters. Additionally, the chapter held a policy meeting with six Alabama state legislators, creating new channels of collaboration between the legislators and the chapter. Lastly, the chapter held a successful community event and launched a mentor program targeting medical students and residents.

Rising Star Chapter

The Rising Star Chapter Award goes to one chapter who has been active for 2 years or less, who in the past 12 months have made improvements to their leadership, stability and growth, and membership. The recipient of the Rising Star Chapter Award for 2019 is the Blue Ridge Chapter of SHM, which has made significant strides to develop since its launch in the fall of 2018. The chapter represents counties in northwest Tennessee, southwest Virginia, and western North Carolina.

The chapter held three meetings in 2019 which were well attended by hospitalists, residents/fellows, administrators, advanced practice providers, and nurses. On average, attendees from five to six different hospitalist groups are represented. The chapter hosted both Chris Frost, MD, immediate past president of the SHM board of directors, and Ron Greeno, MD, a past president of the SHM board of directors.

The SHM Blue Ridge Chapter has collaborated with both the ACP Tennessee Chapter and the Healthcare MBA program at Haslam College of Business at the University of Tennessee.

The chapter leadership regularly attends local medical residency programs at noon conferences to attract and recruit young physicians into chapter activities. Overall, the chapter has seen a growth in membership in 2019. The Blue Ridge Chapter is an active, enthusiastic chapter that is rapidly growing and thriving.

Outstanding Membership Recruitment and Retention

The Outstanding Membership Recruitment and Retention Award is a new exemplary award for 2019 that goes to one chapter who has gone above and beyond to implement initiatives to recruit and retain SHM members in their chapter. The recipient

Continued on following page

Severe COVID-19 may lower hemoglobin levels

By Mark S. Lesney
MDedge News

A meta-analysis of four applicable studies found that the hemoglobin value was significantly lower in COVID-19 patients with severe disease, compared with those with milder forms, according to a letter to the editor of Hematology Transfusion and Cell Therapy by Giuseppe Lippi, MD, of the University of Verona (Italy) and colleague.

The four studies comprised 1,210 COVID-19 patients (224 with severe disease; 18.5%). The primary endpoint was defined as a composite of admission to the ICU, need of mechanical ventilation, or death. The heterogeneity among the studies was high.

Overall, the hemoglobin value

was found to be significantly lower in COVID-19 patients with severe disease than in those with milder forms, yielding a weighted mean difference of -7.1 g/L, with a 95% confidence interval of -8.3 g/L to -5.9 g/L.

“Initial assessment and longitudinal monitoring of hemoglobin values seems advisable in patients with the SARS-CoV-2 infection, whereby a progressive decrease in the hemoglobin concentration may reflect a worse clinical progression,” the authors stated. They also suggested that studies should be “urgently planned to assess whether transfusion support (e.g., with administration of blood or packed red blood cells) may be helpful in this clinical setting to prevent evolution into severe disease and death.”

Continued from previous page

ient of the Outstanding Membership Recruitment and Retention Award for 2019 is the Western Massachusetts Chapter of SHM, which has done outstanding work to recruit and retain the membership. In 2019, the SHM membership in the chapter grew by 24%. The chapter utilized Chapter Development Funds to launch new initiatives to conduct outreach to nonmember hospitalists in the community and invite them to meetings to obtain the SHM experience. Additionally, the chapter encouraged residents to join and get involved by hosting a poster competition.

The Western Massachusetts Chapter focused on being innovative, inclusive, and creative to retain their existing meetings. For example, the chapter hosted a new “Jeopardy Session” event that featured a nontraditional jeopardy game that attracted a large attendance including local residents. Additionally, the chapter insured that all clinical and nonclinical members of the hospital medicine team were included and encouraged to participate in all chapter meetings. Lastly, the chapter launched a local awards program to recognize senior hospitalist and early career hospitalist who contributed to chapter development.

Most Engaged Chapter Leader

The Most Engaged Chapter Leader Award is a new exemplary award for 2019 that goes to one chapter leader or district chair who is either nominated



Dr. Franco

or self-nominated and has demonstrated how they or their nominee has gone above and beyond in the past year to grow and sustain their chapter and/or district and continues

to carry out the SHM mission. The recipient of the Most Engaged Chapter Leader Award for 2019 goes to Thérèse Franco, MD, SFHM, president of the Pacific Northwest Chapter.

Dr. Franco has served as the chapter’s president for 2 years and has served on the SHM Chapter Support Committee for 3 years. She has previously participated as a mentor in the glycemic control mentored implementation program, and as chair and cochair of the RIV contest. She continues to review abstracts, volunteer as a judge, and offer local education on glycemic control through the Washington State Hospital Association, promoting SHM’s work there. One of Dr. Franco’s core strengths has been effective collaboration with past leaders (such as Rachel Thompson, MD, and Kimberly Bell, MD), future leaders, and other organizations (such as the Washington State Medical Association and the King County Medical Association). Dr. Franco has recruited an outstanding leadership team and new advisory committee for the Pacific Northwest Chapter, resulting a fantastic year of growth, innovation, and development.

