July 2021
Volume 25 | No. 7

The Hospitalist

p3 CONVERGE KEYNOTES
U.S. Army Gen. Mark Hertling

p10 SHM AWARDS
2021 winners revealed at Converge

p18 CRITICAL CARE
Mechanical ventilation tips for hospitalists

SPECIAL ISSUE CONVERGE 2021

Dr. Patrick Rendon, assistant professor in the hospital medicine division at the University of New Mexico, Albuquerque

Allan Stone/UNM Health Sciences

Better ways to handle in-hospital conflicts

By Thomas R. Collins
FROM SHM CONVERGE 2021

Imagine a hospitalist, part of a group with 35 hospitalists, is in her second year of practice and is caring for a 55-year-old woman with a history of congestive heart failure and cirrhosis from hepatitis C due to heroin use. The patient was hospitalized with acute back pain and found to have vertebral osteomyelitis confirmed on MRI.

The hospitalist calls a surgeon to get a biopsy so that antibiotic therapy can be chosen. The surgeon says it's the second time the patient has been hospitalized for this condition, and asks, "Why do you need me to see this patient?" He says the hospitalist should just give IV antibiotics and consult infectious disease.

The hospitalist says, "The patient needs this biopsy. I'll just call your chair."

In the course of a busy day, conflicts arise all the time in the hospital – between clinicians, between patients and clinicians, and as internal battles when clinicians face uncertain situations. There are ways to make these conflicts less tense and more in tune with patient care, panelists said recently during a session at SHM Converge 2021, the annual conference of the Society of Hospital Medicine.

In the case of vertebral osteomyelitis, for instance, the hospitalist was using a "position-based" strategy to deal with the conflict with the surgeon – she came in knowing she wanted a biopsy – rather than an "interest-based" strategy, or what is in the patient's interest,

Continued on page 17

shm
the-hospitalist.org

EXPERT TIPS

Jessica Nave Allen, MD, FHM

p8 Resuscitation medicine: Focus on quality.

CONVERGE 2022

Heather Nye, MD, PhD, SFHM

p31 Preparing for an in-person conference.

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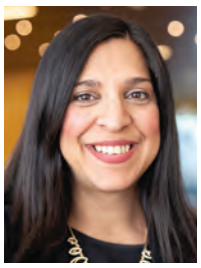
Hospitalist movers and shakers

By Matt Pesyna

Vineet Arora, MD, MHM, has been appointed dean of medical education for the University of Chicago's biological sciences division. She began her assignment on July 1, 2021, taking over for the retiring Halina Brukner, MD, a 36-year veteran in medicine.


Dr. Arora

Dr. Arora will take charge of undergraduate, graduate, and continuing education for the University of Chicago's medical education program, with a focus on simulation-based training. She also will represent the medical school within the university proper, as well as with outside organizations such as the Accreditation Council for Graduate Medical Education.

Dr. Arora has been a faculty member at Chicago Medicine since 2005. She is a professor of medicine, assistant dean for scholarship and discovery, associate chief medical officer for clinical learning, and Master of the Academy of Distinguished Medical Educators.

Zeshan Anwar, MD, SFHM, was named new chief of the section of inpatient internal medicine and director of hospitalist services at Reading Hospital–Tower Health (West Reading, Pa.) in January 2021. He provides support to hospitalists, nurses, pharmacists, care managers, support service professionals, and others.


Dr. Anwar

Previously, Dr. Anwar worked as vice chair of the department of medicine and medical director of the hospitalist program at Evangelical Community Hospital (Lewisburg, Pa.). He has a background in education, having taught as an assistant professor of clinical medicine at Geisinger Commonwealth School of Medicine (Scranton, Pa.) since 2014.

Katherine Hochman, MD, FHM, has been appointed the first director of the newly established division of hospital medicine at NYU Langone Health in New York. Dr. Hochman is the founder of NYU Langone's hospitalist program (2004), and the new division was established this year in the wake of the COVID-19 pandemic.


Dr. Hochman

Dr. Hochman will be charged with expanding on the hospitalist program, analyzing best practices, and educating residents, clinicians, and other health care professionals. She plans to emphasize mentorship and creating career pathways for the program's students.

Dr. Hochman was NYU Langone's first hospitalist and later became associate program director of medicine at Langone's Tisch Hospital. She helped grow the hospitalist program to 40 professionals in 2020.

Daniel Asher, MD, recently was named a Top Hospitalist by Continental Who's Who. Dr. Asher is a night hospitalist at Piedmont Columbus Regional (Columbus, Ga.), where he works with residents and consults with other physicians.

Dr. Asher has spent his entire post–medical school career at Piedmont, serving as a family medicine resident from 2018 to 2020. He was named chief resident in 2019-20, and has practiced at the hospital since then, including front-line work with COVID-19 patients.

Nicholas O'Dell, MD, has been selected as medical director of the Murray Medical Associates hospitalist program at Murray-Calloway County Hospital (Murray, Ky.). Dr. O'Dell, who has been a hospitalist at the facility since 2014, has served as chief medical officer at the hospital since February 2020 and will continue in his role as CMO.

Brad Tate, MD, has been elevated to associate chief medical officer at Children's Medical Center Plano (Tex).

Dr. Tate has been affiliated with Children's Health since 2010, when he was a hospitalist in Plano, as well as medical director of the Children's Health Medical Group Hospitalist Group.

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KEYNOTES

Military leader shows hospitalists a way out of pandemic 'combat'

By Thomas R. Collins
MDedge News

Whether they realize it or not, hospitalists treating patients during the COVID-19 pandemic have been in a combat-like situation, with challenges and stresses similar to those faced by soldiers in a war zone.

And now, as the pandemic shows signs of subsiding, they're about to emerge from this fight, which poses a whole new set of challenges, according to a retired U.S. Army general who gave the opening keynote speech at SHM Converge, the annual conference of the Society of Hospital Medicine.

Lt. Gen. (Ret.) Mark Hertling, DBA, said during his keynote speech that clinicians and soldiers – the only two professions that routinely have to navigate through life and death situations – must lead during all phases of combat.

"This is a period where you're going to experience some things that you may or may not be ready for," he said. "These are the same kind of issues soldiers face when redeploying from a combat zone."

To help draw the comparison between hospitalists during the COVID-19 era and troops during a war, Lt. Gen. Hertling showed a photo of a U.S. paratrooper who'd just dropped into northern Iraq, carrying a backpack engorged with gear. He was on one knee with his face downcast as he seemed to be taking a moment to reflect on the enormity, complexity, and danger of the crisis into which he was about to plunge. He was, Lt. Gen. Hertling said, likely pondering the mission, his family he left behind, and concerns about making mistakes in front of his comrades.


Lt. Gen. Hertling

Then he showed a picture of a health care worker in a hospital corridor slumped on the floor with his or her back against the wall, knees up, and hands loosely clasped, looking exhausted and dazed. Health care workers also have carried a load that has seemed unbearable.

"You can certainly see that they are experiencing an emotional trauma at the very start of the pandemic," he said. "The things you have carried over the last year-plus as the pandemic has raged will be with you in good and sometimes bad ways, and you need to address those things."

Lt. Gen. Hertling described several issues – mirroring those seen in combat – that clinicians will take away from the COVID-19 experience and must grapple with as the closing chapters of the pandemic play out:

A sense of teamwork

While it's not unusual, he said, for physicians not to get along well with administrators, and for nurses sometimes not to trust doctors, the COVID-19 crisis created a sense of effective teamwork.

"They have built trust because they see a common mission and a common requirement," he said.

A sense of loss

"You have lost patients, you probably have lost comrades, and some of you are having this associated survivor's guilt – why did you survive and so many of your patients, perhaps a lot of your friends, did not?"

At memorial services for fallen soldiers, Lt. Gen. Hertling would bring a laminated card with the soldier's picture and put it in a box with the words "Make It Matter" on it.

"That was our code for ensuring that every one of these individual soldiers who sacrificed their lives for the organization, we would carry on their legacy and make their sacrifice matter," he said. "That's one of the few ways you can overcome survivor's guilt."

A sense of accomplishment

Lt. Gen. Hertling said hospitalists, pushed to the extreme, were able to do things they never thought they were capable of.

"You have to relish in that, and you have to write those things down so you can go back and think about the things you did in a crisis environment to help," he said.

In the post-pandemic era, health care workers should reflect on what they have seen, learned, and experienced, to help set a new standard and to establish ways to eliminate "bureaucratic morasses," which seemed more possible than ever because the urgency of the moment demanded it.

Lt. Gen. Hertling also said hospitalists should take time to make a plan to handle personal, professional, team, and organizational requirements. For instance, health care workers should get a physical to take stock of how their bodies reacted to the stress of the pandemic. He said they should also recognize the difference between posttraumatic stress, which is to be expected, and posttraumatic stress disorder (PTSD), which is less common.

"It's only at the extreme that it becomes a dysfunction and you have to address it with the help of others," he said. Hospitalists should also examine the state of their emotional and spiritual relationships with family and friends, he said.

Professionally, hospitalists should review accomplishments and shortcomings and make changes based on those assessments, he said. It's also a good time to assess leadership issues – recall who the contributors were and who could have done more. Hospitalists should consider contributing postpandemic articles to the Journal of Hospital Medicine.

Lt. Gen. Hertling concluded by suggesting that hospitalists seek feedback on themselves, and their own leadership qualities, from their team members.

COVID experience underscores 'vital' role of HM

By Thomas R. Collins
MDedge News

While the COVID-19 pandemic has generated anxiety and confusion in medicine, one thing should bring a sense of clarity to hospitalists: They're needed now more than ever.

Larry Wellikson, MD, MHM, the former, longtime CEO of the Society of Hospital Medicine, in a speech at SHM Converge, said the COVID-19 era has underscored the singular importance of the specialty.

"I think one thing that this recent pandemic has emphasized is just how important and vital hospitalists are to the United States' health care system," Dr. Wellikson said. "The response to the acute care needs in this pandemic would have been impossible in the health care system that existed before hospitalists. And so this is something that we should understand and appreciate."


Dr. Wellikson

The "upheaval" experienced in hospital medicine continues a trend of change that will go on, both in the corporate health care landscape and in the role that hospitalists play in providing care, he said. Insurers have been merging and looking to consolidate. Hospital medicine companies have been merging, and "newfangled bedfellows" have been a trend, such as CVS stepping beyond its pharmacy role into an expanded health care role, Cigna buying Express Scripts, and an Amazon-Berkshire Hathaway-J.P. Morgan health care partnership that ultimately did not pan out, although that hasn't ended Amazon's presence in health care.

"You may not realize it, but Amazon is currently one of the largest hospital supply-chain companies," Dr. Wellikson said. "They're attempting to become a major pharmacy benefits manager and will only further enter into health care and into our personal and professional lives."

New models of care point to the way of the future, he said. Mount Sinai's continuing success with its Hospital at Home program – which involves an acute care nurse and team assigned to a patient in the home – introduces a concept that will be adopted more broadly, because of

Continued on following page

KEYNOTES

Hospitalist leader offers a post–COVID-19 approach to career advancement

By Thomas R. Collins
MDedge News

After navigating a pandemic that turned the world – including the world of hospital medicine – upside down for so long, the very idea of returning to a "normal" career and way of life can seem strange.

Vineet Arora, MD, MAPP, MHM, assistant dean for scholarship and discovery and associate chief medical officer for clinical learning environment at the University of Chicago, offered guidance to hospitalists on the transition from pandemic life to postpandemic life during a keynote speech at SHM Converge.

The pandemic, Dr. Arora said, showed how important it is to develop trust. When resources were scarce as dire COVID-19 cases flooded hospitals, a culture of trust was essential to getting through the crisis.

"My team expects me to speak up on their behalf – it's how we do things. It's so germane to safety," Dr. Arora said. "This is what you're looking for in your organization – a place of psychological safety and trust."

Surveys show that patients do trust their physicians, and healthcare providers "got a big bump" in trust during the pandemic, she said, which offers a unique opportunity.

"Doctors are trusted messengers for the COVID vaccine," she said. "It really does matter." But clinicians should also advocate for social justice, she said. "We must speak up even louder to fight everyday racism."


Dr. Arora

As hospitalists move into the postpandemic medical world, Dr. Arora encouraged them to "get rid of delusions of grandeur," expecting incredible accomplishments around every corner.

"Amazing things do happen, but oftentimes they happen because we sustain the things we start," Dr. Arora said. For instance, physicians should consider small changes in workflow, but then sustain those changes. Maintaining pushes for change is not necessarily the norm, she said, adding that all hospitalists are probably familiar with quality improvement projects that generate only 3 months of data, because of lost focus.

Hospitalists should also "seek out information brokers" in the postpandemic medical world, or those interacting with a variety of groups who are often good sources of ideas. Hospitalists, she said, are "natural information brokers," communicating routinely with a wide variety of specialists and health care professionals.

"You've got to know what's important to your organization and to everybody else," Dr. Arora said.

She suggested that hospitalists find "zero-gravity thinkers," and even to be this type of thinker themselves – one who stays open to new ideas and has diverse interests and experiences. It is easy to settle into the same ways we've always done things, Dr. Arora said.

"The truth is there are ways that it can be better," she said. "But we sometimes have to seek out new ideas and maintain an open mind – and sometimes we need someone to do it for us."

Often, those closest to us are the least valuable in this regard, she said. "They're not going to give you the next breakthrough idea. You have to get outside of your network to understand where the good ideas are coming from."

With the trauma that hospitalists have experienced for more than a year, well-being might never have been a more vital topic.

"We're done with online wellness modules," Dr. Arora said. "Fix the system and not the person because we all know the system is not working for us."

She said that one way to think of how to improve hospitalist well-being is by emphasizing "the Four Ts" – teamwork (such as the use of scribes), time (consider new work schedule models), transitions (refining workflows), and tech (that works rather than creates burdens).

As hospitalists attempt to move ahead in their post–COVID-19 careers, the key is finding new challenges and never stopping the learning process, Dr. Arora said. Referring to a concept described by career coach May Busch, she said physicians can consider successful careers as a "series of S curves" – at the beginning, there is a lot of work without much advancement, followed by a rapid rise, and then arrival at the destination, which brings you to a new plateau higher up the ladder. At the higher plateau, hospitalists should "jump to a new S curve," learning a new skill and embarking on a new endeavor, which will lift them even higher.

Continued from previous page

its cost savings and good outcomes, he said. Mergers of hospital systems, leading to excess hospital capacity, has given rise to what he calls "ED-plus," or using formerly full-service hospitals as more focused centers – providing emergency, obstetrician, cardiology, x-ray, or orthopedics care, or whatever is needed in a given community.

An increasing focus on population health rather than procedures plays into the strengths of hospitalists, Dr. Wellikson said, and the need for their skills will continue to deepen.

When changes in reimbursement began about 4 years ago, specialties such as cardiology entered into new contracts with hospitals, but the facilities began to notice that many of the services – such as initial heart failure and chest pain management – can be provided by hospitalists.

"They're signing fewer cardiologists and needing therefore to hire more hospitalists," he said.

To keep readmissions low and subsequent costs down, hospitalists will continue to handle the first few postdischarge visits with patients, he said. This is crucial in bundled payment systems.

"Most of the savings in those systems comes from being very efficient in the initial postdischarge portion of people's care," Dr. Wellikson said.

At the same time, hospitalists are not in "unlimited supply."

"I think every hospital medicine group should be assessing and working on improving their clinicians' well-being," he said. "We need to ration somewhat, so we're deploying hospitalists for the things that only we can do." He predicted that hospitalists will be required to work in the electronic medical record less frequently, with this task handled by others.

Dr. Wellikson also called on the specialty to continue to expand its racial and ethnic diversity so that it reflects the patient population it serves.

"We're looking to create pathways to leadership for everyone and not just a tokenism moving forward," he said.

The basic strengths of hospital medicine – its flexibility, professional culture, and youth – leave it well prepared for all of these changes, he said.

"There is a bright future and hospitalists are right in the middle of this – we're not going to be marginalized or on the periphery," Dr. Wellikson said. "If I had one message for all of you, I would say be relevant and add value and you will not only survive, but thrive."

