Racism in medicine: Implicit and explicit

By Sarah Ludwig Rausch
MDedge News

With the violent deaths of Breonna Taylor, George Floyd, and other Black citizens setting off protests and unrest, race was at the forefront of national conversation in the United States – along with COVID-19 – over the past year.

“We’ve heard things like, ‘We’re in a post-racial society,’ but I think 2020 in particular has emphasized that we’re not,” said Gregory Johnson, MD, SFHM, chief medical officer of hospital medicine at Sound Physicians, a national physician practice. “Racism is very present in our lives, it’s very present in our world, and it is absolutely present in medicine.”

Yes, race is still an issue in the United States as we head into 2021, though this may have come as something of a surprise to people who do not live with racism daily.

Continued on page 14
Hospitlist movers and shakers

By Matt Pesyna

Daniel Steinberg, MD, SFHM, recently was among 10 medical educators across the country to receive the Accreditation Council for Graduated Medical Education 2021 Parker J. Palmer Courage to Teach Award. Considered the most prestigious award given to graduate medical education program directors, it “recognizes program directors who have fostered innovation and improvement in their residency/fellowship program and served as exemplary role models for residents and fellows.”

Dr. Steinberg was program director for internal medicine residency at Mount Sinai Beth Israel, New York, for 11 years (2009-2020) before becoming associate dean for quality and patient safety in graduate medical education in September. He is a professor of medicine and medical education at Icahn School of Medicine at Mount Sinai, New York.

Dr. Steinberg also is a leader within SHM, serving on the education, physicians-in-training, and annual conference committees. He is the course director for SHM Converge 2021.

Ann Sheehy, MD, SFHM, was honored in a virtual ceremony in December 2020 by the University of Wisconsin celebrating Physician Excellence Award winners. She was presented with the Physician Excellence Leadership Award.

Dr. Sheehy is division chief of the division of hospital medicine at the University of Wisconsin–Madison, and chair of the SHM Public Policy Committee.

Donald Schmidt, MD, has been named chief medical officer and vice president of medical affairs at Madonna Rehabilitation Hospitals in Omaha and Lincoln, Neb. He will replace Thomas Stalder, MD, who is retiring. Dr. Schmidt brings 20 years of experience to Madonna Rehabilitation Hospitals, including his most recent post as a hospitalist and medical director of the hospitalist program at Catholic Health Initiatives Health St. Elizabeth in Lincoln.

Dr. Schmidt currently serves on the board of directors for OneHealth Nebraska, an independent physicians association.

Ezinwe Nwude, MD, recently was presented with the SCP Health Excellence in Leadership Award during the organization’s Medical Leadership Conference. Dr. Nwude is chief of staff and hospitalist at the Medical Center of South Arkansas, El Dorado.

SCP Health coordinates staffing for more than 7,500 providers covering 30 states and is one of the nation’s largest clinical practice management companies. More than 400 medical leaders nationwide were eligible for the award. Dr. Nwude has focused on positive culture and health education since her start at MSCA in 2014. She has been chief of staff since October 2018.

RWJ Barnabas Health (West Orange, N.J.) recently named two new health system leaders from among its hospital medicine ranks, as Christopher Freer, MD, was selected as senior vice president for emergency and hospital medicine, and Maninder “Dolly” Abraham, MD, was picked as chief of hospital medicine. The moves were made as RWJBH takes over as the direct employer for Envision Physician Services in Nashville, Tenn.

Dr. Freer was elevated to her new role after spending the past 5 years as RWJBH’s system director for emergency services. He has nearly 3 decades of experience in hospital medicine.

Dr. Abraham comes to his new position after directing the hospitalist program at Saint Barnabas and serving as regional medical director with Envision.

Newman Regional Health (Emporia, Kan.) recently established a partnership with FreeState Healthcare (Wichita, Kan.). FreeState will be responsible for providing hospitalist services to adult inpatients and observation patients at Newman Regional Health during overnights.