Congratulations to the 2019 Chapter Excellence Award Winners

2019 Chapter Excellence Status Awards



Platinum Chapters

BAAHM	Nashville
Blue Ridge	New Mexico
Hampton Roads	North Carolina Triangle
Houston	Pacific Northwest
Iowa	Piedmont Triad
Knoxville	Pittsburgh
Maryland	San Francisco Bay Area
Michigan	Western Massachusetts
Minnesota	Wiregrass



Gold Chapters

Boston/Eastern Massachusetts	San Diego
Kentucky	St. Louis
Rocky Mountain	North Florida
NYC/Westchester	



Silver Chapters

Charlotte Metro Area	Maine
Delaware	South Central Pennsylvania
Greater Philadelphia Area	Southwest Florida
Hawaii	Upstate South Carolina
Indiana	Wisconsin



Bronze Chapters

Connecticut	North Central Texas
Memphis	North Dakota

2019 Chapter Excellence Exemplary Awards



Outstanding Chapter of the Year

Wiregrass



Rising Star Chapter

Blue Ridge



Outstanding Membership Recruitment & Retention Initiative

Western Massachusetts



Most Engaged Chapter Leader

Thérèse Franco, MD, SFHM
Pacific Northwest Chapter President

Clinician reviews of HM-centric research

By Tony Ho, MD; David Schmit, MD; Sadie Trammell-Velasquez, MD; and Emily Wang, MD

University of Texas Health, San Antonio

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By Tony Ho, MD

1 Post-acute kidney injury proteinuria predicts subsequent kidney disease progression

CLINICAL QUESTION: Does the degree of proteinuria after an episode of acute kidney injury (AKI) predict subsequent loss of kidney function?

BACKGROUND: Recent studies have shown that the level of proteinuria increases after AKI. It is not yet shown if this increases risk of kidney disease progression.

STUDY DESIGN: Prospective matched cohort study.

SETTING: North American hospitals.

SYNOPSIS: A total of 769 hospitalized adults with AKI were matched with those without based on clinical



Dr. Ho

center and preadmission chronic kidney disease (CKD) status. Study authors found that albumin/creatinine ratio (ACR) and estimated glomerular filtration rate (eGFR) 3 months

after hospitalization were highly associated with kidney disease progression, with a hazard ratio of 1.53 for each doubling (95% confidence interval, 1.43-1.64).

Episodes of AKI were also associated with progression, but this is severely attenuated once adjusted for ACR, eGFR, and traditional CKD risk factors. This suggests more routine quantification of proteinuria after AKI for better risk stratification.

BOTTOM LINE: Posthospitalization

ACR predicts progression of kidney disease.

CITATION: Hsu CY et al. Post-acute kidney injury proteinuria and subsequent kidney disease progression. *JAMA Intern Med.* 2020 Jan 27. doi: 10.1001/jamainternmed.2019.6390.

2 Abnormal exercise EKG in the setting of normal stress echo linked with increased CV risk

CLINICAL QUESTION: What is the significance of an abnormal exercise EKG with a normal stress echo?

BACKGROUND: Exercise EKG is often integrated with stress echocardiography, but discordance with +EKG/-Echo has unknown significance.

STUDY DESIGN: Observational cohort study.

SETTING: Duke University Medical Center, Durham, N.C.

SYNOPSIS: 47,944 patients without known coronary artery disease underwent exercise stress echocardiogram (Echo) with stress EKG. Of those patients, 8.5% had +EKG/-Echo results, which was associated with annualized event rate of adverse cardiac events of 1.72%, which is higher than the 0.89% of patients with -EKG/-Echo results. This was most significant for composite major adverse cardiovascular events less than 30 days out, with an adjusted hazard ratio of 8.06 (95% confidence interval, 5.02-12.94). For major adverse cardiovascular events greater than 30 days out, HR was 1.25 (95% CI 1.02-1.53).

BOTTOM LINE: Patients with +EKG/-Echo findings appear to be at higher risk of adverse cardi-

ac events, especially in the short term.

CITATION: Daubert MA et al. Implications of abnormal exercise electrocardiography with normal stress echocardiography. *JAMA Intern Med.* 2020 Jan 27. doi: 10.1001/jamainternmed.2019.6958.

Dr. Ho is a hospitalist and associate professor of medicine at University of Texas Health, San Antonio.

By David Schmit, MD

3 Conservative treatment for spontaneous pneumothorax?

CLINICAL QUESTION: Is conservative management of moderate to large primary spontaneous pneumothorax an acceptable alternative to interventional treatment?