RIV winners announced

The winners of the 2021 RIV competition were also announced at the May 6 general session of Converge. There were two winners in each of the three categories, as follows:

RESEARCH
Overall: "Suboptimal Communication During Inter-Hospital Transfer," Stephanie Mueller, MD, MPH, SFHM
Trainee: "Mentorship in Pediatric Hospital Medicine: A Survey of Division Directors," Brandon Palmer, MD

INNOVATIONS
Overall: "Leveraging Artificial Intelligence for a Team-Based Approach to Advance Care Planning," Ron Li, MD
Trainee: "A Trainee-Designed Initiative Reshapes Communication for Hospital Medicine Patients During COVID-19," Smitha Ganeshan, MD, MBA

CLINICAL VIGNETTES
Adults: "Holy Spontaneous Heparin-Induced Thrombocytopenia," Min Hwang
Pediatrics: "The Great Pretender: A Tale of Two Systems," Shivani Desai, MD

HOT TOPICS

Update in Hospital Medicine relays important findings

By Thomas R. Collins
MDedge News

Two experts scoured the medical journals for the practice-changing research most relevant to hospital medicine in 2020 at a session at SHM Converge.

The presenters chose findings they considered either practice changing or practice confirming, and in areas over which hospitalists have at least some control. Here is what they highlighted:


Dr. Breu


Dr. Herzig

IV iron administration before hospital discharge

In a randomized double-blind, placebo-controlled trial (Lancet. 2020 Dec 12;396[10266]:1895-904) across 121 centers in Europe, South America, and Singapore, 1,108 patients hospitalized with acute heart failure and iron deficiency received either intravenous ferric carboxymaltose or placebo, with a first dose before discharge and a second at 6 weeks.

Those in the IV iron group had a significant reduction in hospitalizations for HF up to 52 weeks after randomization, but there was no significant reduction in deaths because of HF. There was no difference in serious adverse events.

Anthony Breu, MD, assistant professor of medicine at Harvard Medical School, Boston, said the findings should alter hospitalist practice.

"In patients hospitalized with acute heart failure and left ventricular ejection fraction of less than 50%, check iron studies and start IV iron prior to discharge if they have iron deficiency, with or without anemia," he said.

Apixaban versus dalteparin for venous thromboembolism in cancer

This noninferiority trial (N Engl J Med. 2020 Apr 23;382[17]:1599-607) involved 1,155 adults with cancer who had symptomatic or incidental acute proximal deep vein thrombosis or pulmonary embolism. The patients were randomized to receive oral apixaban or subcutaneous dalteparin for 6 months.

Patients in the apixaban group had a significantly lower rate of recurrent venous thromboembolism (P = .09), with no increase in major bleeds, Dr. Breu said. He noted that those with brain cancer and leukemia were excluded.

"In patients with cancer and acute venous thromboembolism, consider apixaban as your first-line treatment, with some caveats," he said.

Clinical decision rule for penicillin allergy

With fewer than 10% of patients who report a penicillin allergy actually testing positive on a standard allergy test, a simpler way to predict an allergy would help clinicians, said Shoshana Herzig, MD, MPH, associate professor of medicine at Harvard Medical School.

A 622-patient cohort that had undergone penicillin allergy testing was used to identify factors that could help predict an allergy. A scoring system called PEN-FAST (JAMA Intern Med. 2020 May 1;180[5]:745-52) was developed based on five factors – a penicillin allergy reported by the patient, 5 years or less since the last reaction (2 points); anaphylaxis or angioedema, or severe cutaneous adverse reaction (2 points); and treatment being required for the reaction (1 point).

Researchers, after validation at three sites, found that a score below a threshold identified a group that had a 96% negative predictive value for penicillin allergy skin testing.

"A PEN-FAST score of less than 3 can be used to identify patients with reported penicillin allergy who can likely proceed safely to oral challenge," Dr. Herzig said.

Prehydration before contrast-enhanced computed tomography in CKD

Previous studies have found that omitting prehydration was noninferior to volume expansion with isotonic saline, and this trial (JAMA Intern Med. 2020 Apr 1;180[4]:533-41) looked at omission versus sodium bicarbonate hydration.

Participants were 523 adults with stage 3 chronic kidney disease who were getting elective outpatient CT with contrast. They were randomized to either no prehydration or prehydration with 250 mL of 1.4% sodium bicarbonate an hour before CT.

Researchers found that postcontrast AKI was rare even in this high-risk patient population overall, and that withholding prehydration was noninferior to prehydration with sodium bicarbonate.

Gabapentin for alcohol use disorder in those with alcohol withdrawal symptoms

Dr. Breu noted that only about one in five patients with alcohol use disorder receive medications to help preserve abstinence or to reduce drinking, and many medications target cravings but not symptoms of withdrawal.

In a double-blind, randomized, placebo-controlled trial (JAMA Intern Med. 2020 May 1;180[5]:728-36) at a single academic medical center, 90 patients were randomized to receive titrated gabapentin or placebo for 16 weeks.

Researchers found that, among those with abstinence of at least 2 days, gabapentin reduced the number of days of heavy drinking and the days of any drinking, especially in those with high symptoms of withdrawal.

Continuity of care and patient outcomes

In a retrospective study (JAMA Intern Med. 2020 Feb 1;180[2]:215-22) examining all medical admissions of Medicare patients with a 3- to 6-day length of stay, and in which all general medical care was provided by hospitalists, researchers examined the effects of continuity of care. Nearly 115,000 patient stays were included in the study, which covered 229 Texas hospitals.

The stays were grouped into quartiles of continuity of care, based on the number of hospitalists involved in a patient's stay. Greater continuity was associated with lower 30-day mortality, with a linear relationship between the two. Researchers also found costs to be lower as continuity increased.

Improving disparities starts with acknowledging racism

By Doug Brunk
MDedge News

Earlier this spring, Kimberly D. Manning, MD, FACP, FAAP, was caring for an elderly Black man with multiple comorbidities at Grady Memorial Hospital in Atlanta, assembling an order for medications and a discharge plan.

"It was very challenging," Dr. Manning, professor of medicine and associate vice chair of diversity, equity, and inclusion at Emory University, Atlanta, recalled during a session at SHM Converge.

At one point, the patient glanced at her, shrugged, and said: "You know, Doc, we get in where we fit in."

"He was talking about the idea that people who come from historically disadvantaged backgrounds just have to try to figure it out, have to try to make a dollar out of 15 cents," Dr. Manning said. "This, to me, really underscores what we mean when we say health disparities, this idea that there are people who are working hard and doing the best that they can but who still are forced to 'get in where they fit in.'"

The Centers for Disease Control and Prevention defines health disparities as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. "When we think about health disparities we often think about many diagnoses," Dr. Manning continued. "We think about HIV and the disparate care and outcomes we've seen in populations of individuals who come from minority backgrounds. We see disparities in obesity, cancer, cardiovascular dis-

Continued on following page

HOT TOPICS

Torsemide over furosemide as first-line loop diuretic for HF

By Doug Brunk
MDedge News

When starting a new loop diuretic for a patient with heart failure, strongly consider torsemide over furosemide, Anthony C. Breu, MD, advised at SHM Converge.

"Whether or not you take a patient who's already on furosemide and you make the switch to torsemide is a little bit tougher for me to advocate, though that has happened in clinical trials," said Dr. Breu, assistant professor of medicine at Harvard Medical School, Boston, who spoke at the Converge session "Things We Do for No Reason." He copresented the session with Leonard Feldman, MD, SFHM, director of the Osler Medical Residency Urban Health Track and associate professor at Johns Hopkins Medicine, Baltimore.

"If you consider doing this it would make sense to do so in concert with the outpatient primary doctor and the outpatient cardiologist," Dr. Breu said. "But in my review of the literature, it's at least worth having these discussions, particularly for a patient who has multiple readmissions for heart failure. That may be a time to pause and ask: 'Could torsemide be of benefit here?'"

In Dr. Breu's opinion, there are at least three reasons why torsemide should be considered a first-line treatment for heart failure. For one thing, the current evidence says so. In a trial published in 2001 (Am J Med. 2001;111[7]:513-20), researchers randomized 234 patients with heart failure to receive torsemide or furosemide for 1 year. The percentage of patients who had one or more hospital readmissions was lower among those who received torsemide, compared with those who received furosemide in the torsemide group for heart failure (17% vs. 32%, respectively; $P < .01$) and for other cardiovascular causes (44% vs. 59%; $P = .03$). In addition, the number of total admissions was numerically lower for patients in the torsemide group, compared with the furosemide group for heart failure (23 vs. 61; $P < .01$) and for cardiovascular causes (78 vs. 130; $P = .02$).


Dr. Breu

In a separate study (Eur J Heart Fail 2003;5[6]:793-801), researchers conducted an open-label trial of 237 patients with New York Heart Association (NYHA) class II-IV heart failure who were randomized to torsemide or furosemide. They found that a significantly higher percentage of patients in the torsemide group improved by one or more NYHA heart failure class, compared with those in the furosemide group (40%; $P = .001$ vs. 31%; $P = .3$). Moreover, patients treated with furosemide had more restrictions of daily life at 9 months, compared with those treated with torsemide ($P < .001$).

A separate, open-label, nonrandomized, post-marketing surveillance trial (Eur J Heart Fail. 2002;4[4]:507-13) also found benefits of torsemide over furosemide or other agents used for patients with NYHA class III and IV heart failure. Patients treated with torsemide had a lower total mortality, compared with those treated with furosemide or other agents (2.2% vs. 4.5%, respectively; $P < .05$) as well as a lower cardiac mortality (1.4% vs. 3.5%; $P < .05$). They were also more likely to improve by one or more heart failure class (46% vs. 37%; $P < .01$) and less likely to have potassium levels less than 3.5 mEq/L or greater than 5.0 mEq/L (13% vs. 18%; $P = .01$).


Dr. Feldman

According to Dr. Breu, meta-analyses of this topic consistently show that the NYHA class improved more with torsemide than with furosemide. "Some meta-analyses find a mortality benefit, while others find a readmissions benefit," he said. "None of them show a benefit of furosemide over torsemide."

A second reason to use torsemide as a first-line treatment for heart failure is that it has superior pharmacokinetics/dynamics, compared with furosemide. "We've all heard that furosemide has variable bioavailability," said Dr. Breu, who also deputy editor of the Journal of Hospital Medicine's "Things We Do for No Reason" article series. "Torsemide and bumetanide are much more reliably absorbed, partially because they are not affected by food, whereas furosemide is. That could be potentially problematic for patients who take their diuretic with meals. The fact that torsemide has less renal clearance is a benefit, because patients with heart failure

Continued on page 8

Continued from previous page

ease, infant mortality and maternal death, hospital readmissions, and COVID-19. We know that people who do not have access to health care or to healthy neighborhoods and environments or who are economically disadvantaged have poorer outcomes. It plays out with all of these diagnoses."

In her opinion, health disparities in hospital medicine fall into in one of three buckets: diagnosis and triage, hospital stay and treatment, and sticking the landing – "that is, after a patient leaves the hospital," Dr. Manning explained. "The hospital stay is the turn on the balance beam. You can do everything perfectly, but then you must dismount. To score a '10' you have to stick the landing. That means being able to get your medications, being able to get to and from clinic appointments, being able to understand the directions you've been given. All of these things are intertwined, the inpatient and outpatient care."

The roots of health disparities in hospitalized patients stem from centuries ago, she said, when America's health care system was built to benefit white male landowners and their families. Health care for Blacks, on the other hand, "was focused on function, almost like veterinary care, or experimentation," Dr. Manning said. "After slavery ended, many historically Black institutions of higher learning opened, including medical schools. In 1909, there were seven historically Black medical schools. Acknowledging the history that preceded disparities is essential."


Dr. Manning

In her view, the path to improving health care disparities starts with conceding that structural racism exists in the practice of medicine. "This means that health disparities are connected to systemic and individual issues, including our biases," Dr. Manning said. "Our system was built on this idea that there is greater value of one group of people above others. Access to care, physician workforce, and biases are impacted by system design. Health equity and health equality are not the same."

She also underscored the importance of the social determinants of health, or "those things we need to be healthy," including economic stability, neighborhood and physical environment, educational opportunities, access to good food, community and social context, and the idea of health care as a human right and understanding our health care system. "This is what is necessary," she declared. "Without all of these together, we can't have the health outcomes that we desire."

As hospital leaders work to build a more diverse physician workforce, Dr. Manning emphasized the importance of forming antiracism policies by addressing questions such as what will we not stand for? How will we protect and create psychologically safe environments? What is our commitment to diversity in leadership and in trainees? What is our commitment to implicit bias training and bystander training?

"We have to get uncomfortable enough to advocate with urgency because all of these are necessary factors to mitigate health disparities," she said. "Though the systemic issues are the most urgent, on an individual level, we must continue to disrupt the negative ideology and stereotypes that threaten our environment every day. When we see those negative things, we have to call them out. We need to continue to listen, to humanize those things that are happening around us, and to understand historical context."

Dr. Manning reported having no financial disclosures.

Meeting Today's Complex Pulmonary Needs **Through LTACH Expertise**

by **Sean Muldoon** MD, MPH, FCCP,
Chief Medical Officer, Kindred Hospitals

Recent research indicates that acute respiratory failure mortality rates are continuing to increase, further heightened by the COVID-19 pandemic. For patients experiencing respiratory failure conditions, such as acute respiratory distress syndrome (ARDS), specialized acute care after the initial hospital stay is playing a critical role in improving patient outcomes, reducing readmissions and decreasing the severity of long-term effects.

The Increasing Demand for Pulmonary Care

A new study finds that rates of acute respiratory distress syndrome have persisted in the U.S. and that acute respiratory failure mortality rates have been increasing over the past five years.[1]

Additional studies show that patients hospitalized for acute viral infections such as COVID-19 can often experience significant pulmonary complications as a result of the virus and its side effects, including severe pneumonia and ARDS.

These patients, often needing mechanical ventilation for a prolonged time, may continue to require considerable medical interventions due to the numerous long-term effects of the virus and acute-on-chronic diseases. Furthermore, studies suggest that the increased need for pulmonary care expertise requires support in other care settings as traditional ICUs face bed and staffing shortages.[2]

LTACH Expertise in Pulmonary Care and Recovery

A patient's long-term lung health is directly dependent on the type and intensity of the care they receive. Long-term acute care hospitals (LTACHs) are uniquely equipped to continue the acute care initiated in the hospital, including the care of patients on mechanical ventilation.

Patients with severe viral respiratory infections can experience strokes and sepsis, which can lead to multi-system failure and leave a critically ill patient with chronic damage to the lungs. LTACHs specialize in treating conditions such as these. Ongoing research also demonstrates the unique value that LTACHs offer to ventilator-dependent patients.[3]

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HOT TOPICS

In-hospital resuscitation: Expert tips

Focus on effective chest pumps, prompt shocks

By Randy Dotinga

The keys to effective resuscitation in the hospital setting include effective compression and early defibrillation, according to Jessica Nave Allen, MD, FHM, a hospitalist with Emory University Hospital in Atlanta. She spoke about best practices in resuscitation medicine at SHM Converge.

"We know CPR [cardiopulmonary resuscitation] and shocking are the two biggest determinants of outcomes, so really strive to make those chest compressions really high quality. And if you get your patient intubated, you want to shock as early as possible," said Dr. Allen. She urged hospitalists to consider mechanical piston compressions and even "reverse CPR" when appropriate.

Dr. Allen offered several other resuscitation tips:

Don't overcrowd the room

There shouldn't be more than eight people inside the room during a code, she said. If you're the code leader, "make sure that somebody has already started high-quality chest compressions. You want to make sure that somebody is already on the airway. It's usually two people, one person to actually hold the mask down to make sure there's a good seal, and the other person to deliver the breaths."

Two to three people should be assigned to chest compressions, Dr. Allen said, "and you need one or two nurses for medication delivery and grabbing things from the runners. And then you need to have a recorder and the code leader. Everyone else who's not in one of those formalized roles needs to be outside the room. That includes the pharmacist, who usually stands at the door if you don't have a code pharmacist at your institution."

A helpful mnemonic for the resuscitation process is I(CA)RAMBO, which was developed at Tufts Medical Center and published in 2020 (J Am Coll Cardiol. 2020 Mar;75[11_Supplement_1]:3517), she said. The mnemonic stands for the following:


Dr. Allen

- I: Identify yourself as code leader.
- CA: Compression, Airway.
- R: Roles (assign roles in the resuscitation).
- A: Access (intravenous access is preferred to intraosseous, per the American Heart Association's 2020 CPR/emergency cardiovascular care guidelines, unless intravenous access is unavailable, Dr. Allen noted).
- M: Monitor (make sure pads are placed correctly; turn the defibrillator on).
- B: Backboard.
- O: Oxygen.