THE HOSPITALIST

The Society of Hospital Medicine’s official newspaper is published weekly from January to December. The Hospitalist provides a perspective on hospital medicine and does not necessarily reflect the views of the Society or its Publisher. THE HOSPITALIST is published by Frontline Medical Communications, 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609. Print subscriptions are free for Society of Hospital Medicine members. Annual paid subscriptions are available to all others for the following rates: Individual: Domicile – $195 (One Year), $360 (Two Years), $520 (Three Years), Canada/Mexico – $235 (One Year), $425 (Two Years), $625 (Three Years), Other Countries – $450 (One Year), $875 (Two Years), $1,305 (Three Years). Institution: United States – $400, Canada/Mexico – $450, All Other Countries – $655. Student/Resident: $55

Single Issue: Current – $35 (US), $45 (Canada/Mexico), $60 (All Other Countries). Back Issue – $45 (US), $60 (Canada/Mexico), $70 (All Other Countries)

To learn more about SHM’s relationship with industry partners, visit www.hospitalmedicine.com/industry.

THE SOCIETY OF HOSPITAL MEDICINE

Phone: 800-843-3360
Fax: 297-720-2190
Website: www.HospitalMedicine.org

Chief Executive Officer
Eric E. Howell, MD

Director of Communications
Brett Radler
bradler@hospitalmedicine.org

Communications Specialist
Catlin Cowan
cowan@hospitalmedicine.org

SHM BOARD OF DIRECTORS

President
Danielle Scheuerer, MD, MSCR, SFHM

President-Elect
Jerome C. Szy, MD, SFHM

Secretary
Kris Rehm, MD, SFHM

Immediate Past President
Christopher Frost, MD, SFHM

Board of Directors
Tracy Cardin, ACNP, BC, SFHM
Steven B. Deitelzweig, MD, MMM, FAAC, SFHM
Bryce Garland, MD, FHM
Flora Kissule, MD, MPH, SFHM
Mark W. Sheehy, MD, SFHM
Darlene Tad-y, MD, SFHM
Chad T. Whelan, MD, FACP, SFHM

FRONTLINE MEDICAL COMMUNICATIONS ADVERTISING STAFF

Senior Director Business Development
Angelicque Ricci, 733-206-2335
cari@mededge.com

 Classified Sales Representative
Heather Gonnoski, 733-290-8259
hgonnoski@mededge.com

 Linda Wilson, 733-290-8243
lwilson@mededge.com

Senior Director of Classified Sales
Tim LaPella, 848-921-5001
cell 610-506-3474 tlapella@mededge.com

Advertising Offices
7 Century Drive, Suite 302, Parsippany, NJ 07054-4609
297-720-3434, fax 297-720-9178

THE SOCIETY OF HOSPITAL MEDICINE

International ISSN 1553-085X is published monthly for the Society of Hospital Medicine by Frontline Medical Communications Inc., 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609. Print subscriptions are free for Society of Hospital Medicine members. Annual paid subscriptions are available to all others for the following rates: Individual: Domicile – $195 (One Year), $360 (Two Years), $520 (Three Years), Canada/Mexico – $235 (One Year), $425 (Two Years), $625 (Three Years), Other Countries – $450 (One Year), $875 (Two Years), $1,305 (Three Years). Institution: United States – $400, Canada/Mexico – $450, All Other Countries – $655. Student/Resident: $55

Single Issue: Current – $35 (US), $45 (Canada/Mexico), $60 (All Other Countries). Back Issue – $45 (US), $60 (Canada/Mexico), $70 (All Other Countries)

POSTMASTER: Send changes of address (with old mailing label) to THE HOSPITALIST, Subscription Services, P.O. Box 3000, Denville, NJ 07834-3000. RECIPIENT: To subscribe, change your address, purchase a single issue, file a missing issue claim, or have any questions or changes related to your subscription, call Subscription Services at 1-833-836-7250 or e-mail custserv.hosp@fulicom.com.
This advertisement is not available for the digital edition.
PRACTICE MANAGEMENT

‘Hospital at home’ increases COVID capacity in large study

By Ken Terry

A “hospital at home” (HaH) program at Atrium Health, a large integrated delivery system in the Southeast, expanded its hospital capacity during the early phase of the COVID-19 pandemic by providing hospital-level acute care to COVID-19 patients at home, according to a new study in Annals of Internal Medicine.