BACKGROUND: Management of primary spontaneous pneumothorax is usually with the insertion of



Dr. Schmit

a chest tube and typically requires hospitalization. This procedure can result in pain, organ injury, bleeding, and infection, and, if unresolved, may require surgery,

introducing additional risks and complications. Few data exist from randomized trials comparing conservative versus interventional management.

STUDY DESIGN: Open-label, multicenter, prospective, randomized, noninferiority trial.

SETTING: A total of 39 metropolitan and rural hospitals in Australia and New Zealand.

SYNOPSIS: Overall, 316 patients with moderate to large primary spontaneous pneumothorax were randomized (154 to the intervention group and 162 in the conservative group). In the conservative group, 25 patients (15.4%) required eventual intervention for prespecified reasons (uncontrolled pain, chest pain or shortness of breath preventing mobilization, clinical instability, enlarging pneumothorax).

In complete-case analysis, 129 out of 131 (98.5%) patients in the intervention group had resolution within

8 weeks, compared with 118 of 125 (94.4%) in the conservative group (risk difference, -4.1 percentage points; 95% confidence interval, -8.6 to 0.5, $P = .02$ for noninferiority).

In sensitivity analysis, in which missing data after the 8-week period were imputed as treatment failures, re-expansion occurred in 129 out of 138 (93.5%) patients in the intervention group and 118 out of 143 (82.5%) in the conservative group (risk difference, -11.0 percentage points; 95% CI, -18.4 to -3.5), which is outside the noninferiority margin of -9.0.

Overall, 41 patients in the intervention group and 13 in the conservative group had at least one adverse event.

BOTTOM LINE: Missing data limit the ability to make strong conclusions, but this trial suggests that conservative management of primary spontaneous pneumothorax was noninferior to interventional management with lower risk of serious adverse events.

CITATION: Brown SG et al. Conservative versus interventional treatment for spontaneous pneumothorax. *N Engl J Med.* 2020; 382:405-15.

4 Lack of fever in ESRD with *S. aureus* bacteremia is common

CLINICAL QUESTION: What is the incidence of fever in *Staphylococcus aureus* bacteremic patients with end-stage renal disease (ESRD) presenting to the emergency department?

BACKGROUND: Fever is a common symptom in patients presenting to the ED. In patients with hemodialysis-dependent ESRD, the literature on febrile response during infection is scarce. In this study, authors compared ED triage temperatures of *S. aureus* bacteremic patients with and without hemodialysis-dependent ESRD.

STUDY DESIGN: Paired, retrospective cohort study.

SETTING: Tertiary care referral center.

SYNOPSIS: A total of 74 patients with methicillin-resistant or meth-

icillin-susceptible *S. aureus* bacteremia were included in this study (37 patients with and 37 patients without hemodialysis-dependent ESRD). Upon triage, 54% (95% confidence interval, 38%-70%) and 82% (95% CI, 65%-91%) of hemodialysis and nonhemodialysis patients did not have a detectable fever (less than 100.4° F), respectively. The estimated mean ED triage temperatures were 100.5° F in the hemodialysis-dependent patients and 99.0° F in the non-hemodialysis-dependent patients ($P < .001$). The authors note the significant lack of fevers may be the result of insensitive methods for measuring body temperature, such as peripheral thermometers.

BOTTOM LINE: In this small retrospective cohort study, these data suggest a high incidence of afebrile bacteremia in patients with ESRD, especially those patients not dialysis dependent. This may lead to delays in obtaining blood cultures and initiating antibiotics. However, given the study design, the authors were unable to conclude a causal relationship between ESRD and febrile response.

CITATION: Weatherall SL et al. Do bacteremic patients with end-stage renal disease have a fever when presenting to the emergency department? A paired, retrospective cohort study. *BMC Emerg Med.* 2020;20:2.

Dr. Schmit is a hospitalist and associate professor of medicine at University of Texas Health, San Antonio.

By **Sadie Trammell-Velasquez, MD**

5 Hotspotting does not reduce readmissions

CLINICAL QUESTION: Does the addition of the Camden Coalition of Healthcare Provider's care-transition program prevent hospital readmission in high utilizers of health care services?

BACKGROUND: In the United States, 5% of the population use half of the annual spending for health care services and 1% account for approximately a quarter of annual spending, considered "superutilizers" of U.S. health care services. The Camden Coalition of Healthcare Providers (the Coalition) developed a model using hospital admission data to identify superutilizers, termed "hotspotting,"



Dr. Trammell-Velasquez

which has gained national recognition. Unlike other similar programs, this model targets a more diverse population with higher utilization than other programs that have been studied.

STUDY DESIGN: Randomized, controlled trial.

SETTING: Two hospitals in Camden, N.J., from June 2, 2014, to March 31, 2018.