Focus on high-quality chest compressions

The number of chest compressions must be 100-120 per minute, Dr. Allen said. You can time them to the beat of a song, such as "Stayin' Alive," or with a metronome, she said, "but whatever it is, you need to stay in that window."

The correct compression depth is 2-2.4 inches. "That's very difficult to do during the middle of a code, which is why it's important to allow full recoil," she said. "This doesn't mean taking your hands off of the chest: You should actually never take your hands off of the chest. But you should allow the chest wall to return to its normal state. Also, make sure you aren't off the chest for more for 10 seconds whenever you're doing a rhythm check."

Audiovisual feedback devices can provide insight into the quality of chest compressions. For example, some defibrillators are equipped with sensors that urge users to push harder and faster when appropriate.

Don't be afraid of mechanical chest compression

Although early research raised questions about the quality of resuscitation outcomes when mechanical piston chest compression devices are used, a 2015 systematic review and meta-analysis (Circulation. 2015 Oct 20;132[16 Suppl 1]:S2-39) found that "man was equal to machine," Dr. Allen said. "These devices may be a reasonable alternative to conventional CPR in specific settings."

American Heart Association guidelines (Circulation. 2015 Nov 3;132[18 Suppl 2]:S436-43) state that mechanical compressions may be appropriate in certain specific situations "where the delivery of high-quality manual compressions may be challenging or dangerous for the provider."

According to Dr. Allen, "there are times when it's useful," such as for a patient with COVID-19, in the cath lab, or in a medical helicopter.

Move quickly to defibrillation

"Most of us know that you want to shock as early as possible in shockable rhythms," Dr. Allen said. Support, she said, comes from a 2008 study (N Engl J Med. 2008;358:9-17) that linked delayed defibrillation to lower survival rates. "We want to shock as soon as possible, because your chances of surviving go down for every minute you wait."

Take special care for patients with COVID-19

"The goals here are to minimize exposure to staff," Dr. Allen said.

Put on personal protective equipment before entering the room even if care is delayed, she advised, and reduce the number of staff members in the room below the typical maximum of eight. "In COVID, it should be a maximum of six, and some institutions have even gotten it down to four where the code leaders are outside the room with an iPad."

Use mechanical compression devices, she advised, and place patients on ventilators as soon as possible. She added: "Use a HEPA filter for all your airway modalities."

CPR may be challenging in some cases, such as when a large, intubated patient is prone and cannot be quickly or safely flipped over. In those cases, consider posterior chest compressions, also known as reverse CPR, at vertebral positions T7-T10. "We have done reverse CPR on several COVID patients throughout the Emory system," she said.

Debrief right after codes

"You really want to debrief with the code team," Dr. Allen said. "If you don't already have a policy in place at your institution, you should help come up with one where you sit down with the team and talk about what could you have done better as a group. It's not a time to place blame. It's a time to learn."

Continued from page 6

have changing renal function." In addition, the half-life of torsemide is 3-4 hours and the duration of action is 12 hours, "which are both longer than those for furosemide or bumetanide," he added.

He also pointed out that torsemide has been shown to block the aldosterone receptor in vitro and in rat models – an effect that has not been observed with other loop diuretics. A randomized trial (Circ J. 2003;67[5]:384-90) of patients with chronic heart failure found that levels of renin and aldosterone increased more with torsemide, compared with furosemide, supporting the hypothesis of aldosterone receptor blockade.

A third main reason to use torsemide as your go-to for heart failure has to do with its purported antifibrotic effects, "so that it could be more than a diuretic," Dr. Breu said. "In heart failure, myocardial fibrosis occurs from increased collagen synthesis and turnover. Aldosterone has been shown to play a role in this myocardial fibrosis. Spironolactone has been shown to mitigate this to some extent. If torsemide acts a little like spironolactone, maybe that could explain some of the long-term effects that we see in these studies."

A study supporting this notion (J Am Coll Cardiol. 2004;43[11]:2028-35) found that torsemide but not furosemide reduced levels of serum carboxyl-terminal peptide of procollagen type I, which is associated with exaggerated myocardial deposition of collagen type I fibers in cardiac diseases.

Going forward, a study known as TRANSFORM-HF, which is currently recruiting about 6,000 patients, should bring more clarity to the topic. The primary objective is to compare the treatment strategy of torsemide versus furosemide on clinical outcomes over 12 months in patients with heart failure who are hospitalized. The estimated completion is mid-2022.

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AWARDS OF EXCELLENCE

SHM 2021 Awards of Excellence and Junior Investigator Awards

Clinical Leadership for Physicians

Christopher P. Bruti, MD, MPH

Dr. Christopher P. Bruti is the division chief of hospital medicine at Rush Medical College, Chicago, and the program director of Rush's combined Internal Medicine–Pediatrics Residency Program. He is an associate professor of internal medicine and pediatrics and practices as a hospitalist in both departments.


Dr. Bruti

Dr. Bruti always rises to any challenge that comes his way with empathetic, organized, and insightful leadership. Dr. Bruti is known for his innovation in patient care and optimization practices in the hospital setting – from expanding and optimizing the nonteaching service and a high-functioning observation unit to geolocalization and reorganization of medical teams. While his reputation as a leader was well established before the pandemic hit, the way he rose to the many challenges over the past year has been truly remarkable. After he identified one of the first cases of COVID-19 in his hospital, Dr. Bruti's leadership was evident. He ensured that his staff was wearing proper PPE, reorganized hospitalist staffing, coordinated onboarding of subspecialists, developed algorithms around testing, and created safety-driven patient transfer strategies.

He is a member of the Rush University Medical Center Medical Executive Committee and is the chair of its Medical Records Committee. He has been recognized by both Internal Medicine and Pediatrics clerkships multiple times for excellence in teaching.

Dr. Bruti became a member of SHM in 2014 and has been extremely active with the Chicago chapter. He has also served on the Quality Improvement and Pediatric Medicine Special Interest Groups.

Clinical Leadership for NPs and PAs

Krystle D. Apodaca, DNP, FHM

Dr. Krystle D. Apodaca is a nurse practitioner hospitalist at the University of New Mexico Hospital in Albuquerque, where she is assistant professor of medicine within the university's Clinician Education Track.


Dr. Apodaca

She was one of the first APPs welcomed into the UNM Hospital Medicine division and has been integral not only in the development of UNM's APP program, but also its APP Hospital Medicine Fellowship, which she helped to cofound. She is a member of the UNM Hospital Medicine Executive Committee as well as its LGBTQ Collaborative.

She is known for her leadership within Project ECHO at UNM, a worldwide program focused on democratizing medical knowledge. She is the co–medical director of its National Nursing Home COVID-19 Safety and Medicaid Quality Improvement Hospitalization Avoidance efforts, both focused on improving nursing home practices. This program, in partnership with the Agency for Healthcare Research and Quality, UNM's ECHO Institute, and the Institute for Healthcare Improvement, is now a national initiative dedicated to standardizing COVID-19 best practices at nursing homes across the country. To achieve its goals, more than 15,000 nursing homes have been certified and a community of more than 250 training centers has been built through Project ECHO.

Dr. Apodaca has been a member of SHM since 2015. She has been an active member of SHM's NP/PA Special Interest Group since she joined and was appointed as the first APP president of SHM's New Mexico chapter in April 2020. Under her leadership, the chapter achieved Gold and Platinum status as well as the Chapter of the Year Award. She is also a Fellow in Hospital Medicine.

Certificate of Leadership in Hospital Medicine

Mihir Patel, MD, MBA, MPH, CLHM, SFHM

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.


Dr. Patel

Dr. Mihir Patel serves as medical director of virtual medicine and a full-time hospitalist at Ballad Health in Johnson City, Tenn. He also works part time as a telehospitalist with Sound Physicians, covering multiple hospitals in California and Washington State. He has previously served in a number of administrative roles including medical director of the hospitalist program, chief of staff, and director of the medical informatics committee, in addition to working as a hospitalist in both rural and urban hospitals. He is cofounder and president of the Blue Ridge Chapter of the Society of Hospital Medicine.

Dr. Mihir's research and clinical interests focus on integration of telemedicine, electronic medical records, and principles of lean health care to reduce waste and cost of care while improving overall quality and safety.

Humanitarian Services

Eileen Barrett, MD, MPH, MACP, SFHM

Dr. Eileen Barrett is an internal medicine hospitalist at the University of New Mexico, Albuquerque, where she also serves as associate professor of medicine and the director of Continuing Medical Education in the Office of Continuous Professional Learning.

In addition to current clinical and educational roles at UNM, Dr. Barrett has extensive leadership experience as the former director of Graduate Medical Education Wellness Initiatives, the current District 10 Chair of SHM, chair of a multiorganizational Diversity Equity and Inclusion (DEI) Collaborative Task Force, and a former regent of the American College of Physicians.


Dr. Barrett

Her tremendous efforts in humanitarian services are reflected in her dedication to supporting communities in need. In 2015, Dr. Barrett traveled to Sierra Leone, where she served as an Ebola response clinician. There, she helped to develop safer care protocols, including initiating morning huddles, standardizing onboarding, and improving medication administration and documentation. These skills were developed while she worked for the Navajo Area Indian Health Service (including as an infection control consultant) for more than 9 years and in volunteering at the Myanmar-Thai border with refugees. Her work abroad helped support her training for directing UNM hospitalist COVID-19 Operations while also providing direct care.

Dr. Barrett has represented the specialty of hospital medicine both nationally and internationally. She has served on national committees and spoken from the perspective of an academic and community hospitalist leader on issues such as performance management, patient engagement, DEI, and professional fulfillment.

She has been a member of SHM since 2014 and has served as cochair of the three most recent Innovations Poster Competitions. Dr. Barrett is a former president of SHM's New Mexico chapter where under her leadership the chapter received SHM's Outstanding Chapter Award in 2018. She is a dedicated member of SHM's Physicians in Training Committee and Chapter Support Committee. Dr. Barrett is an elected member of the Gold Humanism Honor Society, received a 2019 Exemplary Mentor Award from the American Medical Women's Association, and is a Senior Fellow in Hospital Medicine.

Leadership for Practice Management

Leah Lleras, MS

Leah Lleras is the division administrator for the University of Colorado Anschutz Medical Campus, and holds a Master of Science Management and Organization degree from the University of Colorado.

Her leadership as a practice manager is exemplified through her efforts in challenges of salary inequity. After joining the Division of Hospital Medicine in 2018, Ms. Lleras was successful in launching and achieving compensation equity and transparency across the department. She has demonstrated an incredible ability to collaborate with clinical leadership to marry the vision of clinical leaders with the administrative

support required to turn a vision into a reality. During the COVID-19 pandemic, Ms. Lleras has been instrumental in ensuring that the division was prepared and supported to care for an influx of new patients. She did this by leading emergent onboarding of new practitioners, strategizing financial management of hazard pay for frontline clinicians, and creating a streamlined budget system during rapid change.


Ms. Lleras

Ms. Lleras joined the Society in 2018 and has been an active member of the Rocky Mountain Chapter and the Hospital Medicine Administrator Special Interest Group.

Outstanding Service

Robert Zipper, MD, MMM, SFHM

Dr. Robert Zipper is a physician advisor and senior policy advisor for Sound Physicians, with more than 20 years of clinical experience as a hospital medicine leader.


Dr. Zipper

He has a diverse background in quality and patient safety, hospitalist program design, and performance management. He began working as a hospitalist in 1999, in private practice. In 2006, he launched his career at Sound, where he began as a hospitalist but eventually managed Sound's West Coast programs. In 2017, he was appointed Sound vice president of innovation technology. He later became Sound's leader for health care policy, and now serves as a senior policy advisor for Sound, and physician advisor within the Advisory Services line.

Dr. Zipper has been a longtime supporter and advocate of SHM and the field of hospital medicine since joining in 2005. He attended his first Leadership Academy in 2006 and went on to serve as facilitator four times. His passion for SHM's conferences is evident, as he has presented at three Annual Conferences alongside notable SHM leaders. He has been active in a variety of committees, including Quality and Safety, Leadership, and Performance Measurement and Reporting.

He is a member of the Society's Public Policy Committee, and his insight has elevated hospital medicine both in the eyes of peer specialties and in discussions with the Centers for Medicare and Medicaid Services. Dr. Zipper has joined a number of calls with key Capitol Hill and CMS staff to help advocate for issues affecting hospital medicine. His ability to explain issues clearly and eloquently has helped stakeholders better understand the issues and move them forward on lawmakers' agendas.

Research

S. Ryan Greysen, MD, MHS, SFHM

Dr. S. Ryan Greysen is chief of the Section of Hospital Medicine and associate professor at the University of Pennsylvania. He is the executive director for the Center for Evidence-based Practice (CEP) which serves all hospitals in the University of Pennsylvania Health System.

Dr. Greysen's work comprises more than 80 peer-reviewed publications focused on improving outcomes of care for older adults during and after acute illness. Prior to arriving at Penn, he practiced at the University of California, San Francisco, where the impact of his work was extremely visible on the wards. He helped implement care pathways for an Acute Care for Elders (ACE) unit that uses evidence-based protocols and order sets to prevent functional decline and delirium of vulnerable seniors.


Dr. Greysen

At Penn, he has continued to champion care for seniors and has supported other successful programs focused on vulnerable populations: SOAR (Supporting Older Adults at Risk), STEP (Supporting Transitions and Empowering Patients), and MED (Mental health Engagement navigation & Delivery).

During the COVID-19 pandemic, Dr. Greysen helped to accelerate the synthesis of emerging evidence through CEP and the Hospital Medicine Re-engineering Network (HOMERuN) to produce rapid evidence summaries in record speed. These reports have been broadly disseminated across other networks, such as AHRQ and the VA Evidence Synthesis Program.

Since joining the Society 10 years ago, Dr. Greysen has been an engaged member of SHM's Greater Philadelphia Chapter and has held leadership roles on SHM's Research Committee and the JHM Editorial Team as an associate editor. He has presented at multiple SHM annual conferences and is an ambassador of the specialty and of the importance of research in hospital medicine.

He is a Senior Fellow in Hospital Medicine.

Teaching

Grace C. Huang, MD

Dr. Grace C. Huang is an educator and hospitalist at Beth Israel Deaconess Medical Center and associate professor of medicine at Harvard Medical School, Boston, who epitomizes commitment to education and lifelong learning.

Dr. Huang's nationally recognized hospitalist expertise spans medical education and innovation, administrative management, and editorial leadership. She was among the early hospitalist pioneers who helped to transform how residents were trained to do procedures. Her early work led to the creation of one of the first procedure rotations for residents in the country – an RCT on central line simulation, the validation of a central line placement instrument, and a systematic review on procedural training for nonsurgeons.


Dr. Huang

Dr. Huang is vice chair for career development and mentoring in the department of medicine and oversees faculty development at the institutional level. She leads a Harvard Medical School–wide medical education fellowship for faculty and codirects the BIDMC Academy. On a broader scale, her efforts in the field have helped to catalyze the growth of computer-based simulation, define new standards for critical thinking education, and influence high-value care and invasive bedside procedure teaching approaches. Finally, she is editor-in-chief of MedEdPORTAL, an innovative journal of the Association of American Medical Colleges that publishes and disseminates educational resources.

Dr. Huang has been awarded the Gordon J. Strewler Mentoring of Resident Research Award in 2018, the Robert Stone Award for Excellence in Teaching Award, and most recently the A. Clifford Barger Excellence in Mentoring Award at Harvard Medical School, among many others. She is an editorial board member of Academic Medicine.

Dr. Huang joined SHM in 2010. Since then, she has been an engaged member of the Boston Chapter and has regularly participated in SHM's annual conferences. She was also a member of SHM's Practice Analysis Committee for 7 years.

Teamwork in Quality Improvement

Intermountain Healthcare

Intermountain Healthcare is a not-for-profit health system based in Salt Lake City serving the needs of patients primarily in Utah, Idaho,

Continued on following page


INTERMOUNTAIN HEALTHCARE

The Med/Surg Operations team at Intermountain Healthcare in Salt Lake City

Continued from previous page

and Nevada. Intermountain recently reimagined its leadership structure with an integrated approach focused on developing and implementing common goals across its 23-hospital health care system, which was previously divided into regions. With key focus areas including communication, best practices, and goal setting, this structure has helped to combat former fragmentation struggles by creating an environment that provides a consistent high-level care experience regardless of the treatment center a patient selects.