“Virtual hospital programs have the potential to provide health systems with additional inpatient capacity during the COVID-19 pandemic and beyond,” wrote Kranthi Sitammagari, MD, from the Atrium Health Hospitalist Group, Monroe, N.C., and colleagues.

Whereas most previous HaH programs have relied on visiting nurses and physicians, the new study uses telemedicine to connect with patients. Advocate Health Care researchers published the only other study using the telemedicine-powered model in 2015.

The new Atrium Health study evaluated 1,477 patients who received care in the HaH program between March 23 and May 7 of this year after having been diagnosed with COVID-19. The program provided home monitoring and hospital-level care in a home-based virtual observation unit (VOU) and a virtual acute care unit (VACU).

Patients were tested for the virus in Atrium emergency departments, primary care clinics, urgent care centers, and external testing sites. Those who tested positive were invited to be cared for either in the VOU, if they had mild to moderate symptoms, or in the VACU, if they were sick enough to be admitted to the hospital.

Patients hop onboard

Nearly all COVID-positive patients tested in these sites agreed to be admitted to the hospital at home, coauthor Stephanie Murphy, DO, medical director of the Atrium Health HaH program, said in an interview.

Patients with moderate symptoms were glad to be monitored at home, she said. When they got to the point where the nurse supervising their care felt they needed escalation to acute care, they were asked whether they wanted to continue to be cared for at home. Most opted to stay home rather than be admitted to the hospital, where their loved ones couldn’t visit them.

Low-acuity patients in the VOU received daily telemonitoring by a nurse to identify disease progression and escalate care as needed. For those who required more care and were admitted to the VACU, a team of paramedics and registered nurses (RNs; mobile clinicians) visited the patient’s home within 24 hours, setting up a hospital bed, other necessary medical equipment, videoconferencing gear, and a remote-monitoring kit that included a blood pressure cuff, a pulse oximeter, and a thermometer.

Dedicated hospitalists and nurses managed patients with 24/7 coverage and monitoring, bringing in other specialties as needed for virtual consults. Mobile clinician and virtual provider visits continued daily until a patient’s condition improved to the point where they could be deescalated back to the VOU. After that, patients received mobile app–driven symptom monitoring and telephone follow-up with a nurse until they got better.

“Virtual hospital programs have the potential to provide health systems with additional inpatient capacity during the COVID-19 pandemic and beyond.”

Few patients go to hospital

Overall, patients had a median length of stay of 31 days in the VOU or the VACU or both. The vast majority, 1,295 patients (88%), received care in the VOU only. In that cohort, just 40 patients (3%) required hospitalization in an Atrium facility. Sixteen of those patients spent time in an ICU, seven required ventilator support, and two died in the hospital.

A total of 184 patients (12%) were admitted to the VACU. Twenty-one (11%) required intravenous fluids, 16 (9%) received antibiotics, 40 (22%) required inhaler or nebulizer treatments, 41 (22%) used supplemental oxygen, and 24 (13%) were admitted to a conventional hospital. Of the latter patients, 10 were admitted to an ICU, 1 required a ventilator, and none died in the hospital.

Dr. Sitammagari, a hospitalist and co-medical director for quality at Atrium Health, said that, overall, the outcomes for patients in the system’s HaH were comparable to those seen in the literature among other COVID-19 cohorts.

Hospital capacity augmented

The authors note that treating the 160 VACU patients within the HaH saved hospital beds for other patients. The HaH maintained a consistent census of between 20 and 30 patients for the first 6 weeks as COVID-19 cases spread.

Since last spring, Dr. Murphy said, the Atrium HaH’s daily census has grown to between 30 and 45 patients. “We could absorb 50 patients if our hospitals required it.”

How much capacity does that add to Atrium Health? While there are 50 hospitals in the health system, the HaH was set up mainly to care for COVID-19 patients who would otherwise have been admitted to the 10 acute-care hospitals in the Charlotte, N.C., area.