SYNOPSIS: Eight-hundred superutilizers (at least one hospital admission at any of the four Camden-area hospital systems in the past 6 months, greater than one chronic medical condition, more than one high-risk traits/conditions) were randomly assigned to the intervention group or usual care. Once enrolled in the hospital, a multidisciplinary team began working with the patient in the intervention group on discharge. Team members conducted home visits, scheduled/took patients to appointments, managed medications, monitored and coached patients in disease-specific self-care, and assisted with applying for social and other assistive programs.

The readmission rate within 180 days after hospital discharge (primary outcome) between groups was not significant, with 62.3% readmitted in the intervention group and 61.7% in the control group. There was also no effect on the defined secondary outcomes (number of readmissions, proportion of patients with more than two readmissions, hospital days, charges, payments received, mortality).

The trial was not powered to detect smaller reductions in readmissions or to analyze effects within specific subgroups.

BOTTOM LINE: The addition of the Coalition's program to patients with very high use of health care services did not decrease hospital readmission rate when compared to usual care.

CITATION: Finkelstein A et al. Health care hotspotting – a randomized, controlled trial. *N Engl J Med.* 2020;382:152-62.

6 Clinician practices to connect with patients

CLINICAL QUESTION: What practices foster physician presence and connection with their patients?

BACKGROUND: As technology and medical advances improve patient care, physicians and patients have become more dissatisfied with their interactions and relationships. Practices are needed to improve the

Short Takes

Adjuvant vitamin C and thiamine ineffective in improving recovery from septic shock

A multicenter, open-label, randomized, controlled trial in 10 ICUs of septic shock patients showed that treatment with the combination of intravenous vitamin C, thiamine, and hydrocortisone did not significantly improve duration of time alive and free of vasopressors over 7 days with a hazard ratio of 1.18 (95% confidence interval, 0.69-2.01), compared with hydrocortisone alone.

CITATION: Fujii T et al. Effect of vitamin c, hydrocortisone, and thiamine vs hydrocortisone alone on time alive and free of vasopres-

or support among patients with septic shock. *JAMA.* 2020 Jan 17. doi: 10.1001/JAMA.2019.22176.

Frailty predicts mortality with stroke

In this retrospective cohort study, clinical frailty as measured by the Clinical Frailty Scale is independently associated with increased 28-day mortality after ischemic stroke and a decreased improvement in National Institutes of Health Stroke Scale (NIHSS) postthrombolytic therapy.

CITATION: Evans NR et al. Clinical frailty independently predicts early mortality after ischaemic stroke. *Age Ageing.* 2020. doi: 10.1093/ageing/afaa004.

connection between physician and patient.

STUDY DESIGN: Mixed-methods.

SETTING: Three diverse primary care settings (academic medical center, Veterans Affairs facility, federal-qualified health center).

SYNOPSIS: Initial evidence- and narrative-based practices were

identified from a systematic literature review, clinical observations of primary care encounters, and qualitative discussions with physicians, patients, and nonmedical professionals. A three-round modified Delphi process was performed with experts representing different

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aspects of the patient-physician relationship.

Five recommended clinical practices were recognized to foster presence and meaningful connections with patients: 1. Prepare with intention (becoming familiar with the patient before you meet them); 2. Listen intently and completely (sit down, lean forward, and don't interrupt, but listen); 3. Agree on what matters most (discover your patient's goals and fit them into the visit); 4. Connect with the patient's story (take notice of efforts by the patient and successes); 5. Explore emotional cues (be aware of your patient's emotions). Limitations of this study include the use of convenience sampling for the qualitative research, lack of international diversity of the expert panelists, and the lack of validation of the five practices as a whole.

BOTTOM LINE: The five practices of prepare with intention, listen intently and completely, agree on what matters most, connect with the patient's story, and explore emotional cues may improve the patient-physician connection.

CITATION: Zulman DM et al. Practices to foster physician presence and connection with patients

in the clinical encounter. *JAMA*. 2020;323(1):70-81.

Dr. Trammell-Velasquez is a hospitalist and associate professor of medicine at University of Texas Health, San Antonio.

By Emily Wang, MD

7 Default EMR settings can influence opioid prescribing

CLINICAL QUESTION: Does changing the EMR default setting for opioid prescriptions change the



Dr. Wang

quantity of opioids prescribed at discharge from the emergency department?

BACKGROUND: The opioid crisis is in the forefront as a public health emergency and there are concerns regarding addiction stemming from opioid prescriptions written in the acute setting, such as the ED and hospitals.

STUDY DESIGN: Quality improvement project, randomized.

SETTING: Two large EDs in San Francisco and Oakland, Calif.