With this reorganization came improved structure allowing for a unique team-based approach while still promoting clear communication lines across the 23 hospitals. This innovative Med/Surg Operations Lane allowed for flexible adaptation to the rapidly changing landscape of the COVID-19 pandemic. Intermountain Healthcare utilized its new framework to ensure crisis-ready operations by defining best practices through real-time literature review and teaming with ED, ICU, and Nursing to create COVID-19 workflows, order sets, and dashboards. Capacity issues were addressed with a variety of strategies: (1) daily systemwide huddles to facilitate load leveling between hospitals; (2) the use of telehealth for early discharges; and (3) remote patient monitoring and admission to the "Intermountain at Home" program, which preserved the ability to deliver critical surgical services.

This new value model clearly sets Intermountain apart from its peers.

Diversity

Lilia Cervantes, MD

Dr. Lilia Cervantes is associate professor in the department of medicine at Denver Health Medical Center and the University of Colorado, where she demonstrates an unparalleled commitment to diversity through her patient care, community service efforts, research, and health policy activism.

Dr. Cervantes

Following her internal medicine residency at the University of Colorado in 2008, Dr. Cervantes went on to obtain her master of science degree in clinical science, and became associate professor of medicine and a hospitalist at Denver Health Medical Center. In addition to her patient-centric roles at Denver Health, Dr. Cervantes has held a variety of roles in the health equity space. These include founding Denver Health Medical Center's Health Equity Learning Series and the Healthcare Interest Program, a pre–health pipeline program for undergraduate students interested in a health care career.

Dr. Cervantes attributes her passion for becoming a physician to her background as a bilingual Latina who grew up in poverty. She says that her upbringing allows her to use this unique lens to connect with her diverse patient population and to advocate for marginalized communities and eliminate structural inequities.

Her experience with Hilda, an undocumented immigrant with kidney failure, was the catalyst for further research on marginalized patients without access to health care, which earned her interviews with NPR and CNN's Chief Health Correspondent Dr. Sanjay Gupta. Her research and advocacy led to Colorado Medicaid's expanding access to scheduled dialysis for undocumented immigrants with kidney failure. Upon announcement of the change, Dr. Cervantes was recognized as the driving force whose research informed the decision.

During the COVID-19 pandemic, Dr. Cervantes has worked diligently to launch research projects and create grant-funded programs to reduce the disproportionate burden of COVID-19 cases and deaths in the Latinx community in Denver. One of her studies centers on the Latinx community – through qualitative interviews of Latinx who had survived a COVID-19 hospitalization, Dr. Cervantes learned about the challenges faced during the pandemic. These findings informed local and national interventions to reduce COVID-19 in the Latinx community.

She has received numerous accolades, including the inaugural Outstanding Service to the Community in 2019 by Denver Health, the Florence Rena Sabin Award from the University of Colorado, and awards from the community – Health Equity Champion Award from the Center for Health Progress and the Unsung Heroine Award from the Latina First Foundation. She serves on several boards including two community-based organizations – the Center for Health

Continued on following page

Making sense of LAMA discharges

Streamlined process and detailed documentation are essential

By P. Dileep Kumar, MD, MBA

Converge 2021 session

LAMA's DRAMA: Left AMA – Documentation and Rules of AMA

Presenter

Venkatrao Medarametla, MD, SFHM

Session summary

Most hospitalists equate LAMA (left against medical advice) patients with noncompliance and stop at that. During the recent SHM Converge conference session on LAMA, Dr. Venkatrao Medarametla, medical director for hospital medicine at Baystate Medical Center, Springfield, Mass., delved into the etiology and pathophysiology of LAMA discharges.

According to Dr. Medarametla, LAMA accounts for 1.4% of all discharges, amounting to more than 500,000 discharges per year nationwide. LAMA discharges are at high risk for readmissions (20%-40% higher), have longer length of stay on readmission, have higher morbidity and mortality (10% higher), and result in higher costs of care (56% higher).

The reasons for LAMA discharges could be broadly divided into patient and provider factors. Patient factors include refusal to wait for administrative delays, extenuating domestic and social concerns, conflicts with care providers, disagreement with providers' judgment of health status, mistrust of the health system, substance dependence with inadequate treatment for withdrawal, patient's perception of respect, stereotyping or stigma, and even ambiance and diet at the hospital.

Provider factors include conflict with the patient, concerns of legal and ethical responsibilities, formally distancing from nonstandard plan, and deflecting blame for worse outcomes.

Faced with a LAMA discharge, the important role of a hospitalist is to assess capacity. Help may be sought from other specialists such as psychiatrists and geriatricians. Some of the best practices also include a clear discussion of risks of outpatient treatment, exploration of safe alternative care plans, patient-centered care, shared decision-making (for example, needle exchange), and harm reduction.

Dr. Medarametla

Dr. Medarametla advised hospitalists not to rely on the AMA forms the patients are asked to sign for liability protection. The forms may not stand up to legal scrutiny. Excellent documentation regarding the details of discussions with the patient, and determination of capacity encompassing the patients' understanding, reasoning, and insight should be made. Hospitalists can also assess the barriers and mitigate them. Appropriate outpatient and alternative treatment plans should be explored. Postdischarge care and follow-ups also should be facilitated.

According to Dr. Medarametla, another myth about AMA discharge is that insurance will not pay for it. About 57% of a survey sample of attendings and residents believed the same, and 66% heard other providers telling patients that insurance would not cover the AMA discharges. In a multicentric study of 526 patients, payment was refused only in 4.1% of AMA cases, mostly for administrative reasons.

PANDPSTOCK001/GETTY IMAGES

Another prevalent myth is that patients who leave AMA will lose their right to follow-up. Prescriptions also could be given to LAMA patients provided hospitalists adhere to detailed and relevant documentation. Overall, the session was very interesting and informative.

Key takeaways

- There are patient and provider factors leading to LAMA.
- Patients' signing an AMA form does not provide legal protection for providers, but a streamlined discharge process and a detailed documentation are likely to.
- There is no evidence that insurance companies will not pay for LAMA discharges.
- LAMA patients could be given prescriptions and follow-up as long as they are well documented.

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Dr. Kumar is a hospitalist in Port Huron, Mich. He is a member of the editorial advisory board for the Hospitalist.

Continued from previous page

Progress and Vuela for Health.

Dr. Cervantes has been an active member of SHM since 2009 and served as keynote speaker for the annual "Summit of the Rockies" Rocky Mountain Chapter SHM conference, "The role of advocacy: Moving the needle towards health equity."

Junior Investigator Award

Matthew Pappas, MD, MPH, FHM

Dr. Matthew Pappas is a staff physician at the Cleveland Clinic, where he serves as assistant professor at the Lerner College of Medicine and Research Investigator at the Center for Value-Based Care Research.

Dr. Pappas completed his residency at the University of Michigan Health System and a postdoctoral fellowship with the VA Ann Arbor Healthcare System in 2016. Currently a hospitalist, he believes in addressing the tension between evidence-based and personal decisions, a fundamental hypothesis of his research career. As a Fellow, he created a model to predict the benefit of bridging anticoagulation for patients with atrial fibrillation. He sees his research mission as addressing the importance of these balanced decisions.

Dr. Pappas

In 2019, Dr. Pappas secured a K08 award from the National Heart, Lung, and Blood Institute, and has turned his attention to preoperative cardiac testing and perioperative outcomes. He has published two manuscripts from this project, with a robust pipeline of others in progress.

He was recognized for his research by the Society of General Internal Medicine in 2018 with the Hamolsky Award for best abstract and had one of his research articles included in the Top 10 Articles of 2019 by the Journal of Hospital Medicine. Dr. Pappas has ongoing research support from the National Heart, Lung, and Blood Institute.

He has been a member of SHM since 2015 and currently serves on the Perioperative Special Interest Group and Research Committee.

A snapshot of nationwide COVID-19 discharge practices

Isolation guidelines was area of greatest consensus

By Doug Brunk
MDedge News

Discharge practices for COVID-19 patients vary widely at the nation's academic medical centers, but there are some areas of strong concordance, especially related to procedures for isolation and mitigating transmission of COVID-19.

In addition, most sites use some form of clinical criteria to determine discharge readiness, S. Ryan Greysen, MD, MHS, SFHM, said at SHM Converge.


Dr. Greysen

Those rank among the key findings from of a survey of 22 academic medical centers conducted by the Hospital Medicine Re-engineering Network (HOMERuN), which was launched in 2011 as a way to advance hospital medicine through rigorous research to improve the care of hospitalized patients.

"When COVID came and changed all of our lives, HOMERuN was well positioned to examine the state of practices in member hospitals, and we set out some key principles," Dr. Greysen said. "First, we wanted to respect the challenges and needs of sites during this extraordinary time. We wanted to support speed and flexibility from our study design to get results to the front lines as quickly as possible. Therefore, we used lightweight research methods such as cross-sectional surveys, periodic evaluations, and we use the data to support operational needs. We have developed linkages to more granular datasets such as electronic health records, but our focus to date has been mostly on the frontline experience of hospitalists and gathering consensus around clinical practice, especially in the early stages of the pandemic."

In March and April of 2020, Dr. Greysen and colleagues collected and analyzed any discharge protocols, policies, or other documents from 22 academic medical centers. From this they created a follow-up survey containing 21 different domains that was administered to the same institutions in May and June of 2020. "It's not meant to be a completely comprehensive list, but these 21 domains were the themes we saw coming out of these discharge practice documents," explained Dr. Greysen, chief of hospital medicine at the University of Pennsylvania, Philadelphia, which is one of the participating sites.

Next, the researchers used a concordance table to help them keep track of which institution responded in which way for which domain, and they bundled the discharge criteria into five higher order domains: procedures for isolation and mitigating transmission; clinical criteria for discharge; nonclinical/nonisolation issues; discharge to settings other than home; and postdischarge instructions, monitoring, and follow-up.

In the procedures for isolation and mitigating transmission domain, Dr. Greysen reported that the use of isolation guidelines was the area of greatest consensus in the study, with 19 of 22 sites (86%) citing the Centers for Disease Control and Prevention and 7 (32%) also citing state department of health guidance. "Specifically, most sites included the ability to socially isolate at home (until no longer necessary per CDC guidance) as part of the criteria," he said. Most sites (73%) required use of personal protective equipment (PPE) in transportation from the hospital, and 73% gave masks and other PPE for use at home.

> *"Our focus to date has been mostly on the frontline experience of hospitalists and gathering consensus around clinical practice, especially in the early stages of the pandemic."*

Session copresenter Maralyssa A. Bann, MD, a hospitalist at the University of Washington/Harborview Medical Center, Seattle, another participating site, pointed out that the institutions surveyed look to the CDC as being "the single source of truth on discharge practices," specifically material for health care workers related to discharging COVID-19 patients. "Notable specific recent updates include the recommendation that meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge from a health care facility," Dr. Bann said. "Also, as of August 2020, use of symptom-based strategy for discontinuation of isolation precautions instead of repeat testing is recommended for most patients. This is a rapidly evolving area."

> *"Notable specific recent updates include the recommendation that meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge from a health care facility."*

Practices in the clinical criteria for discharge domain varied by site. Slightly more than one-quarter of sites (27%) gave little or no guidance by using terms like "use clinical judgment," while 14% gave very specific detailed algorithms. "Most sites fell in between and gave some parameters, usually along the lines of symptom improvement, temperature, and oxygen requirement, but the criteria were variable," Dr. Greysen said. "For example, in terms of temperature, many sites said that patients should be afebrile for a specific length of time, 24-72 hours, while other sites simply said afebrile at discharge." Meanwhile, the following criteria for discharge were addressed by relatively few sites: lab criteria (36%), age (36%), high-risk comorbidities (32%), or ID consultation (18%).

In the nonclinical/nonisolation domain, 73% of sites assessed for level of support available, though this was variably defined. Slightly more than half (55%) specifically assessed activities of daily living or the presence of a caregiver to assist, while 18% reported addressing durable medical equipment such as beds and toilets and access to food or medication supplies in ways that were specific for COVID-19 patients.

In the discharge to settings other than home domain, 77% of sites addressed discharge to skilled nursing facilities, inpatient rehabilitation, or long-term care, although specific requirements were often set by the accepting facilities. In addition, 65% of sites gave specific guidance for patients experiencing unstable housing/homelessness, usually recommending a respite facility or similar, and 59% addressed congregate/shared living spaces such as assisted living facilities. "Often the strictest criteria [two negative COVID tests] were applied to discharge to these types of settings," he said.


Dr. Bann

In the postdischarge instructions, monitoring, and follow-up domain, 73% of sites reported providing home monitoring and/or virtual follow-up care. Programs ranged from daily texting via SMS or patient portals, RN phone calls, home pulse oximeters, and/or thermometers. In addition, 55% of sites had created COVID-specific brochures, discharge instructions, and other materials to standardize content such as use of PPE, travel restrictions, social distancing, signs and symptoms to watch out for, and what to do if worsening clinically.

Dr. Bann predicted future trends on the heels of the HOMERuN survey, including the development of more evidence and consensus related to discharge criteria. "Clarity is needed specifically around hypoxemia at rest/on ambulation, as well as more flexible criteria for oxygen supplementation," she said. "We also think there will be a considerable amount of growth in posthospitalization monitoring and support, in particular home-based and virtual/remote monitoring."

HOMERuN is supported by the Gordon and Betty Moore Foundation, the AAMC, the Patient-Centered Outcomes Research Institute, the Clinical Data Research Networks, the Patient-Powered Research Networks, and Agency for Healthcare Research and Quality. Dr. Greysen and Dr. Bann reported having no financial disclosures.

Hospitalists' role in advance care planning

Time pressure a significant barrier to conversations

By Heidi Splete

Advance care planning (ACP) is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences for future medical care, according to Meredith A. MacMartin, MD, director of inpatient palliative care at the Dartmouth-Hitchcock Medical Center in Lebanon, N.H.

ACP "is really about planning for care in advance," and in many ways, the inpatient setting is uniquely suited to this process, Dr. MacMartin said in a presentation at SHM Converge. "The key part is the advance part. You want conversations to happen before the care is actually needed," she said.

Dr. MacMartin emphasized the importance of distinguishing between ACP and advance directives (ADs). ACP is a process, whereas ADs are documentation, "ideally of the content of advance care planning discussions," she explained. ACP involves discussion about what is important to the patients, their goals, what information is helpful for them, and whether their current care is aligned with their goals, Dr. MacMartin said. ADs might involve a designated power of attorney for health care, a living will, and, in some states, specific clinician-signed orders regarding resuscitation or transport to hospital.

ACP is "more than whether a patient wants CPR [cardiopulmonary resuscitation] or not," said Dr. MacMartin. ACP matters because it helps ensure that the care a patient receives aligns with the patient's wishes and values, she said. ACP increases the likelihood that patients will die in their preferred locations, it allows them to discuss their wishes and prepare for decline, and it relieves family members of the burden of decision-making, she said. From a hospital perspective, data show that use of an ACP can decrease intensive care unit (ICU) utilization and overall health care costs. "Often, when people are given the opportunity to express their wishes, they get less unnecessary care," Dr. MacMartin noted.

Although ACP often takes place in an outpatient setting, hospitalists are in a unique position to conduct some ACP conversations with their patients, Dr. MacMartin said. "Hospitalists are available" and are physically present at least once a day, so there is a pragmatic advantage. Also, some data suggest that patients may feel more comfortable having ACP conversations with a hospitalist than with a primary care provider with whom they have a long-standing relationship, Dr. MacMartin added.

Another important advantage of ACP in the hospital setting is that "as hospitalists, you are the expert on inpatient illness; you know what sick looks like, and you have a unique perspective on prognostication that may be harder to recreate in the outpatient setting," Dr. MacMartin said.

Barriers include patient ID, logistics, attitudes

Settings in which ACP is appropriate include those in which a patient is undergoing "sentinel hospitalization," meaning that the patient is at a transition point in the disease course. Examples are a patient newly diagnosed with metastatic solid cancer, a patient with progressive chronic kidney disease who is considering hemodialysis, or a patient who receives treatment in the ICU for longer than 7 days, Dr. MacMartin said.

Guidelines for identifying patients who might benefit from ACP include the use of the "surprise question" ("would you be surprised if this patient dies in the next year?") as well as functional status assessments using tools such as the Australia-modified Karnofsky Performance Status or the Eastern Cooperative Oncology Group score, said Dr. MacMartin. Some studies suggest that any hospitalized patient older than 65 years should have an ACP discussion, she added.