In the 4 weeks ending Nov. 16, these facilities carried an average daily census of around 150 COVID-19 patients, Dr. Murphy noted. “During that time, the Atrium Health HaH has carried, on average, about 20%-25% of that census.”

If the pandemic were to overwhelm area hospitals, she added, “the structure would support flexing up our staffing and supplies to expand to crisis capacity,” which could be up to 200 patients a day.

For the nurses who make most of the phone calls to patients, patients average about 12-15 per RN, Dr. Murphy said, and there’s one mobile clinician for every 6-9 patients. That’s pretty consistent with the staffing on med-surg floors in hospitals, she said.

The physicians in the program include hospitalists dedicated to telemedicine and some doctors

Continued on following page
CMS launches ‘hospital at home’ program to free up hospital capacity

By Ken Terry

As an increasing number of health systems implement “hospital at home” (HaH) programs to increase their traditional hospital capacity, the Centers for Medicare & Medicaid Services has given the movement a boost by changing its regulations to allow acute care to be provided in a patient’s home under certain conditions.

The CMS announced last November that it was launching its Acute Hospital Care at Home program “to increase the capacity of the American health care system” during the COVID-19 pandemic. At the same time, the agency announced it was giving more flexibility to ambulatory surgery centers (ASCs) to provide hospital-level care.

The CMS said its new HaH program is an expansion of the Hospitals Without Walls initiative that was unveiled last March. Hospitals Without Walls is a set of “temporary new rules” that provide flexibility for hospitals to provide acute care outside of inpatient settings. Under those rules, hospitals are able to transfer patients to outside facilities, such as ASCs, inpatient rehabilitation hospitals, hotels, and dormitories, while still receiving Medicare hospital payments.

Under CMS’s new Acute Hospital Care at Home, which is not described as temporary, patients can be transferred from emergency departments or inpatient wards to hospital-level care at home. The CMS said the HaH program is designed for people with conditions such as the acute phases of asthma, heart failure, pneumonia, and chronic obstructive pulmonary disease. Altogether, the agency said, more than 60 acute conditions can be treated safely at home.

However, the agency didn’t say that facilities can’t admit COVID-19 patients to the hospital at home. Rami Karjian, MBA, cofounder and CEO of Medically Home, a firm that supplies health systems with technical services and software for HaH programs, said in an interview that several Medically Home clients plan to treat both COVID-19 and non–COVID-19 patients at home when they begin to participate in the CMS program in the near future.

The CMS said it consulted extensively with academic and private industry leaders in building its HaH program. Before rolling out the initiative, the agency noted, it conducted successful pilot programs in leading hospitals and health systems. Participating hospitals will be required to have specified screening protocols in place before beginning acute care at home. An in-person physician evaluation will be required before starting care at home. A nurse will evaluate each patient once daily in person or remotely, and either nurses or paramedics will visit the patient in person twice a day.

In contrast, Medicare regulations require nursing staff to be available around the clock in traditional hospitals. So the CMS has to grant waivers to hospitals for HaH programs. “While not going into detail on the telemonitoring capabilities that will be required in the acute hospital care at home, the release said, "Today’s announcement builds upon the critical work by CMS to expand telehealth coverage to keep beneficiaries safe and prevent the spread of COVID-19.”

More flexibility for ASCs

The agency is also giving ASCs the flexibility to provide 24-hour nursing services only when one or more patients are receiving care on site. This flexibility will be available to any of the 5,700 ASCs that wish to participate, and will be immediately effective for the 85 ASCs currently participating in the Hospital Without Walls initiative, the CMS said.

The new ASC regulations, the CMS said, are aimed at allowing communities “to maintain surgical capacity and other life-saving non–COVID-19 [care], like cancer surgeries.” Patients who need such procedures will be able to receive them in ASCs without being exposed to known COVID-19 cases.

Similarly, the CMS said patients and families not diagnosed with COVID-19 may prefer to receive acute care at home if local hospitals are full of COVID-19 patients. In addition, the CMS said it anticipates patients may value the ability to be treated at home without the visitation restrictions of hospitals.