SYNOPSIS: In five 4-week blocks,

the prepopulated opioid dispense quantities were altered on a block randomized treatment schedule without prior knowledge by the prescribing practitioners with the default dispense quantities of 5, 10, 15, and null (prescriber determined dispense quantity). Opiates included oxycodone, oxycodone/acetaminophen, and hydrocodone/acetaminophen. The primary outcome was number of opioid tablets prescribed at discharge from the ED. In this study, a total of 104 health care professionals issued 4,320 opioid study prescriptions. With use of linear regression, an increase of 0.19 tablets prescribed was found for each tablet increase in default quantity. When comparing default pairs – that is, 5 versus 15 tablets – a lower default was associated with a lower number of pills prescribed in more than half of the comparisons. Limitations of this study include a small sample of EDs, and local prescribing patterns can vary greatly for opioid prescriptions written. In addition, the reasons for the prescriptions were not noted.

BOTTOM LINE: Default EMR opioid quantity settings can be used to decrease the quantity of opioids prescribed.

CITATION: Montoy JCC et al. Association of default electronic medical record settings with health care professional patterns of opioid prescribing in emergency departments: A randomized quality improvement study. *JAMA Intern Med*. 2020;180(4):487-93.

8 Asymptomatic *C. diff* carriers have increased risk of symptomatic infection

CLINICAL QUESTION: Do admitted patients who are asymptomatic carriers of *Clostridioides difficile* progress to symptomatic *C. difficile*?

BACKGROUND: *C. difficile* infections (CDI) are significant with more than 400,000 cases and almost 30,000 deaths annually. However, there is uncertainty regarding asymptomatic *C. difficile* carriers and whether they have higher rates of progression to symptomatic infections.

STUDY DESIGN: Prospective cohort study.

SETTING: Large university hospital in the New York from July 2017 through March 2018.

SYNOPSIS: Patients admitted were screened, enrolled, and tested to include an adequate sample of nursing facility residents because of prior studies that showed nursing facility residents with a higher

Short Takes

High-risk, critically ill patients may benefit from acid suppression prophylaxis to prevent GI bleeding

A guideline panel weakly recommends acid suppression with proton pump inhibitors for high-risk (greater than 4%), critically ill patients without other indications for gastric acid suppression based on a linked systematic review and network meta-analysis. A weak recommendation was made for not using acid suppression for prophylaxis in critically ill patients with a lower risk of bleeding (4% or less).

CITATION: Ye Z et al. Gastrointestinal bleeding prophylaxis for critically ill patients: A clinical practice guideline. *BMJ*. 2020. doi: 10.1136/bmj.l6722.

prevalence of carriage. Patients underwent perirectal swabbing and stool swabbing if available. Test swab soilage, noted as any visible material on the swab, was noted and recorded. Two stool-testing methods were used to test for carriage. A *C. difficile* carrier was defined as any patient with a positive test without diarrhea. Patients were followed for 6 months or until death; 220 patients were enrolled, with 21 patients (9.6%) asymptomatic *C. difficile* carriers. Having a soiled swab was the only statistically significant characteristic, including previous antibiotic exposure within the past 90 days, to be associated with carriage; 8 of 21 (38.1%) carriage patients progressed to CDI within 6 months versus 4 of 199 (2.0%) noncarriage patients. Most carriers that progressed to CDI did so within 2 weeks of enrollment. Limitations included lower numbers of expected carriage patients, diarrhea diagnosing variability, and perirectal swabbing was used rather than rectal swabbing/stool testing.

BOTTOM LINE: Asymptomatic carriage of *C. difficile* has increased risk of progression to symptomatic CDI and could present an opportunity for screening to reduce CDI in the inpatient setting.

CITATION: Baron SW et al. Screening of *Clostridioides difficile* carriers in an urban academic medical center: Understanding implications of disease. *Infect Control Hosp Epidemiol*. 2020;41(2):149-53.

Dr. Wang is a hospitalist and associate professor of medicine at University of Texas Health, San Antonio.

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Key Clinical Question

Sarcopenic obesity: The wasting within

This form of deconditioning occurs naturally with age.

By Robert Killeen, MD

Case

The patient is a 65-year-old white female who recently was discovered to have a 2-cm spiculated lung mass in the right upper lobe. She is undergoing an evaluation at present but her main complaint today is that of profound weakness and fatigue. Her appetite and energy level are noticeably less; her family ascribes this to anxiety and depression. Her other medical problems include diabetes, hypertension, osteoporosis, and obesity. The patient believes that she's lost about 20-25 pounds recently, though her family is skeptical, adding that "she's been heavy all her life." Her body mass index is 40. What additional interventions would you add to her workup?

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index of greater than 30 kg/m².

Muscle mass is an important part of this entity, too, but the inclusion of muscle function in this definition brings, seemingly, a point of conjecture. Is muscle function necessary? By what scale do you measure it? This imprecision makes comparative research in the field somewhat more difficult.