Time pressure remains a significant barrier to ACP conversations. Some strategies to overcome this problem include enlisting help from other specialists, particularly social workers, Dr. MacMartin said. Social workers report a higher comfort level for talking to patients about death than any other medical specialty; "this is something they want to be doing," she said. Also, the possibility of reimbursement may act as a buffer to create more time to have ACP conversations with patients, she noted.

Addressing clinicians' discomfort with ACP conversations can be "a tougher nut to crack," Dr. MacMartin acknowledged. Clinicians report that they don't want to cause their patients distress, and some report that having conversations about end-of-life care is distressing for them as well. Some of these barriers can be overcome with skills training, including use of a prepared guideline or framework to help increase the comfort level for both clinicians and patients, said Dr. MacMartin.

Training strategies

"For hospitalists interested in developing their ACP skills, I highly recommend two resources," Dr. MacMartin said in an interview. "The Serious Illness Conversation Guide, from Ariadne Labs, is an excellent tool for any clinician to guide discussion about a patient's goals and values," she said.

"For clinicians wanting to build or improve their communication, including advance care planning discussions but also topics like responding to patient's emotions, VitalTalk training offers a deeper dive into core communications skills," she added.

"If your hospital has a palliative care team, they may also have more local resources available. To learn more about billing for ACP discussions, I recommend starting with your institutional billing and coding group, as these practices vary some and they will be able to provide the best guidance for clinicians. These are new codes that aren't yet being very widely used so it's a chance to innovate," Dr. MacMartin noted.

"The hospital setting is an opportunity for patients to reflect on their health, both present and in the future, with a physician who has expertise in acute illness and prognostication and who is available for discussion on a daily basis during the hospitalization," she said.

Dr. MacMartin had no financial conflicts to disclose.

Avoid presumptions with LGBTQ+ patients

'Unique psychosocial considerations' in hospital care

By Heidi Splete
MDedge News

More than 11 million individuals in the United States identify as LGBTQ+, and data show that this population has a shorter life expectancy and increased rates of suicide, violence, and cardiovascular disease, according to Keshav Khanijow, MD, of Northwestern University, Chicago, and Nicole Rosendale, MD, of the University of California, San Francisco.

More than half of these individuals report experiencing discrimination, and one in three transgendered individuals have reported prejudice when visiting a doctor or health clinic, they said in a presentation at SHM Converge.

"It is impossible to know how someone identifies by gender just by looking at them," Dr. Rosendale emphasized.

However, attention to terminology, use of affirming language and documentation, and attention to clinical considerations can help LGBTQ+ patients feel comfortable in the health care setting.

Ask, don't assume

Do ask patients how they identify themselves, Dr. Khanijow said. It is important to ask about sexual orientation as part of a social history. One big "Don't" in terminology is to avoid the use of the term "homosexual," he added. Although the description "homosexual" began as a scientific term, it has become associated with pathology, rather than identity, and is often used by hate groups. Also, do not assume sexual orientation based on a patient's partner.

Always ask about sexual orientation before assuming it, and include that information in documentation. Dr. Khanijow used an example of a "one-liner" case of a 45-year-old male who self-identifies as "queer" and presents with a migraine. The most appropriate version would be "45yoM who identifies as queer with PMHx Migraines presents with Headache," Dr. Khanijow said. However, as a clinician, consider why you are including sexual orientation in the one-liner. If there isn't any real reason to include it (such as stress related to coming out, increased risk for other conditions), it may not be necessary in all visits.

Transgender considerations

Dr. Khanijow shared some specific considerations for the transgender/nonbinary population.

In terms of gender, "it is most respectful to identify the patient as they would like to be identified," he said.


Dr. Khanijow

> *"One big 'Don't' in terminology is to avoid the use of the term 'homosexual'... Although the description 'homosexual' began as a scientific term, it has become associated with pathology, rather than identity."*

Ask how they identify their gender, including their preferred pronouns, and be sure to note this identification in their documents, he said. Be vigilant in addressing a transgender patient correctly. Mistakes happen, and when they do, correct yourself, apologize succinctly, and move on.

> *"Clinicians seeing LGBTQ+ patients in an acute care setting should keep in mind that socioeconomic disparities may limit access to outpatient care...this population has higher rates of unemployment, exacerbated by the...COVID-19 pandemic."*


Dr. Rosendale

Clinical challenges

Research on LGBTQ+ health is limited, and these individuals are often grouped into a single category despite diverse experiences, Dr. Rosendale said. Another limitation in LGBTQ+ research is that some studies assess based on identity (such as gay, lesbian, bisexual), while others assess behavior (studies of men who have sex with men).

Dr. Rosendale went on to highlight several important clinical concerns for the LGBTQ+ population. Compared with the general population, lesbian women are at higher risk for breast cancer, and gay men are at increased risk for prostate, colon, and testicular cancers. Potential heart disease risk factors of physical inactivity, obesity, and smoking are more prevalent among lesbian women, use of tobacco and alcohol is more prevalent among gay men, and men who have sex with men are at increased risk for STIs.


AlexRaths/Thinkstock

Clinicians also should be aware that "bisexual individuals face worse health outcomes than their lesbian, gay, and heterosexual counterparts," Dr. Rosendale said.

LGBTQ+ patients often use hormone therapy, so clinicians should be aware of some potential adverse effects, Dr. Rosendale said. For example, trans women on gender-affirming estrogen therapy may have increased cardiovascular risks including incident MI, ischemic stroke, and cardiovascular mortality, compared with cisgender women.

In trans men, testosterone use has not been definitively linked to cardiovascular risk, although patients may show small changes in systolic blood pressure, lipid profiles, and blood glucose, Dr. Rosendale noted.

In-hospital issues

Inpatient and critical care of transgender and LGBTQ+ patients may have unique psychosocial considerations in hospital care, Dr. Rosendale said. To provide some guidance, a document on "Transgender-Affirming Hospital Policies" has been developed jointly by Lamda Legal, the Human Rights Campaign, the law firm of Hogan Lovells, and the New York City Bar.

Best practices noted in the document include rooming transgender individuals according to their identity, and recognizing that these patients may experience additional stress while an inpatient if personal clothing or other means of gender expression are replaced during the hospital stay, Dr. Rosendale noted.

Finally, clinicians seeing LGBTQ+ patients in an acute care setting should keep in mind that socioeconomic disparities may limit access to outpatient care, and that this population has higher rates of unemployment, exacerbated by the ongoing COVID-19 pandemic, Dr. Rosendale said. In addition, she advised clinicians to be aware that LGBTQ+ people may experience discrimination in rehabilitation centers, and their surrogate decision makers may be individuals other than family members.

Dr. Khanijow and Dr. Rosendale said they had no financial conflicts to disclose.

Hospital conflicts

Continued from page 1

said Patrick Rendon, MD, FHM, assistant professor in the hospital medicine division at the University of New Mexico, Albuquerque.


Dr. Gottenborg

"What we really need to do is realign the thinking from both the hospitalist as well as the consult perspective," Dr. Rendon said. "It is not us versus the consultant or the consult versus us. It should be both, together, versus the problem."

Instead of saying something like, "I need this biopsy," it might be better to ask for an evaluation, he said.

Handling conflicts better can improve patient care but can also benefit the clinicians themselves. While hospitalists say they routinely experience "pushback" when making a request of a consultant, they also say that they prefer to receive instruction when consulting about a case. Dr. Rendon said that hospitalists also say they want this teaching done "in the right way," and consultants routinely say that their instruction, when they give it, is often met with resistance.

"The idea here is to open up perspectives," Dr. Rendon said.

Emily Gottenborg, MD, hospitalist and assistant professor of medicine at the University of Colorado Anschutz Medical Campus, discussed the case of an intern caring for a patient who says something offensive.


Dr. Esquivel

Conflicts, she said, come in all sorts – intimidation, harassment, bias. And they can be based on race, gender, disability, and hierarchy, she said. When on the receiving end of offensive remarks from patients, it's important for a clinician to set boundaries and quickly move on, with responses such as, "I care about you as a person, but I will not tolerate offensive behavior. Let's focus on how I can help you today."

"Practice that behavior so that you have a script in your mind and then use it when needed so that you can nip this behavior in the bud," Dr. Gottenborg said.

In her hypothetical case, the intern asks for help from her program, and monthly morbidity and mortality workshops on bias and harassment are scheduled. She also receives counseling, and faculty and staff receive discrimination and bias training. Getting help from the institution can help systematically reduce these problems, Dr. Gottenborg said.

Ernie Esquivel, MD, SFHM, hospitalist and assistant professor of clinical medicine at Weill Cornell Medicine, New York, said internal conflicts test physicians routinely – and this has been especially true during the COVID-19 pandemic, in which urgent clinical situations arose with no clear answers.

"In the past year, physicians have experienced an incredible amount of anxiety and stress," he said. "Tolerating uncertainty is probably one of the most mature skills that we need to learn as a physician."

The culture of medicine, to a large degree, promotes the opposite tendency: Value is placed on nailing down the diagnosis or achieving certainty. Confidence levels of physicians tend not to waver, even in the face of difficult cases full of uncertainty, Dr. Esquivel said.

He urged physicians to practice "deliberate clinical inertia" – to resist a quick response and to think more deeply and systematically about a situation. To show the importance of this, he asks residents to rank diagnoses, using sticky notes, as information about a case is provided. By the fourth round, when much more information is available, the diagnoses have changed dramatically.

Dr. Esquivel suggested physicians switch from thinking in terms of "diagnoses" to thinking in terms of "hypotheses." That approach can help clinicians tolerate uncertainty, because it reinforces the idea that they are dealing with an "iterative process."

"There may not be one diagnosis to consider," he said, "but several in play at once."

Mechanical ventilation tips for hospitalists

Avoiding excess oxygen 'seems sensible'

By Doug Brunk
MDedge News

The respiratory therapists at Mount Sinai Beth Israel, New York, know when Lina Miyakawa, MD, starts a week in the ICU, because she turns down the fraction of inspired oxygen (FiO_2) levels if patients tolerate it.

"Hyperoxia in mechanical ventilation is a topic that's near and dear to my heart," Dr. Miyakawa, a pulmonary and critical care medicine specialist at Mount Sinai Beth Israel, said during SHM Converge. "You can always find 'wean down FiO_2' in my consult notes."

While it is believed that humans have built up evolutionary defenses against hypoxia but not against hyperoxia, medical literature on the topic of hyperoxia with supplemental oxygen is fairly young. "In medical school we were taught to give oxygen for anybody with chest pain and concern about acute coronary syndrome," she said. "This was until recent data suggested harm from liberal oxygen use."

In a single-center trial of 434 critical care patients with an ICU length of stay of 72 hours or longer, Italian researchers examined the effects of a conservative protocol for oxygen therapy versus conventional therapy on ICU mortality (JAMA. 2016;316[15]:1583-9). The trial was stopped because the patients who were assigned to receive conservative therapy had a significantly lower mortality than the ones who received usual care (P = .01). "The study was not perfect, and the premature stoppage likely exaggerated the effect size," said Dr. Miyakawa, who was not affiliated with the trial. "However, subsequent retrospective studies continue to support a benefit with conservative oxygen use, especially in different groups of patients. One of note is hyperoxia following cardiac arrest. There's something called a two-hit model that speaks to worsening ischemia with reperfusion injury after the initial hypoxic event from the cardiac arrest itself" (see Intensive Care Med. 2015;41:534-6).


Dr. Miyakawa

In a multicenter cohort study that drew from the Project IMPACT critical care database of ICUs at 120 U.S. hospitals between 2001 and 2005, researchers led by J. Hope Kilgannon, MD, tested the hypothesis that post-resuscitation hyperoxia is associated with increased in-hospital mortality (JAMA. 2010;303[21]:2165-71). The study population consisted of 6,326 patients who were divided into three groups: the hypoxic group (a PaO_2 of less than 60 mm Hg); the normoxic group (a PaO_2 of 60-299 mm Hg), and the hyperoxic group (a PaO_2 of over 300 mm Hg). The mortality for the hyperoxic group was at 63%, the hypoxic group at 57%, and the normoxic group at 45%.

More recently, the ICU-ROX Investigators and the Australian and New Zealand Intensive Care Society Clinical Trials Group evaluated conservative versus liberal approaches in providing oxygen to 965 patients who were mechanically ventilated between 2015 and 2018 at 21 ICUs (N Eng J Med. 2020;382:989-98). Of the 965 patients, 484 were randomly assigned to the conservative oxygen group (defined as an SpO_2 of 97% or lower) and 481 were assigned to the usual oxygen group (defined as having no specific measures limiting FiO_2 or the SpO_2).

The primary outcome was the number of ventilator-free days from randomization until day 28, while the secondary outcome was mortality at 180 days. The researchers also performed a subgroup analysis of patients at risk for hypoxic-ischemic encephalopathy.

No significant differences were observed in the number of ventilator days between the two groups (a median of 21 days in the conservative oxygen group versus 22 days in the usual oxygen group, respectively; P = .80) nor in mortality at 180 days (35.7% vs. 34.5%). However, in the subgroup analysis, patients with hypoxic-ischemic encephalopathy were noted to have more ventilator-free days (21 vs. 0 days), improved 180-day mortality (43% vs. 59%), and less functional impairment (55% vs. 68%) than the conservative-oxygen group.

"The results of this study suggest that conservative oxygen therapy has no additional advantage over standard oxygen therapy, but there may be benefits in those vulnerable to hyperoxia, which warrants further investigation," Dr. Miyakawa said. "There are a few points to note on this topic. First, many of the previous studies had more liberal oxygen strategies than the ones used in this study, which could be the reason why we are seeing these results. In addition, O_2 titration relies on imperfect approximations. PaO_2 cannot be measured continuously; we really depend on the SpO_2 on a minute-by-minute basis. Critically ill patients can also undergo episodes of hypoperfusion and shock state minute-by-minute. That's when they're at risk for hypoxemia. This would not be captured continuously with just O_2 saturations."

Dr. Miyakawa also highlighted the Liberal Oxygenation versus Conservative Oxygenation in Acute Respiratory Distress Syndrome trial ($LOCO_2$) a prospective, multicenter, randomized, open-label trial involving patients with ARDS. It was carried out at 13 ICUs in France between June 2016 and September 2018 in an effort to determine whether conservative oxygenation would reduce mortality at 28 days, compared with the usual liberal-oxygen strategy (N Eng J Med. 2020;382:999-1008). The researchers detected a signal of increased mortality in the conservative oxygen group (34% vs. 27%), which led to a premature stoppage of the trial.

"I'd like to postulate that the higher incidence of proning in the liberal oxygenation group compared to the conservative oxygen group (51% to 34%) may be the reason for the difference in mortality," said Dr. Miyakawa, who was not affiliated with $LOCO_2$. "This is supported from the 2013 PROSEVA Study Group, which reported that prone positioning in ARDS significantly decreases 28- and 90-day mortality" (see N Engl J Med. 2013;368:2159-68).

Trends in the management of pulmonary embolism

By Doug Brunk
MDedge News

One of the newest trends in pulmonary embolism management is treatment of cancer-associated venous thromboembolism (VTE), which encompasses deep vein thrombosis (DVT) and PE. Following the clinical management of cancer-associated venous thromboembolism in the hospital, direct oral anticoagulant therapy at discharge is your starting point, except in cases of intact luminal cancers, Scott Kaatz, DO, MSc, FACP, SFHM, said during SHM Converge.

Dr. Kaatz, of the division of hospital medicine at Henry Ford Hospital, Detroit, based his remarks on emerging recommendations from leading medical societies on the topic, as well as a one-page algorithm from the Anticoagulation Forum that can be accessed at https://acforum-excellence.org/Resource-Center/resource_files/1638-2020-11-30-121425.pdf.

For the short-term treatment of VTE (3-6 months) for patients with active cancer, the American Society of Hematology guideline panel suggests direct oral anticoagulants, such as apixaban, edoxaban, or rivaroxaban, over low-molecular-weight heparin (LMWH) – a conditional recommendation based on low certainty in the evidence of effects (Blood Adv 2021;5[4]:927-74).


Dr. Kaatz

Dr. Kaatz also discussed the latest recommendations regarding length of VTE treatment. After completion of primary treatment for patients with DVT and/or PE provoked by a chronic risk factor such as a surgery, pregnancy, or having a leg in a cast, the ASH guideline panel suggests indefinite antithrombotic therapy over stopping anticoagulation. "On the other hand, patients with DVT and/or PE provoked by a transient factor typically do not require antithrombotic therapy after completion of primary treatment," said Dr. Kaatz, who is also

Continued on following page

Hospitalists innovate in ICU management

By Thomas R. Collins
MDedge News

With intensive care units stretched to their limits – and beyond – during the COVID-19 pandemic, hospitalists became more central than ever in orchestrating the response.