Early HaH participants

Six health systems with extensive experience in providing acute hospital care at home have been approved for the new HaH waivers from Medicare rules. They include Brigham and Women’s Hospital (Mass.); Huntsman Cancer Institute (Utah); Massachu-

Continued on following page

who can’t work in the regular hospital because they’re immunocompromised. The physicians round virtually, covering 12-17 HaH patients per day, according to Dr. Murphy.

Prior planning paid off

Unlike some other health care systems that have launched HaH programs with the aid of outside vendors, Atrium Health developed its own HaH and brought it online just 2 weeks after deciding to launch the program. Atrium was able to do this, Dr. Stamaglari explained, because before the pandemic its hospitalist program was already developing an HaH model to improve the care of high-risk patients after hospital discharge to prevent readmission.

While Atrium’s electronic health record system wasn’t designed for hospital at home, its health information technology department and clinicians collaborated in rewriting some of the workflows and order sets in the EHR. For example, they set up a nursing questionnaire to administer after VACH admission, and they created another form for automatic admission to the HaH after a patient tested positive for COVID-19. Atrium staff also modified a patient-doctor communications app to help clinicians monitor HaH patients, Dr. Murphy noted.

Other hospital systems have gotten up to speed on HaH pretty quickly by using platforms supplied by outside vendors. Adventist Health in Los Angeles, for example, started admitting patients to its hospital at home just a month after approaching a vendor called Medically Home.

COVID and non-COVID patients considered

Atrium’s decision to focus its HaH effort on COVID-19 patients is unusual among the small but growing number of health systems that have adopted the HaH model to increase their capacity. (Atrium is now transferring some hospitalized patients with other conditions to its HaH, but is still focusing mainly on COVID-19.)

Bruce Leff, MD, a professor of health policy and management at Johns Hopkins Bloomberg School of Public Health, Baltimore, a leading expert on the HaH model, agrees that it can increase hospital capacity significantly.

Dr. Leff praised the Atrium Health study. “It proves that within an integrated delivery system you can quickly deploy and implement a virtual hospital in the specific-use of COVID and help patients and help the system at scale,” he said. “They took a bunch of people into the virtual observation unit and thereby kept people from overwhelming their [emergency department] and treated those people safely at home.”

Dr. Leff had no problem with Atrium’s focus on patients with COVID-19 rather than other conditions. “My guess is that they have the ability to take what they developed and apply it to other conditions. Once you have the ability to do acute care at home, you can do a lot at home.”

The biggest barrier to the spread of hospital at home remains the lack of insurer coverage. Dr. Murphy said that health plans are covering virtual physician consultations with patients in the HaH, as well as some other bits and pieces, but not the entire episode of acute care.

Dr. Leff believes that this will start changing soon. COVID-19 has altered the attitudes of physicians and hospitals toward telehealth, he noted, “and it has moved policy makers and payers to start thinking about the new models – home-based care in general and hospital at home in particular. For the first time in 25 years, payers are starting to get interested.”

Most of the authors are employees of Atrium Health. In addition, one coauthor reports being the cofounder of a digital health company, Enroll, and receiving grants from The Heineman Foundation. Dr. Leff is an adviser to Medically Home, which provides support to hospital at home programs.

A version of this article originally appeared on Medscape.com.
Leading in crisis
Lessons from the trail

By Danielle Scheurer, MD, MSCR, SFHM

I have learned a lot about crisis management and leadership in the rapidly changing COVID health care environment. I have learned how to make quick and imperfect decisions with limited information, and how to move on swiftly. I have learned how to quickly fade out memories of how we used to run our business, and pivot to unknown and untested delivery modalities. I have learned how to take regulatory standards as guidance, not doctrine. And I have learned how to tell long-standing loyal colleagues that they are being laid off.

Many of these leadership challenges are not new, but the rapidity of change and the weight and magnitude of decision-making is unparalleled in my relatively short career. In some ways, it reminds me of some solid lessons I have learned over time as a lifelong runner, with many analogies and applications to leadership.