As clinical acumen remains the major diagnostic approach to this disease, confirmatory testing for sarcopenic obesity comprises MRIs/CTs and dual-energy x-ray absorptiometry (DXA) scans. Currently DXA is used to assess bone density in the diagnosis of osteoporosis. It also reveals the decreased lean appendicular (extremity) muscle mass which, along with the increased BMI, forms the basic diagnosis of sarcopenic obesity. DXA scans are favored over CTs for the assessment of appendicular lean muscle mass. DXA scans provide a relatively inexpensive method of estimating fat, muscle, and additionally, bone density. CTs are less favored because of their radiation exposure as well as their high cost. Assessing muscle strength, using handgrip dynamometry, is available though not widely advocated.

Of the myriad modalities tried in sarcopenic obesity, many have short-



Dr. Killeen is a physician in Tampa. He practices internal medicine, hematology, and oncology, and has worked in hospice and hospital medicine.

Background

Sarcopenic obesity occurs as a natural consequence of aging. As a general rule, as many as half the women and a quarter of the men over age 80 years are affected. A total of about 18 million people are involved.

One thought as to etiology is that, as one ages, proteolysis outdoes protein synthesis. Fat then replaces the body's muscle, permeates the viscera, and becomes the prominent body form. Chronic lipodeposition leads to chronic inflammation which, in turn, augments protein catabolism. The elderly become less energetic and less active, and the muscle mass decreases further. A vicious cycle develops. Concurrently with obesity, patients suffer with the onset of dyslipidemia, osteoarthritis,

osteoporosis (due to vitamin D deficiency), insulin resistance, and an overall increase in frailty.

Sarcopenic obesity also plays a prognostic role in the management of cancer patients where the presence of sarcopenia correlates with earlier death and decreased capacity for therapy. Patients seen as obese are less likely to receive the intensive care (particularly nutritional support) that patients seen as a higher risk receive. The cancer cachexia is less pronounced. The obesity seen externally masks the wasting within.

Diagnosis and treatment

Sarcopenic obesity suffers from an inexact definition. According to the World Health Organization, obesity is defined, officially, as a body mass

comings. No particular diet format can be advocated. Hypocaloric diets, with or without protein supplementation, offer little advantage to a good physical exercise program. The administration of vitamin D, with calcium, can be of benefit to those sarcopenically obese patients suffering with osteoporosis. Other medications, as exemplified by testosterone, vitamin K, myostatin inhibitors, or mesenchymal stem cells, are either anecdotal or dubious in

Continued on page 26

Quiz

1. What is the best treatment for sarcopenic obesity?

- A. Testosterone
- B. Vitamin K
- C. Myostatin inhibitors
- D. None of the above

Answer: D

There is no particular pharmaceutical treatment, to date, for sarcopenic obesity. Only an exercise program has proved to be of benefit. Those for whom fatigue might be problematic might benefit from "energy banking" or taking programmed naps/rest periods prior to exercise.

2. DXA scans are favored over CT scans because of which of the following?

- A. Less cost
- B. Capacity to diagnose osteoporosis

- C. Less radiation exposure
- D. All of the above

Answer: D

DXA scans offer all of the above advantages over CT scans. Also, patients with sarcopenic obesity found to be osteoporotic could be started on vitamin D and calcium supplementation.

3. Which of the following hamper the diagnosis and treatment of sarcopenic obesity?

- A. The issue of muscle function
- B. Difficulties in comparative research studies
- C. Remembering that muscle wasting can occur without external evidence of cachexia
- D. All of the above

Answer: D

Obtaining a precise definition of sarcopenic

obesity and dealing with the issue of muscle strength and capacity make comparative studies difficult. The sarcopenic obese patient needs as much attention as the cachectic one as their wasting is from within.

4. In sarcopenic obesity and cancer, the presence of sarcopenia is likely to lead to which of the following?

- A. Earlier death
- B. Decreased capacity for therapy
- C. Less treatment focus compared to nonsarcopenic patients
- D. All of the above

Answer: D

The presence of sarcopenia correlates to all of the above particularly as the obese patient is thought to require less intensive attention than others.