At SHM Converge, two hospitalists shared how their teams helped to develop new critical care units and strategies for best managing and allocating care to COVID patients in the ICU.

"The pandemic has been a selective pressure on us as a specialty," said Jason Stein, MD, SFHM, a full-time clinical hospitalist at Roper Hospital, a 332-bed facility in Charleston, S.C.

Dr. Stein explained how hospitalists at Roper helped create the Progressive Care Unit – a negative-pressure unit with 12 high-flow oxygen beds overseen by a hospital medicine team, with the help of a respiratory therapist, a pharmacist, and nurses. Patients in this unit had escalating acuity – quickly increasing oxygen needs – or deescalating acuity, such as ICU transfers, Dr. Stein said. Cardiac catheterization space was converted for the unit, which was intended to preserve beds in the hospital ICU for patients needing mechanical ventilation or vasoactive medication.

Interdisciplinary rounds – to assess oxygen and inflammatory marker trends, and run through a COVID care checklist – took place every day at 10 a.m.

"Consistency was the key," Dr. Stein said.

At Weill Cornell Medical Center in New York, hospitalists helped build the COVID Recovery Unit, which was dedicated to the care of patients coming out of the ICU, said Vishwas Anand Singh, MD, MS, FHM, cochief of hospital medicine at New York Presbyterian–Lower Manhattan Hospital.

> *"These innovations not only helped serve patients and families better, but also gave hospitalists training and experience in palliative care."*

"The pandemic created an unprecedented need for critical care, and post-ICU care," Dr. Singh said. "After extubation, patients remain very complicated and they have unique needs."

The 30-bed COVID Recovery Unit – converted from a behavioral health unit – was designed to meet those needs. It was staffed by one lead hospitalist, 3 hospitalist physicians, 3 advanced practitioners, about 12 nurses, and a neurologist, psychiatrist, and neuropsychologist.

The idea was to integrate medical care with careful attention to rehab and neuropsychological needs, Dr. Singh said. To be in the unit, patients had to be medically stable but with ongoing medical and rehabilitation needs and able to tolerate about half an hour of physical or occupational therapy each day.

The space was set up so that patients could interact with one another as well as staff, and this ability to share their experiences of trauma and recovery "led to an improved sense of psychological well-being and to healing," according to Dr. Singh. Group therapy and meditation were also held several times a week.

"All this together, we thought we were really meeting the need for a lot of these patients from medical to psychosocial," he said.

New York Presbyterian–Lower Manhattan Hospital also established a program called ICU Outreach to give hospitalists a "bird's eye view" of the ICU in order to help move patients from unit to unit for optimized care. One hospitalist acted as a bridge between the ICU, the floors, and the emergency room.

The hospitalist on duty touched based with the ICU each day at 10 a.m., assessed the available beds, compiled a list of patients being discharged, met with all of the hospitalists and individual teams in inpatient and emergency services, and compiled a list of "watchers" – the sickest patients who needed help being managed.

The broad perspective was important, Dr. Singh said.

"We quickly found that each individual team or provider only knew the patients they were caring for, and the ICU Outreach person knew the whole big picture and could put the pieces together," he said. "They could answer who was next in line for a bed, who benefited from a goals of care discussion, who could be managed on the floor with assistance. And this bridge, having this person fill this role, allowed the intensivists to focus on the patients they had in the unit."

Palliative care and patient flow

Dr. Singh also described how hospitalists played an important role in palliative care for COVID patients. The hospital medicine team offered hospitalist palliative care services, which included COVIDtalk, a course on communicating about end of life, which helped to expand the pool of palliative care providers. Those trained were taught that these difficult conversations had to be honest and clear, with the goals of care addressed very early in the admission, should a patient decompensate soon after arrival.

A palliative "rapid response team" included a virtual hospitalist, a palliative care nurse practitioner, and a virtual psychiatrist – a team available 24 hours a day to have longer conversations so that clinicians could better tend to their patients when the in-person palliative care service was stretched thin, or at off hours like the middle of the night.

These innovations not only helped serve patients and families better, but also gave hospitalists training and experience in palliative care.

At Roper Hospital, Dr. Stein explained, hospitalists helped improve management of COVID patient flow. Depending on the time of day and the staffing on duty, there could be considerable confusion about where patients should go after the ED, or the COVID progressive unit, or the floor.

Hospitalists helped develop hospitalwide algorithms for escalating and deescalating acuity, Dr. Stein said, providing a "shared mental model for where a patient should go."

"There are many ways hospitalists can and did rise to meet the unique demands of COVID," Dr. Singh said, "whether it was innovating a new unit or service or workflow or leading a multidisciplinary team to extend or support other services that may have been strained."

Continued from previous page

a clinical professor of medicine at Wayne State University, Detroit.

After completion of primary treatment for patients with unprovoked DVT and/or PE, the ASH guideline panel suggests indefinite antithrombotic therapy over stopping anticoagulation. "The recommendation does not apply to patients who have a high risk for bleeding complications," he noted.

Transient or reversible risk factors should be also considered in length of VTE treatment. For example, according to guidelines from the European Society of Cardiology (Eur Heart J 2020; 41[4]:543-603), the estimated risk for long-term VTE recurrence is high (defined as greater than 8% per year) for patients with active cancer, for patients with one or more previous episodes of VTE in the absence of a major transient or reversible factor, and for those with antiphospholipid antibody syndrome.

Dr. Kaatz also highlighted recommendations for the acute treatment of intermediate risk, or submassive PE. The ESC guidelines state that if anticoagulation is initiated parenterally, LMWH or fondaparinux is recommended over unfractionated heparin (UFH) for most patients. "One drug-use evaluation study found that, after 24 hours using UFH, only about 24% of patients had reached their therapeutic goal," Dr. Kaatz said. Guidelines for intermediate risk patients from ASH recommend anticoagulation as your starting point, while thrombolysis is reasonable to consider for submassive PE and low risk for bleeding in selected younger patients or for patients at high risk for decompensation because of concomitant cardiopulmonary disease.

Another resource Dr. Kaatz mentioned is the Pulmonary Embolism Response Team (PERT) Consortium, which was developed after initial efforts of a multidisciplinary team of physicians at Massachusetts General Hospital. The first PERT sought to coordinate and expedite the treatment of pulmonary embolus with a team of physicians from a variety of specialties. In 2019 the PERT Consortium published guidelines on the diagnosis, treatment, and follow-up of acute PE (Clin Appl Throm Hemost. 2019;1076029619853037).

Dr. Kaatz is a consultant for Janssen, Pfizer, Portola/Alexion, Bristol-Myers Squibb, Novartis, and CSL Behring. He has received research funding from Janssen, Bristol-Myers Squibb, and Osmosis, and holds board positions with the AC Forum and the National Blood Clot Alliance Medical and Scientific Advisory Board.

Telehealth takeaways for hospitalists outlined

By Heidi Splete
MDedge News

Although the COVID-19 pandemic put telehealth on fast forward, more than one-third of patients in the United States engaged with telehealth services before February 2020, according to Ameet Doshi, MD, and Chrisanne Timpe, MD, of HealthPartners in Bloomington, Minn.

Broadly speaking, telehealth is "using virtual tools to evaluate, manage, and care for our patients, regardless of where they are located," Dr. Doshi said during a session at SHM Converge.

The entirety of telehealth includes remote ways to meet almost any patient demand, he said. Some common health terms are used interchangeably, but some use telehealth as a broad term for electronic health care services, while telemedicine may refer specifically to remote patient care, he said.

Telemedicine allows flexibility of delivering patient care in inpatient, outpatient, or at-home settings, said Dr. Doshi. To illustrate the current application of telemedicine, he used an example of a 25-bed critical access hospital serving a growing regional population in which outpatient volume is expanding and ambulatory care services are being added. In this example, inpatient volume is growing, but not enough to support an inpatient consult service, but telehealth access to specialists such as cardiology would be useful in this case, he said.

Hospitalist telehealth means "being able to provide services to changing patient populations regardless of location; we can bring services to where patients are," said Dr. Doshi.

Benefits of telehealth to patients include less travel and easier access to care, benefits to clinicians include expanding services at lower financial costs, he said.

The COVID-19 pandemic presented both challenges and opportunities for telehealth, Dr. Doshi said. One opportunity was the sudden broad acceptance of virtual care out of necessity and concern for patient and staff safety, and to preserve the use of personal protective equipment, he said. In addition, a loosening of regulatory and financial pressures allowed more institutions to expand and initiate telehealth services.


Dr. Doshi

Challenges included technological limitations and, in some cases, the need to develop a telehealth infrastructure from scratch, Dr. Doshi explained. Concerns also remain regarding how telehealth will evolve post pandemic.

In the meantime, Medicare data show the impact of the pandemic on telehealth services, said Dr. Doshi. A telehealth waiver issued in March 2020 led to an increase in virtual encounters, and Medicare data show approximately 25 million virtual Medicare encounters between March 2020 and October 2020, representing a 3,000% increase from the same period in 2019, he said.

Dr. Timpe shared some examples of the evolution of telehealth care during the pandemic, including a case of an asymptomatic but frail patient with diabetes, dementia, and coronary artery disease undergoing outpatient care for a foot infection. The patient presented to an emergency department but refused to be hospitalized because of family concerns about patient isolation (no visitors were allowed at the time) and the concerns about COVID-19 infection.

The need to help treat acutely ill patients such as this patient while avoiding hospital admission during and after the pandemic continues to lead to the development of telehealth programs, Dr. Timpe said. She shared details of the Hospital@Home program developed by HealthPartners. The program is designed to treat acutely ill people in the home, if possible, and avoid the need for hospital admission. Patients receive daily medical management from a hospitalist and care from staff, including registered nurses and community paramedics. Services include provision of IV medications and fluids, but the staff also conduct labs and imaging services, Dr. Timpe said.

Conditions that the program has managed at patients' homes include pneumonia, COPD, asthma, bronchitis, flu, COVID-19, congestive heart failure, cellulitis, and urinary tract infections.

"We do not accept people into the program who have treatment needs that can only be met in a hospital," such as the need for blood products, vasopressor support, telemetry, or positive pressure support, she noted.

Between November 2019 and February 15, 2021, the Hospital@Home program provided services to 132 patients for a total of 287 visits. The program has averted 50 ED visits and 40 hospitalizations, and shorted hospital stays in 57 cases.

Hospitalists are suited for telehealth for several reasons, including the ability to triage acutely ill patients, familiarity with resource utilization, and expertise in management of complex medical care, said Dr. Timpe.

Dr. Doshi emphasized several ongoing issues regarding the future of telemedicine, primarily the need for standardized regulation and reimbursement; reduction of health equity disparity and attention to technological barriers; and identification of the next frontiers in telehealth.

Research on the impact and effectiveness of telehealth is limited, but growing, and next frontiers might include making patients more active participants in telehealth via patient-operated kits, or the option of an open telemedicine marketplace, in which patients can select providers from across the country, he said.

Wellness tips: How to build on failure

By Tiffani Panek, MA, SFHM, CLHM

Converge 2021 session

Fall Down Seven Get Up Eight: Making Your Setbacks Count: Strategic Risk Taking, Maintaining Resilience, and Finding Success

Presenters

Marisha Burden, MD, and Flora Kisuule, MD, MPH, SFHM

Session summary

The speakers at this Converge session, in the "Wellness and Resilience" track, covered four major topics: strategic risk-taking, wrestling with failure, embracing constraints, and embracing institutional chaos. First, they began by relating a personal story about failure and discussed how reframing failure could help you learn how to "fail forward." They outlined how building upon failures can lead to many benefits, such as gaining personal strength, gaining perspective, and seeing new possibilities. They also introduced three roadblocks to failing forward: Personalization, Pervasiveness, and Permanence.

Next, the speakers led the attendees through an exercise called The Nine Dot Problem, the purpose of which was to illustrate how thinking outside the box can help you find solutions that you cannot otherwise see. They also discussed how thinking inside the box could have its own advantages in that it teaches us to embrace our limitations, which can open up our creativity. They expounded upon this by showing a TED talk about finding liberation in constraints. The speakers wrapped up the session relating the tale of David and Goliath, and explained how David used his own unique advantages to gain power over a seemingly insurmountable problem.

Key takeaways

- Failing forward helps you continue to push ahead and grow, and perspective can help you fail forward.
- When failing, beware the Three Ps.
- Reframe constraints and be sure to think both inside and outside of the box – embrace limitations as a way to inspire new thinking.
- When facing something bigger than you, play to your own advantages in order to succeed.

Ms. Panek is hospital medicine division administrator at the Johns Hopkins Bayview Medical Center, Baltimore.

Care of post–acute COVID-19 patients requires multidisciplinary collaboration

By Heidi Splete
MDedge News

In the wake of the COVID-19 pandemic, a population of patients has arisen with a range of symptoms and complications after surviving the acute phase of illness, according to Mezgebe Berhe, MD, of Baylor University Medical Center, Dallas.

Different terms have been used to describe this condition, including post COVID, long COVID, chronic COVID, and long-haulers, Dr. Berhe said in a presentation at SHM Converge. However, the current medical consensus for a definition is post–acute COVID-19 syndrome.

Acute COVID-19 generally lasts for about 4 weeks after the onset of symptoms, and post–acute COVID-19 is generally defined as "persistent symptoms and/or delayed or long-term complications beyond 4 weeks from the onset of symptoms," he said. The postacute period may be broken into a subacute phase with symptoms and abnormalities present from 4-12 weeks beyond the acute phase, and then a chronic or post–acute COVID-19 syndrome, with symptoms and abnormalities present beyond 12 weeks after the onset of acute COVID-19.

Patients in the subacute or post–COVID-19 phase of illness are polymerase chain reaction negative and may have multiorgan symptomatology, said Dr. Berhe. Physical symptoms include fatigue, decline in quality of life, joint pain, and muscle weakness; reported mental symptoms include anxiety and depression; sleep disturbance; PTSD; cognitive disturbance (described by patients as "brain fog"); and headaches.

Pulmonary symptoms in post–acute COVID-19 patients include dyspnea, cough, and persistent oxygen requirements; patients also have reported palpitations and chest pain. Thromboembolism, chronic kidney disease, and hair loss also have been reported in COVID-19 patients in the postacute period.

What studies show

Early reports on postacute consequences of COVID-19 have been reported in published studies from the United States, Europe, and China, and the current treatment recommendations are based on findings from these studies, Dr. Berhe said.

In an observational cohort study from 38 hospitals in Michigan (Ann Intern Med. 2020 Nov 11. doi: 10.7326/M20-5661), researchers assessed 60-day outcomes for 1,250 COVID-19 patients who were discharged alive from the hospital. The researchers used medical record abstraction and telephone surveys to assess long-term symptoms. Overall, 6.7% of the patients died and 15.1% required hospital readmission. A total of 488 patients completed the telephone survey. Of these, 32.6% reported persistent symptoms, 18.9% reported new or worsening symptoms, 22.9% reported dyspnea while walking up stairs, 15.4% reported a cough, and 13.1% reported a persistent loss of taste or smell.

> *"COVID-19 patients with acute kidney infections should have a follow-up with a nephrologist soon after hospital discharge."*

Data from multiple countries in Europe have shown similar prevalence of post–acute COVID-19 syndrome, but Dr. Berhe highlighted an Italian study in which 87% of 143 patients discharged from hospitals after acute COVID-19 reported at least one symptom at 60 days (JAMA. 2020 Aug 11. doi: 10.1001/jama.2020.12603). "A decline in quality of life, as measured by the EuroQol visual analog scale, was reported by 44.1% of patients" in the Italian study, Dr. Berhe noted.

In a prospective cohort study conducted in Wuhan, China (Lancet. 2021 Jan 16. doi: 10.1016/S0140-6736[20]32656-8), researchers conducted a comprehensive in-person evaluation of symptoms in 1,733 COVID-19 patients at 6 months from symptom onset, and found that 76% reported at least one symptom, said Dr. Berhe. "Similar to other studies, muscle weakness and fatigue were the most common symptoms, followed by sleep problems and anxiety/depression."