Some people ask why I run. The truth is, I have never had a runner’s high. I feel every step. In fact, the truth is, I have never had a runner’s high. I feel hard, but not too hard. I have seen firsthand the effects of under and over-delegating, and both are dysfunctional. Good leadership is a blend of being humble and servant, but also ensuring self-care and endurance. The other aspect of leadership that I find really hard is that often, people’s anger is misdirected at leaders as a natural outlet for that anger. Part of being a leader is enduring such anger, gaining an understanding for it, and doing what you can to help people through it.

They both work better when you are restored. It sounds generic and cliché, but you can’t be a good runner or a good leader when you are totally depleted.

They both require efficiency. When I was running my first marathon, a complete stranger ran up beside me and told me I should run in as straight of a line as possible, regardless of the road, to preserve energy and save steps. He recommended picking a point on the horizon and running toward that point. As he sped off ahead of me, his parting words were, “You’ll thank me at mile 24.” The same can be said for leadership; as you pick a point on the horizon, keep yourself and your team heading toward that point with intense focus, and before you realize it, you’ve reached your destination.

They both require having a goal. That same stranger who gave me advice on running efficiently also asked what my goal was. It caught me off guard a bit, as I realized my only goal was to finish. He encouraged me to make a goal for the run, which could serve as a motivator when the going got tough.

They both can be endured by committing to continuous forward motion. Running and leadership both become psychologically much easier when you realize all you really have to do is maintain continuous forward motion.

They both are easier if you don’t overthink things. When I first started in a leadership position, I would have moments of anxiety if I thought too hard about what I was responsible for. Similar to running, it works best if you don’t overthink what difficulties it may bring; rather, just put on your shoes and get going.

Continued from previous page

sets General Hospital; Mount Sinai Health System (N.Y.); Presbyterian Healthcare Services (N.M.); and UnityPoint Health (Iowa).

The CMS said that it’s in discussions with other health care systems and expects new applications to be submitted soon.

To support these efforts, the CMS has launched an online portal to streamline the waiver request process. The agency said it will closely monitor the program to safeguard beneficiaries and will require participating hospitals to report quality and safety data on a regular basis.

Support from hospitals

The first health systems participating in the CMS HaH appear to be supportive of the program, with some hospital leaders submitting comments to the CMS about their view of the initiative.

“The CMS has taken an extraordinary step today, facilitating the rapid expansion of Hospitalization at Home, an innovative care model with proven results,” said Kenneth L. Davis, MD, president and CEO of the Mount Sinai Health System in New York City. “This important and timely move will enable hospitals across the country to use effective tools to safely care for patients during this pandemic.”

David Levine, MD, assistant professor of medicine and medical director of strategy and innovation at Brigham Health Home Hospital in Boston, was similarly laudatory: “Our research at Brigham Health Home has shown that we can deliver hospital-level care in our patients’ homes with lower readmission rates, more physical mobility, and a positive patient experience,” he said. “We are so encouraged that CMS is taking this important step, which will allow hospitals across the country to increase their capacity while delivering the care all patients deserve.”

Quick scale up

If other hospitals and health systems recognize the value of HaH, how long might it take them to develop and implement these programs in the midst of a pandemic?

Atrium Health, a large health system in the Southeast, ramped up a hospital at home initiative last spring for its 10 hospitals in the Charlotte, N.C., area, in just 2 weeks. However, it had been working on the project for some time before the pandemic struck. Focusing mostly on COVID-19 patients, the initiative reduced the COVID-19 patient load by 20%-25% in Atrium’s hospitals.

Medically Home, the HaH infrastructure company, said in a news release that it “enables health systems to establish new hospital-at-home services in as little as 30 days.” Medically Home has partnered in this venture with Huron Consulting Group, which has about 200 HaH-trained consultants, and Cardinal Health, a large global medical supplies distributor.

Mr. Karjian said in an interview that he expects private insurers to follow CMS’s example, as they often do. “We think this decision will cause not only CMS but private insurers to cover hospital at home after the pandemic, if it becomes the standard of care, because patients have better outcomes when treated at home,” he said.

Asked for his view on why the CMS specified that patients could be admitted to an HaH only from emergency departments or inpatient settings, Mr. Karjian said that the CMS wants to make sure that patients have access to brick-and-mortar hospital care if that’s what they need. Also, he noted, this model is new to most hospitals, so the CMS wants to make sure it starts “with all the safety guardrails” in place.