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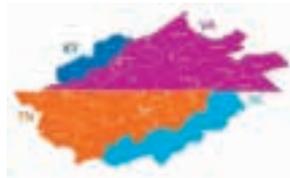
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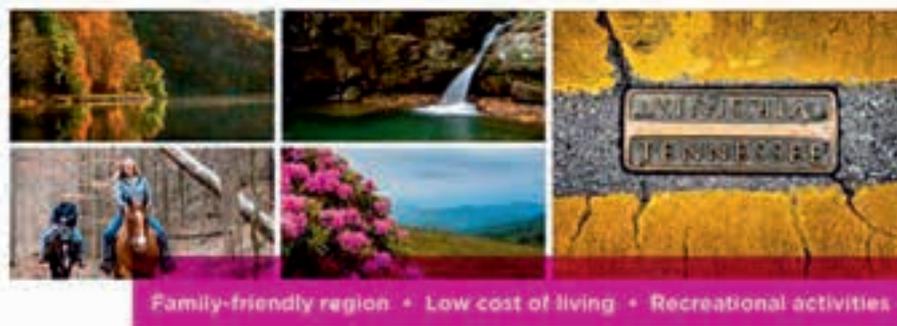
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THE Hospitalist

Moving beyond the hospital ward

By Weijen W. Chang, MD,
SFHM, FAAP

SHM is entering an exciting new chapter in its history because we will soon see Dr. Eric Howell take the reins from Dr. Larry Wellikson as CEO, as we watch Dr. Danielle Scheurer assume the role of president from Dr. Chris Frost, and as a side note, I will try to fill Dr. Scheurer's shoes as physician editor of *The Hospitalist*.

This changing of the guard of SHM's leadership will take place amid the backdrop of an acrimonious presidential election and the emergence of a novel coronavirus that threatens to upend the typical routines of our social and professional lives.

Without a doubt, our leaders, whether national, regional, or local, will be at the helm during one of the most uncertain times in the history of modern health care. Will we see a U.S. President who is a proponent of supporting the Affordable Care Act? Will we see further erosion of Obamacare under a second term of President Trump? Will we see rural hospitals continue to close or shrink¹ as their margins get squeezed by skyrocketing denials for inpatient status in favor of observation or outpatient status?²

Forces that seem beyond our control threaten to drastically alter our professions and even our livelihoods. In the space of the few weeks during which I began and finished this piece, every day brought a whole new world of changes in my hospital, town, state, and country.

No leader can predict the future with any semblance of certitude.

In the face of these swirling winds of uncertainty, what is clear is that maintaining our commitment as hospitalists to providing evidence-based, high-quality care to our patients while providing support to our colleagues in the health care industry will greatly benefit from collaborating effectively under the "big tent" philosophy of SHM. Over my career, I have benefited from great role models and colleagues as my career took me from primary care med-peds to the "new" field of hospital medicine as a med-

"As we move bravely into this new era of SHM, our clarion call is to collaborate whenever and wherever we can."

ped hospitalist, to a leadership role in pediatric hospital medicine. I have also benefited from "learning opportunities," as I have made my fair share of mistakes in efforts to improve systems of care. Nearly all of these mistakes share a common thread – not collaborating effectively with critical stakeholders, both within and outside of my institution.³ As this pandemic progresses, I am (and likely you are) witnessing your leaders succeed or fail based on their ability to collaborate across the institution.

As a field, we risk making similar errors by being too narrowly focused as we strive to improve the

care of our patients. Recently, Dr. Russell Buhr and his colleagues at the University of California, Los Angeles, demonstrated that a majority of 30-day readmissions for chronic obstructive pulmonary disease (COPD) are due to non-COPD diagnoses.⁴ As we discharge our COPD patients, we may be satisfied that we've "tuned up" our patient's COPD, but have we adequately arranged for appropriate ongoing care of their other medical problems? This requires an activity undertaken less and less these days in medicine – a conversation between hospitalists and outpatient medical providers. The coronavirus disease 2019 (COVID-19) pandemic has made this more challenging, but I can assure you that you can neither transmit nor catch the coronavirus from a phone call.

Perhaps we can learn from our hospitalist colleagues trained in family medicine. A recent study found that hospitalists in a team made up of family medicine-trained physicians in an academic health center achieved a 33% shorter length of stay for patients from the family medicine clinic, after adjustment for disease, demographics, and disease severity.⁵ The conclusion of the authors was that this was likely caused by greater familiarity with outpatient resources. I would conjecture that family medicine hospitalists were also more likely to have a conversation with a patient's outpatient primary care provider (PCP).

Of course, I am the first to admit that chatting with a PCP is not as easy as it used to be – when we



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could bump into each other in the doctor's lounge drinking coffee or in radiology while pulling x-ray films (remember those?) – and in the age of COVID-19, these interactions are even less likely. It can take considerable time and effort to get PCP colleagues on the phone unless you're chummy enough to have their cell phone numbers. And time is a resource in short supply because most hospital medicine groups are understaffed – in the 2018 SHM *State of Hospital Medicine (SoHM)* Report, 66.4% of responding groups had open positions, with a median of 12% understaffing reported. The 2020 *SoHM* report is being compiled as we speak, but I suspect this situation will not have improved, and as

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nature. More research is definitely needed.