Dr. Berhe also cited a literature review published in Clinical Infectious Diseases (2020 Dec 3. doi: 10.1093/cid/ciaa556) that addressed COVID-19 in children; in one study of postacute COVID-19, approximately 12% of children had 5 weeks' prevalence of persistent symptoms, compared with 22% of adults. This finding should remind clinicians that "Children can have devastating persistent symptoms following acute COVID-19 disease," Dr. Berhe said.

In the post–acute COVID clinic

"Multidisciplinary collaboration is essential to provide integrated outpatient care to survivors of acute COVID-19," Dr. Berhe said. Such collaboration includes pulmonary and cardiovascular symptom assessment through virtual or in-person follow-up at 4-6 weeks and at 12 weeks after hospital discharge. For those with dyspnea and persistent oxygen requirements at 12 weeks, consider the 6-minute walk test, pulmonary function test, chest x-ray, pulmonary embolism work-up, echocardiogram, and high-resolution CT of the chest as indicated.

With regard to neuropsychiatry, patients should be screened for anxiety, depression, PTSD, sleep disturbance, and cognitive impairment, said Dr. Berhe.

For hematology, "consider extended thromboprophylaxis for high-risk survivors based on shared decision-making," he said. The incidence of thrombotic events post COVID is less than 5%, so you have to be very selective and they should be in the highest-risk category.

COVID-19 patients with acute kidney infections should have a follow-up with a nephrologist soon after hospital discharge, he added.

From a primary care standpoint, early rehabilitation and patient education are important for managing symptoms; also consider recommending patient enrollment in research studies, Dr. Berhe said.

Dr. Berhe has been involved in multiple clinical trials of treating acute COVID-19 patients, but had no financial conflicts to disclose.

Mentor-mentee relationships in hospital medicine

By Thomas R. Collins
MDedge News

Your mentor has been looking for someone to help lead a new project in your division, and tells you she's been having a hard time finding someone – but that you would be great. The project isn't something you are very interested in doing and you're already swamped with other projects, but the mentor seems to need the help. What do you do?

Mentor-mentee relationships can be deeply beneficial, but the dynamics – in this situation and many others – can be complex. At SHM Converge, panelists offered guidance on how best to navigate this terrain.

Vineet Arora, MD, MAPP, MHM, associate chief medical officer for clinical learning environment at the University of Chicago, suggested that, in the situation involving the mentor's request to an uncertain mentee, the mentee should not give an immediate answer, but consider the pros and cons.

"It's tough when it's somebody who's directly overseeing you," she said. "If you're really truly the best person, they're going to want you in the job, and maybe they'll make it work for you." She said it would be important to find out why the mentor is having trouble finding someone, and suggested the mentee could find someone with whom to discuss it.


Dr. Arora

"Six things all mentors should do: Choose mentees carefully, establish a mentorship team, run a tight ship, head off rifts or resolve them, prepare for transitions when they take a new position...and don't commit 'mentorship malpractice.'"

Calling mentoring a "team sport," Dr. Arora described several types: the traditional mentor who helps many aspects of a mentee's career, a "coach" who helps on a specific project or topic, a "sponsor" that can help elevate a mentee to a bigger opportunity, and a "connector" who can help a mentee begin new career relationships.

"Don't invest in just one person," she said. "Try to get that personal board of directors."

She mentioned six things all mentors should do: Choose mentees carefully, establish a mentorship team, run a tight ship, head off rifts or resolve them, prepare for transitions when they take a new position and might have a new relationship with a mentee, and don't commit "mentorship malpractice."

Mentoring is a two-way street, with both people benefiting and learning, but mentoring can have its troubles, either through active, dysfunctional behavior that's easy to spot, or passive behavior, such as the "bottleneck" problem when a mentor is too preoccupied with his or her own priorities to mentor well, the "country clubber" who mentors only for popularity and social capital but doesn't do the work required, and the "world traveler" who is sought after but has little time for day-to-day mentoring.


Dr. Vaughan


Dr. Press

Valerie Vaughan, MD, MSc, assistant professor of medicine at the University of Utah, Salt Lake City, described four "golden rules" of being a mentee. First, find a CAPE mentor (for capable, availability, projects of interest, and easy to get along with). Then, be respectful of a mentor's time, communicate effectively, and be engaged and energizing.

"Mentors typically don't get paid to mentor and so a lot of them are doing it because they find joy for doing it," Dr. Vaughan said. "So as much as you can as a mentee, try to be the person who brings energy to the mentor-mentee relationship. It's up to you to drive projects forward."

Valerie Press, MD, MPH, SFHM, associate professor of medicine at the University of Chicago, offered tips for men who are mentoring women. She said that, while cross-gender mentorship is common and important, gender-based stereotypes and "unconscious assumptions" are alive and well. Women, she noted, have less access to mentorship and sponsorship, are paid less for the same work, and have high rates of attrition.

Male mentors have to meet the challenge of thinking outside of their own lived experience, combating stereotypes, and addressing these gender-based career disparities, she said.

She suggested that male mentors, for one thing, "rewrite gender scripts," with comments such as, "This is a difficult situation, but I have confidence in you! What do you think your next move should be?" They should also "learn from each other on how to change the power dynamic," and start and participate in conversations involving emotions, since they can be clues to what a mentee is experiencing.

When it comes to pushing for better policies, "be an upstander, not a bystander," Dr. Press said.

"Use your organizational power and your social capital," she said. "Use your voice to help make more equitable policies. Don't just leave it to the women's committee to come up with solutions to lack of lactation rooms, or paternity and maternity leave, or better daycare. These are family issues and everybody issues."

Maylyn S. Martinez, MD, clinical associate professor of medicine at the University of Chicago, suggested that mentors for physicians from minority groups should resist the tendency to view their interests narrowly.

"Don't assume that their interests are going to center on their gender or minority status – invite them to be on projects that have nothing to do with that," she said. They should also not be encouraged to do projects that won't help with career advancement any more than others would be encouraged to take on such projects.

"Be the solution," she said. "Not the problem."

Infections in infants: An update

By Erin E. King, MD, FAAP

Converge 2021 session
Febrile Infant Update

Presenter
Russell J. McCulloh, MD

Session summary
Infections in infants aged younger than 90 days have been the subject of intense study in pediatric hospital medicine for many years. With the guidance of our talented presenter Dr. Russell McCulloh of Children's Hospital & Medical Center in Omaha, Neb., the audience explored the historical perspective and evolution of this scientific question, including successes, special situations, newer screening tests, and description of cutting-edge scoring tools and platforms.

The challenge – Tens of thousands of infants present for care in the setting of fever each year. We know that our physical exam and history-taking skills are unlikely to be helpful in risk stratification. We have been guided by the desire to separate serious bacterial infection (SBI: bone infection, meningitis, pneumonia, urinary tract infection, bacteremia, enteritis) from invasive bacterial infection (IBI: meningitis and bacteremia). Data has shown that no test is 100% sensitive or specific, therefore we have to balance risk of disease to cost and invasiveness of tests. Important questions include whether to test and how to stratify by age, who to admit, and who to provide antibiotics.

The wins and exceptions – Fortunately, the early Boston, Philadelphia, and Rochester criteria set the stage for safely reducing testing. The current American College of Emergency Physicians guidelines for infants aged 29-90 days allows for lumbar puncture to be optional knowing that a look back using prior criteria identified no cases of meningitis in the low-risk group. Similarly, in low-risk infants aged less than 29 days, in nearly 4,000 cases there were just 2 infants with meningitis. Universal screening of moms for Guillain-Barré syndrome disease with delivery of antibiotics in appropriate cases has dramatically decreased incidence of SBI. The Hib and pneumovax vaccines have likewise decreased incidence of SBI. Exceptions persist, including knowledge that infants with herpes simplex virus disease will not have fever in 50% of cases and that risk of HSV transmission is highest (25%-60% transmission) in mothers with primary disease. Given risk of HSV CNS disease after 1 week of age, in any high-risk infant less than 21 days, the mantra remains to test and treat.

The cutting edge – Thanks to ongoing research, we now have the PECARN and REVISE study groups to further aid decision-making. With PECARN we know that SBI in infants is extremely unlikely (negative predictive value, 99.7%) with a negative urinalysis , absolute neutrophil count less than 4,090, and procalcitonin less than 1.71. REVISE has revealed that infants with positive viral testing are unlikely to have SBI (7%-12%), particularly with influenza and RSV disease. Procalcitonin has also recently been shown to be an effective tool to rule out disease with the highest negative predictive value among available inflammatory markers. The just-published Aronson rule identifies a scoring system for IBI (using age less than 21 days/1pt; temp 38-38.4˚ C/2pt; >38.5˚ C/4pt; abnormal urinalysis/3pt; and absolute neutrophil count >5185/2pt) where any score greater than2 provides a sensitivity of 98.8% and NPV in validation studies of 99.4%. Likewise, multiplex polymerase chain reaction testing of spinal fluid has allowed for additional insight in pretreated cases and has helped us to remove antibiotic treatment from cases where parechovirus and enterovirus are positive because of the low risk for concomitant bacterial meningitis. As we await the release of revised national American Academy of Pediatrics guidelines, it is safe to say great progress has been made in the care of young febrile infants with shorter length of stay and fewer tests for all.

Key takeaways
- Numerous screening tests, rules, and scoring tools have been created to improve identification of infants with IBI, a low-frequency, high-morbidity event. The most recent with negative predictive values of 99.7% and 99.4% are the PECARN and Aronson scoring tools.
- Recent studies of the febrile infant population indicate that the odds of UTI or bacteremia in infants with respiratory symptoms is low, particularly for RSV and influenza.
- Among newer tests developed, a negative procalcitonin has the highest negative predictive value.
- Viral pathogens identified on cerebrospinal fluid molecular testing can be helpful in pretreated cases and indicative of low likelihood of bacterial meningitis allowing for observation off of antibiotics.

Dr. King is a hospitalist, associate director for medical education and associate program director for the pediatrics residency program at Children's Minnesota in Minneapolis. She has shared some of her resident teaching, presentation skills, and peer-coaching work on a national level.

Hospital medicine leaders offer tips for gender equity

By Thomas R. Collins

When Marisha Burden, MD, division head of hospital medicine at the University of Colorado Anschutz Medical Campus, would go to medical conferences, it seemed as if very few women were giving talks. She wondered if she could be wrong.

"I started doing my own assessments at every conference I would go to, just to make sure I wasn't biased in my own belief system," she said in a session at SHM Converge.

She wasn't wrong.

In 2015, only 35% of all speakers at the SHM annual conference were women, and only 23% of the plenary speakers were women. In the years after that, when the society put out open calls for speakers, the numbers of women who spoke increased substantially, to 47% overall and 45% of plenary speakers.

The results – part of the SPEAK UP study Dr. Burden led in 2020 – show how gender disparity can be improved with a systematic process that is designed to improve it. The results of the study also showed that as the percentages of female speakers increased, the attendee ratings of the sessions did, too.

> *"At the University of Colorado, leaders set out to reach salary equity in a year and a half – and 'it was a painful, painful process.'"*

"You can do these things, and the quality of your conference doesn't get negatively impacted – and in this case, actually improved," Dr. Burden said.

That study marked progress toward leveling a traditionally uneven playing field when it comes to men and women in medicine, and the panelists in the session called on the field to use a variety of tools and strategies to continue toward something closer to equality.

Sara Spilseth, MD, MBA, chief of staff at Regions Hospital, in St. Paul, Minn., said it's well established that although almost 50% of medical school students are women, the percentage shrinks each step from faculty to full professor to dean – of which only 16% are women. She referred to what's known as the "leaky pipe."

In what Dr. Spilseth said was one of her favorite studies, researchers in 2015 found that only 13% of clinical department leaders at the top 50 U.S. medical schools were women – they were outnumbered by the percentage of department leaders with mustaches, at 19%, even though mus-

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Pandemic experience taught lessons about clinician wellness

By Doug Brunk
MDedge News

As a member of the Society of Hospital Medicine Wellbeing Task Force, Mark Rudolph, MD, SFHM, thought he understood a thing or two about resilience, but nothing could prepare him for the vulnerability he felt when his parents became infected with COVID-19 following a visit to New York City in March 2020 – which soon became an epicenter of disease outbreak.


Dr. Rudolph


Dr. Richards

"They were both quite ill but fortunately they recovered," Dr. Rudolph, chief experience officer for Sound Physicians said during SHM Converge. He had completed his residency training in New York, where he cared for patients following the 9/11 terrorist attacks, "so I had a lot of PTSD related to all that stuff," he recalled. Then he started to worry about the clinicians who work for Sound Physicians, a multispecialty group with roots in hospital medicine. "I found it difficult knowing there was someone in the hospital somewhere taking care of our patients all day long, all night long," he said. "I felt fearful for them."

Other members of the SHM Wellbeing Task Force shared challenges they faced during the pandemic's early stages, as well as lessons learned. Task force chair Sarah Richards, MD, said the COVID-19 pandemic brought on feelings of guilt after hearing from fellow hospitalists about the surge of cases they were caring for, or that their best friend or colleague died by suicide. "I felt a sense of guilt because I didn't have a loved one get COVID or die from COVID," said Dr. Richards, a hospitalist at the University of Nebraska Medical Center in Omaha. "I felt like the world was crumbling around me and I was still okay. That guilt was almost like a helplessness. I didn't know how to make it better. I didn't know how to help people because the problem was so big, especially during the height of the pandemic. That was tough for me because I'm a helper. I think we go into this field wanting to help and I feel like we didn't know how to help make things better."

Sonia George, MD, recalled first hearing about COVID-19 as she was preparing to attend the 2020 SHM annual conference in San Diego, which was planned for April but was canceled amid the escalating health concerns. "That was difficult for me, because I wanted to travel more in 2020," said Dr. George, a hospitalist at Long Island Jewish Medical Center in New Hyde Park, N.Y. "Traveling is something that I've been wanting to do ever since I finished residency, after all that training. I wanted to reward myself. What I have learned about myself is that I've learned to be more patient, to take every day as it is, to find some small moments of joy within each day and try to take that forward with me, and try to remember what I do have, and celebrate that a bit more every day."

> *"I found it difficult knowing there was someone in the hospital somewhere taking care of our patients all day long, all night long. I felt fearful for them."*

Over the past 14 months or so, Dr. Rudolph said that he grew to appreciate the importance of connecting with colleagues, "however short [the time] may be, where we can talk with one another, commiserate, discuss situations and experiences – whether virtually or in person. Those have been critical. If you add those all up, that's what's keeping us all going. At least it's keeping me going."

Dr. Richards echoed that sentiment. "The lesson I learned is that people really do want to share and to talk," she said. "I can't tell you how many times I told people about my [sense of] guilt and they would say things like, 'Me, too!' Knowing 'it's not just me' made me feel so much better."

During the course of the pandemic, the SHM Wellbeing Task Force created a one-page resource for clinicians known as the "Hospital Medicine COVID-19 Check-in Guide for Self & Peers," which can be accessed here: www.hospitalmedicine.org/globalassets/clinical-topics/covid-19coronavirus-blocks/covid-check-in-guide-for-self--peers-resource.pdf. The three main recommended steps are to identify ("self-assess" to see if you are experiencing physical, emotional, cognitive, or behavioral stress); initiate ("reach out to your colleagues one-on-one or in small informal groups"); and intervene ("take action to make change or get help.")

"Wellness and thriving are a team sport," observed task force member Patrick Kneeland, MD, vice president of medical affairs at DispatchHealth, which provides hospital to home services. "It's not an individual task to achieve. The team sport thing is complicated by gowns and masks and the lack of in-person meetings. You can't even grab a cup of coffee with colleagues. That part has impacted most of us." However, he said, he learned that clinicians can "double down on those small practices that form human connection" by using virtual communication platforms like Zoom. "For me, it's been a great reminder [of] why presence with others matters, even if it's in an unusual format, and how sharing our humanity across [communication] channels or through several layers of PPE is so critical." Dr. Kneeland said.

None of the presenters reported having financial disclosures.

Continued from previous page

taches are dwindling in popularity.

"Why does this exist? Why did we end up like this?" Part of the problem is a "respect gap," she said, pointing to a study on the tendency of women to use the formal title of "doctor" when introducing male colleagues, whereas men who introduce women use that title less than half the time.

The COVID-19 pandemic has only made these disparities worse. Women are responsible for childcare much more frequently than men, Dr. Burden said, although the pandemic has brought caregiving duties to the forefront.

Dr. Spilseth said mentoring can help women navigate the workplace so as to help overcome these disparities. At Regions, the mentoring program is robust.