Overall, Mr. Karjian said, “What CMS has done is terrific in terms of letting patients get the care they want, where they want it, and get the benefit of better outcomes while the nation is going through this capacity crunch for hospital beds.”

A version of this article originally appeared on Medscape.com.

January 2021

The Hospitalist
This advertisement is not available for the digital edition.

The Hospitalist
Finding meaning in ‘Lean’?
Using systems improvement strategies to support the Quadruple Aim

By Pallabi Sanyal-Dey, MD, FHM; Larissa Thomas, MD, MPH; and David Chia, MD, MSc

Background on well-being and burnout
With burnout increasingly recognized as a shared responsibility that requires addressing organizational drivers while supporting individuals to be well,14 practical strategies and examples of successful implementation of systems interventions to address burnout will be helpful for service directors to support their staff. The Charter on Physician Well-Being, developed through collaborative input from multiple organizations, defines guiding principles and key commitments at the societal, organizational, and interpersonal and individual levels and may be a useful framework for organizations developing well-being initiatives.5

The charter advocates including physician well-being as a quality improvement metric for health systems, aligned with the concept of the Quadruple Aim of optimizing patient care by enhancing provider experience, promoting high-value care, and improving population health.6 Identifying areas of alignment between the charter’s recommendations and systems improvement strategies that seek to optimize efficiency and reduce waste, such as Lean Management, may help physician leaders to contextualize well-being initiatives more easily within ongoing systems improvement efforts. In this perspective, we provide one division’s experience using the Charter to assess successes and identify additional areas of improvement for well-being initiatives developed using Lean Management methodology.

The state of affairs
In 2011, the division of hospital medicine at Zuckerberg San Francisco General Hospital was established and has seen continual expansion in terms of direct patient care, medical education, and hospital leadership. In 2015, the division of hospital medicine experienced leadership transitions, faculty attrition, and insufficient recruitment resulting in staffing shortages, service line closure, schedule instability, and low morale.

A baseline survey was conducted using the 2-Item Maslach Burnout Inventory. This survey, which uses one item in the domain of emotional exhaustion and one item in the domain of depersonalization, has shown good correlation with the full Maslach Burnout Inventory.1 At baseline, approximately one-third of the division’s physicians experienced burnout.

In response, a subsequent retreat focused on the three greatest areas of concern identified by the survey: scheduling, faculty development, and well-being.

Like many health systems, the hospital has adopted Lean as its preferred systems improvement framework. The retreat was structured around the principles of Lean philosophy, and was designed to emulate that of a consolidated Kaizen workshop. ‘Kaizen’ in Japanese means “change for the better.” A typical Kaizen workshop revolves around rapid problem-solving over the course of 3-5 days, in which a team of people come together to identify and implement significant improvements for a selected process. To this end, the retreat was divided into subgroups for each area of concern. In turn, each subgroup mapped out existing workflows (“value stream”), identified areas of waste and non-value added time, and generated ideas of what an idealized process would be. Next, a root-cause analysis was performed and subsequent interventions (“countermeasures”) developed to address each problem. At the conclusion of the retreat, each subgroup shared a summary of their findings with the larger group.

Next, this information served as a guiding framework for service and division leadership to run small tests of change. We enacted a series of countermeasures over several years, and multiple cycles of improvement work addressed the three areas of concern. We developed an A3 report (a Lean project management tool that incorporates the plan-do-study-act cycle, organizes strategic efforts, and tracks progress on a single page) to summarize and present these initiatives to the Performance Improvement and Patient Safety Committee of the hospital executive leadership team. This structure illustrated alignment with the hospital’s core values (“true north”) of “developing people” and “care experience.”

In 2018, interval surveys demonstrated a gradual reduction of burnout to approximately one-fifth of division physicians as measured by the 2-item Maslach Burnout Inventory.