The key component for the treatment of sarcopenic obesity is exercise, both aerobic and resistant. Physical exercise recruits muscle satellite cells into the muscle fibers strengthening their composition. Growth factors are also released that stimulate the production of muscle satellite cells. Muscle mass becomes augmented and fortified. Aerobic exercise counteracts the negative metabolic effects of lipids. Resistance training is felt to improve strength when in combination with aerobic exercise, compared with aerobic exercise alone. Research has shown that high-speed resistance training, over a 12-week period, had shown a greater improvement in muscle power and capacity when compared to low-speed training. It was also recommended that patients exercise only

until fatigued, not until "failure," as a stopping point. Programs must be customized to fit the individual.

Sarcopenic obesity is a form of deconditioning that occurs naturally with age but is compounded by cancer. Research into this disease is confounded by a lack of accepted definitions. Radiographic workup and lifestyle changes are the mainstay of medical management. The foremost diagnostic tool remains, as always, clinical suspicion.

Recommended reading

Barcos VE, Arribas L. Sarcopenic obesity: Hidden muscle wasting and its impact for survival and complications of cancer therapy. *Ann Oncol.* 2018;29(suppl. 2):ii1-9.

Gruber ES et al. Sarcopenia and sarcopenic obesity are independent adverse prognostic factors in resectable pancreatic ductal adenocarcinoma. *PLoS One.* 2019;14(5): e02115915.10.1371/journal.pone.02115915 (PMID 31059520).

Key Points



In sarcopenic obesity a patient's muscle loss in mass can be clouded, overshadowed by the obese body habitus. The major diagnostic tool initially is clinical suspicion.

- The diagnostic tests for sarcopenic obesity are DXA and CT scans.
- The best treatment for sarcopenic obesity is a good exercise plan.

Lombardo M et al. Sarcopenic Obesity: Etiology and lifestyle therapy. *Eur Rev Med Pharmacol Sci.* 2019;23: 7152-62.

Petroni M et al. Prevention and treatment of sarcopenic obesity in women. *Nutrients.* 2019 Jun 8.10.3390/nu1161302 (PMID 31181771).

Zhang X et al. Association of Sarcopenic Obesity with the risk of all-cause mortality among adults over a broad range of different settings: An update meta-analysis. *BMC Geriatr.* 2018;19:183-97.

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the pandemic strikes, staffing models have been completely blown up.

For us to get out of this staffing hole and still stay under (or not too over) budget, bringing more advanced practice providers (APP) into our groups/divisions will be needed. We must recognize, however, that APPs can't just be hired rapidly and thrown into the schedule. As Tracy Cardin, ACNP-BC, SFHM, stated in her December 2019 blog post on the Hospital Leader website, leaders need to implement consistent onboarding, training, and support of APPs, just as they would for any

“It can take considerable time and effort to get PCP colleagues on the phone. ... And time is a resource in short supply because most hospital medicine groups are understaffed.”

other hospitalist in their group.⁶ Physician hospitalists need to develop and maintain proven competency in effectively interacting with APPs practicing at the top of their skills and productivity. No time has ever proven the need to allow APPs to practice at the top of their skills than the age of COVID-19.⁷

But if your “field” doesn't even recognize you at all? That is the fate of many providers left behind by the field of pediatric hospital medicine. Over the past year, we have seen PHM attain a great achievement in its recognition as a board-certified subspecialty established by the American Board of Pediatrics, only to have the process beset by allegations of gender and maternal bias. While a groundswell of opposition from pediatric hospitalists triggered by the exclusion of applicants to the Practice Pathway to board certification led the ABP to remove the practice interruption criteria, other potential sources of gender and maternal bias remain.⁸

This does not even address pediatric hospitalists trained in family medicine who cannot be eligible for PHM board certification through experience or fellowship, med-peds trained pediatric hospitalists who cannot qualify because of insufficient time spent on pediatric inpatient care, newborn hospitalists (who do not qualify), and APPs specialized in pediatric inpatient care. While it is completely understand-

able that the ABP cannot provide a certification pathway for all of these groups, this still leaves a gap for these providers when it comes to being in a professional community that supports their professional development, ongoing education, and training. Fortunately, leaders of the three societies that have significant numbers of pediatric hospitalists – SHM, American Academy of Pediatrics, and Academic Pediatric Association – are working to develop a PHM designation outside of the ABP board certification pathway that will extend the professional community to those left out of board certification.

As we move bravely into this new era of SHM, our clarion call is to collaborate whenever and wherever we can, with our practice administrators, APPs, outpatient providers, subspecialist providers, and patient/family advocates – pandemic or no pandemic. In fact, what this pandemic has shown us is that rapid cycle, fully 360-degree collaboration is the only way hospitalists and hospital leaders will weather the storms of changing reimbursement, pandemics, or politics. This will be our challenge for the next decade, to ensure that SHM collaboratively moves beyond the confines of the hospital ward.

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