"Even before a new hire steps foot in the hospital, we have established them with a mentor," she said. Sponsoring – the "ability of someone with political capital to use it to help colleagues" – can also help boost women's careers, she said.

Her hospital also has a Women in Medicine Cooperative, which provides a way for women to talk about common struggles and to network.

Flexible work opportunities – working in transitional care units, being a physician advisor, and doing research – can all help boost a career as well, Dr. Spilseth said.

She said that at the University of Colorado, leaders set out to reach salary equity in a year and a half – and "it was a painful, painful process." They found that different people held different beliefs about how people were paid, which led to a lot of unnecessary stress as they tried to construct a fairer system.

"On the back end of having done that, while it was a rough year and half, it has saved so much time – and I think built a culture of trust and transparency," she said.

Recruiting in a more thoughtful way can also have a big impact, Dr. Spilseth said. The manner in which people are told about opportunities could exclude people without intending to.

"Are you casting a wide net?" she asked.

Adia Ross, MD, MHA, chief medical officer at Duke Regional Hospital, Durham, N.C., said that even in the face of obvious disparities, women can take steps on their own to boost their careers. She encouraged taking on "stretch assignments," a project or task that is a bit beyond one's current comfort level or level of experience or knowledge. "It can be a little scary, and sometimes there are bumps along the way," she said.

All of these measures, though incremental, are the way to make bigger change, she said. "We want to take small steps but big strides forward."

Improving racial and gender equity in pediatric HM programs

By Amit Singh, MD

Converge 2021 session
Racial and Gender Equity in Your PHM Program

Presenters
Jorge Ganem, MD, FAAP, and Vanessa N. Durand, DO, FAAP

Session summary
Dr. Ganem, associate professor of pediatrics at the University of Texas at Austin and director of pediatric hospital medicine at Dell Children's Medical Center, and Dr. Durand, assistant professor of pediatrics at Drexel University and pediatric hospitalist at St. Christopher's Hospital for Children, Philadelphia, presented an engaging session regarding gender equity in the workplace during SHM Converge 2021.

Dr. Ganem and Dr. Durand first presented data to illustrate the gender equity problem. They touched on the mental burden underrepresented minorities face professionally. Dr. Ganem and Dr. Durand discussed cognitive biases, defined allyship, sponsorship, and mentorship, and shared how to distinguish among the three. They concluded their session with concrete ways to narrow gaps in equity in hospital medicine programs.

The highlights of this session included evidence-based "best practices" that pediatric hospital medicine divisions can adopt. One important theme was regarding metrics. Dr. Ganem and Dr. Durand shared how important it is to evaluate divisions for pay and diversity gaps. Armed with these data, programs can be more effective in developing solutions. Some solutions provided by the presenters included "blind" interviews where traditional "cognitive metrics" (that is, board scores) are not shared with interviewers to minimize anchoring and confirmation biases. Instead, interviewers should focus on the experiences and attributes of the job that the applicant can hopefully embody. This could be accomplished using a holistic review tool from the Association of American Medical Colleges.

One of the most powerful ideas shared in this session was a quote from a Harvard student shown in a video regarding bias and racism where he said, "Nothing in all the world is more dangerous than sincere ignorance and conscious stupidity." Changes will only happen if we make them happen.

Key takeaways
- Racial and gender equity are problems that are undeniable, even in pediatrics.
- Be wary of unconscious biases and the mental burden placed unfairly on underrepresented minorities in your institution.
- Becoming an amplifier, a sponsor, or a champion are ways to make a small individual difference.
- Measure your program's data and commit to making change using evidence-based actions and assessments aimed at decreasing bias and increasing equity.

References
Association of American Medical Colleges. Holistic Review. 2021. www.aamc.org/services/member-capacity-building/holistic-review.

Dr. Singh is a board-certified pediatric hospitalist at Stanford University and Lucile Packard Children's Hospital Stanford, both in Palo Alto, Calif. He is a native Texan living in the San Francisco Bay area with his wife and two young boys. His nonclinical passions include bedside communication and inpatient health care information technology.

A primer on COVID-19 in hospitalized children

By Mirna Giordano, MD, FAAP, FHM

Converge 2021 session
COVID-19 in Children

Presenter
Philip Zachariah, MD, MPH

Session summary
Children have been less severely affected by COVID-19 than adults (hospitalization rates around 5%). However, once hospitalized, ICU admission rates in children have been similar to adults, around 30%. Mortality has been 1%-2%.

Multisystem-inflammatory-syndrome-in-children (MIS-C) continues to present among persistently febrile children with multisystem findings and the history of acute COVID-19 infection in prior 3-6 weeks.

Dr. Giordano is an associate professor of pediatrics at Columbia University Medical Center in New York. She is a pediatric hospitalist with expertise in pediatric surgical comanagement.

Key takeaways
- Once hospitalized, the ICU admission rates for children have been similar to those in adults, ~30%.
- MIS-C is showing lower failure rates if treated with IVIG and steroids, and most reliable laboratory findings should be elevated C-reactive protein, lymphopenia, and elevated brain natriuretic peptide.
- In hospitalized children with COVID-19, clinical VTEs are rare.

How to utilize the updated PHM Core Competencies

By Klint Schwenk, MD, MBA, SFHM, FAAP

Converge 2021 session
Making *The Pediatric Hospital Medicine Core Competencies* Work for You

Presenters
Erin Fisher, MD, MHM, FAAP; Sandra Gage, MD, PhD, SFHM, FAAP; Jennifer Maniscalco, MD, MPH, MAcM, FAAP; Sofia Teferi, MD, SFHM, FAAP

Session summary
The Pediatric Hospital Medicine (PHM) Core Competencies were originally published in the Journal of Hospital Medicine in 2010, and created a framework for graduate and continuing medical education, reflecting the roles and expectations for all pediatric hospitalists in the U. S. Since that time, the field of PHM, scope of practice, and roles of hospitalists have evolved, making a substantial update necessary.

The 2020 PHM Core Competencies consist of four sections, including common clinical diagnoses and conditions, specialized services, core skills, and the health care system. The four topics are covered in 66 chapters, which were updated or created for the present version.

The Core Competencies have many practical applications, including teaching or curriculum development. The speakers gave real-world examples of the competencies' application to evaluations, and the continuum of knowledge, skills, attitudes, and system implementation in the development of a trainee from student to practicing hospitalist. Trainees' knowledge gaps can be identified using the competencies, and utilization of the provided compendium will help identify sources that can aid in teaching.

Professional development is an excellent way to utilize the Core Competencies. Division directors may identify a needed area for improvement and the competencies can serve as a road map for establishing goals, plan development, and analysis of results of the intervention. They are also a great resource for PHM board prep, as they contain all 13 PHM content domains set forth by the American Board of Pediatrics for PHM.

The Core Competencies can also be used to justify service line needs and resources in discussions with administration. For instance, if a pediatric hospitalist at a community hospital is asked to take over the newborn nursery, the competencies can be used to get buy-in from the group, as a guide for additional training, to provide a framework for development of practice pathways, and to request resources needed.

Key takeaways
- Given a change in scope of practice of pediatric hospitalists over the past 10 years, the PHM Core Competencies were updated and published in the Journal of Hospital Medicine in 2020.
- The Core Competencies have many practical applications including education, curriculum development, professional development, and PHM board preparation.
- The Core Competencies provide a framework for improvement of knowledge, skills, and attitudes within an organization.

Dr. Schwenk is a pediatric hospitalist at Norton Children's Hospital in Louisville, Ky., where he serves as a medical director of inpatient services. He is an associate professor of pediatrics at the University of Louisville School of Medicine. He is a Senior Fellow of Hospital Medicine and has served on the executive council of the Pediatrics Special Interest Group and the Annual Meeting Committee for SHM Converge.

Some things pediatric hospitalists do for no reason

By Ann-Marie Tantoco MD, FAAP, FHM

Converge 2021 session
High Value Care in Pediatrics – Things We Do for No Reason

Presenter
Ricardo Quinonez, MD, FAAP, FHM

Session summary
Dr. Ricardo Quinonez, chief of pediatric hospital medicine at Texas Children's Hospital, Houston, presented key topics in pediatric hospital medicine with low-value care management practices which are not supported by recent literature.

Dr. Quinonez began by discussing high flow nasal cannula (HFNC) in bronchiolitis. At first, early observational studies showed a decrease in intubation rate for children placed on HFNC, which resulted in its high utilization. Randomized, controlled trials (RCTs) later showed that early initiation of HFNC did not affect rates of transfer to the ICU, duration of oxygen need, or length of stay.

He then discussed the treatment of symptomatic spontaneous pneumothorax in children, which is often managed by hospital admission, needle aspiration and chest tube placement, and serial chest x-rays. Instead, recent literature supports an ambulatory approach by placing a device with an 8 French catheter with one way Heimlich valve. After placement, a chest x-ray is performed and if the pneumothorax is stable, the patient is discharged with plans for serial chest x-rays as an outpatient. The device is removed after re-expansion of the lung.

Dr. Quinonez then discussed the frequent pediatric complaint of constipation. He stated that abdominal x-rays for evaluation of "stool burden" are not reliable, and x-rays are recommended against in both U.S. and British guidelines. Furthermore, a high-fiber diet is often recommended as a treatment for constipation. However, after review of recent RCTs and cohort studies, no relationship between a low-fiber diet and constipation was seen. Instead, genetics likely plays a large part in causing constipation.

Lastly, Dr. Quinonez discussed electrolyte testing in children with acute gastroenteritis. Electrolyte testing is commonly performed, yet testing patterns vary greatly across children's hospitals. One quality improvement project found that after decreasing electrolyte testing by more than a third during hospitalizations, no change in readmission rate or renal replacement therapy was reported.

Key takeaways
- Early use of high flow nasal cannula in bronchiolitis does not affect rates of transfer to the ICU or length of stay.
- Abdominal x-rays to assess for constipation are not recommended and are not reliable in measuring stool burden.
- A low-fiber diet does not cause constipation.
- Quality improvement projects can help physicians "choose wisely" and decrease things we do for no reason.

Dr. Tantoco is an academic med-peds hospitalist at Northwestern Memorial Hospital and Ann & Robert H. Lurie Children's Hospital of Chicago. She is an instructor of medicine (hospital medicine) and pediatrics at Northwestern University, Chicago.

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Looking toward SHM Converge 2022

Planning is underway for an in-person event

By Heather Nye, MD, PhD, SFHM

A hospitalist for 18 years and Annual Conference Committee (ACC) member for the last 4 years, I have always felt immense pride in this meeting. This year, we experienced constant evolution and adapted in ways unimaginable; frameshifts, detours, course corrections, wearing out words like "pivot" and "unprecedented," whilst contending with virus lulls and surges at hospitals across the country. And SHM Converge 2021 was a landmark success despite it all.

Our SHM community successfully connected through the marvels of modern technology and enjoyed

"This year's conference-from-home luxury is one we hope to dispense with for SHM Converge 2022."

a snappy new logo and name to mark the occasion. Our unflappable course director Dan Steinberg, MD, SFHM, led an intrepid and creative team through uncertainty and produced an extraordinary educational event truly worthy of the term "unprecedented." ACC members, talented in so many ways, each brought a unique perspective to the planning table to craft a balanced, relevant, and cutting-edge program. The only thing harder than planning a conference for thousands of hospitalists is planning TWO CONFERENCES – one in person, then one virtually.

For their facilitation of virtual adaptation of everything from clinical talks to hot dog sales, our SHM administrative staff deserve a medal. Industry sponsors likewise performed pretzel maneuvers for the virtual interface, and we thank them for their creativity and support. Freshly minted SHM CEO Eric Howell, MD, MHM, kicked off Converge by adeptly filling some very large shoes with aplomb, humor, and humility – telegraphing that our society is in good hands indeed (and that 2020 was NOT the 'final frontier'). And, finally, each of you, in the suspended reality of a conference hall, tapped into session after session from the comfort of your hometown chairs, indefatigably learning and networking during a pandemic year.

So, beyond adaptability, what did we learn? We renewed our commitment to resilience and wellness in medicine, and reemphasized how critical diversity, equity, and inclusion are both in the workplace and in clinical practice. These topics were complemented by the usual standing-room-only clinical updates and rapid-fire sessions – where everyone could enjoy a front row seat. We talked about parenting in the pandemic, compared clinical approaches in friendly debates – for patients big and small – and deeply dived into leadership strategies for a sustainable workforce.

Here are some SHM Converge 2021 nuggets (Apologies for so few … there were thousands!):

Plenaries

Eric Howell, MD, MHM

- Make the world a better place, be transparent, act with integrity, invest in others, do what you love.
- SHM has been leading the pack in providing e-learning options, promoting clinician self-care, and intensifying diversity, equity, and inclusion efforts before and throughout the pandemic.
- SHM has 18,000 members, 68 chapters, 26 special interest groups, 15 committees, 12 board of directors, 50 staff – growing and getting stronger every day.
- Rainbows need both rain and sunshine to form.

Gen. Mark Hertling

- Our COVID experience as hospitalists shared many features with active combat, including post-COVID combat fog.
- Use your ears, eyes, and mouth in that order: Listen more, see more, speak less.

Vineet Arora, MD, MHM

- Don't pass up your "career gates."
- Find "zero-gravity thinkers" – not innovation killers.
- Keep track of your state of mind using the "Bob Wachter scale."

U.S. Surgeon Gen. Vivek Murthy, MD, and Danielle Scheurer, MD, SFHM

- Mental health and well-being of clinicians is *imperative*; "heal thyself" doesn't work. Culture must support policies to truly craft a more sustaining and rewarding environment.
- We are a nation hyperfocused on episodic and salvage care (and are good at it) but must move the needle toward continuity and prevention. Sadly, nobody celebrates the heart attack that was prevented.
- What can hospitalists do about social determinants of health? Advocate for policies individually or through SHM – if you don't know how, receive training – this is *invaluable*. More lobbying as a profession may yield legislation and funding aimed at such determinants and improve health care.

Larry Wellikson, MD, MHM

- New models hospitalists may soon inhabit: Hospital at Home, ED+, Micro-Hospitals.
- More than 50% of revenue comes from "vertical" services (outside the hospital) rather than horizontal services (in hospital) – trend to increase efforts in population health initiatives.
- Emphasis on value must go from looking at episodes of care to *outcomes*.
- Hospitalists Complexologists? Be relevant, add value – survive, thrive, and prosper.

Other sessions

Stroke

- Mobile stroke units are a thing!
- Neurologists are not great at predictions after stroke – but scoring tools are!
- Focus on patient-centered outcomes (100% disability free vs. able to walk vs. happy to be alive).

Drug allergies

- Penicillin allergy: 2% cross-reactivity for cephalosporins – not 10%.

Navigating work/life balance

- Have two phones for work/home – church and state – keep them separate!

Becoming an expert

- Avoid "analysis paralysis": "Better a good decision quickly than the best decision too late" – H. Geneen

Misc. revelations

- It's pretty cool to know the Surgeon General is a hospitalist!
- Our SHM community rocks!

Dr. Nye is a hospitalist and professor of medicine at the University of California, San Francisco. She is the course director of SHM Converge 2022.

- Eric Howell is an avid Star Trek and overalls enthusiast!
- It's exceedingly difficult to become an MHM – 35 total, 3 this year.
- Danielle Scheurer is a warm and natural interviewer, sensational leader, and closet REM-rapper.
- No matter how hard I try, I'll always be a social media Luddite: "Am I hashtagging?"

Convenience notwithstanding, this year's conference-from-home luxury is one we hope to dispense with for SHM Converge 2022, in exchange for wandering of halls, jockeying to be closer to the front of the room, collecting freebies in exhibit halls, and seeing 50 old friends on the way to the session for which you're already late.

Nashville, Tenn., aka Music City, will be the site of our *first in-person meeting in 3 years in April 2022.* I will be there with my guitar for SHM's open mic and I hope you too bring your diverse talents from across the country to spend a week learning and energizing with us, making hospital medicine music in "Honky Tonk Hall," "Elvis Lives Lounge," or the "Grand Ol' Opry-ation Suite." The band is getting back together! Be a part of the excitement. Bring your voice, bring your talent, and let's do Nashville in numbers!

Planning is now underway … and we need your ideas and suggestions! Share thoughts on topics and speakers, and don't forget to watch on-demand talks you missed from SHM Converge 2021 – a veritable treasure trove of learning.

The Hospitalist