Initiatives in faculty well-being
The Charter of Physician Well-Being outlines a framework to promote well-being among doctors by maximizing a sense of fulfillment and minimizing the harms of burnout. It shares this responsibility among societal, organizational, and interpersonal and individual commitments.5 As illustrated here, we used principles of Lean Management to prospectively create initiatives to improve well-being in our division. Lean in health care is designed to optimize primarily the patient experience; its implementation has subsequently demonstrated mixed provider and staff experiences,8 and many providers are skeptical of Lean’s potential to improve their own well-being. If, however, Lean is aligned with best practice frameworks for well-being such as those outlined in the charter, it may also help to meet the Quadruple Aim of optimizing both provider well-being and patient experience. To further test this hypothesis, we retrospectively categorized our Lean-based interventions into the commitments described by the charter to identify areas of alignment and gaps that were not initially addressed using Lean Management (Table).

Organizational commitments
We optimized scheduling and enhanced physician staffing by budgeting for a physician staffing buffer each academic year in order to minimize mandatory moonlighting and jeopardize pool activations that result from operating on a

Mapping the charter of well-being to Lean Management

Societal commitments

<table>
<thead>
<tr>
<th>Charter principle</th>
<th>Lean philosophy</th>
<th>Division goal and intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supportive culture and policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Kaizen,&quot; &quot;Going to the Gemba&quot;</td>
<td>Use Lean as a tool to optimize well-being in the division of hospital medicine</td>
<td></td>
</tr>
</tbody>
</table>

Organizational commitments

<table>
<thead>
<tr>
<th>Supportive systems</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sort, Set in order, Shine, Standardize, Sustain (&quot;5S&quot;)</td>
<td>Optimize workspace using SS with new workstations and power standing desks</td>
<td></td>
</tr>
<tr>
<td>Automated method to prevent any possible errors (&quot;Mistake Proofing&quot;)</td>
<td>Improve communication and access to policies through mobile and cloud-based platforms</td>
<td></td>
</tr>
<tr>
<td>Identifying areas of value-added time and waste, designing future state (&quot;Value Stream&quot;)</td>
<td>Eliminate mandatory moonlighting and reduce clinical back-up pool activations through increased physician staffing</td>
<td></td>
</tr>
<tr>
<td>Standard work</td>
<td>Optimize workflow of clinical shifts to eliminate waste (waiting, minimizing nonclinical tasks, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

Interpersonal and individual commitments

<table>
<thead>
<tr>
<th>Anticipate and respond to inherent challenges</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No direct parallel</td>
<td>Provide a forum to discuss clinical and emotional aspects of caring for patients through case conferences, Schwartz rounds</td>
<td></td>
</tr>
</tbody>
</table>

Practice and promote self care

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No direct parallel</td>
<td>Incorporate well-being topics into divisional meetings</td>
<td></td>
</tr>
</tbody>
</table>

Prioritize mental health

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No direct parallel</td>
<td>Educate faculty about existing resources (Faculty and staff assistance program)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Dr. Sanyal-Dey, Dr. Thomas, Dr. Chia
Did you know...

• 48.7% of Adult HMGs report patient satisfaction as a performance metric in compensation plans

• 57% of HMGs lost provider time due to quarantine and 48% lost time due to illness

• Or that 70% of HMGs created dedicated COVID and non-COVID teams in 2020?

Stay informed and alert about evolving healthcare trends with the 2020 State of Hospital Medicine (SoHM) Report and COVID-19 Addendum.

Order your copy today.
hospitalmedicine.org/sohm

Dr. Sanyal-Dey is visiting associate clinical professor of medicine at Zuckerberg San Francisco General Hospital and director of client services, LeanTaaS. Dr. Thomas is associate clinical professor of medicine at Zuckerberg San Francisco General Hospital. Dr. Chia is associate professor of clinical medicine at Zuckerberg San Francisco General Hospital.

Continued on following page
Racism in medicine

“If you have a brain, you have bias, and that bias will likely apply to race as well,” Dr. Johnson said. “When we’re talking about institutional racism, the educational system and the media have led us to create presumptions and prejudices that we don’t necessarily recognize off the top because they’ve just been a part of the fabric of who we are as we’ve grown up.”

The term “racism” has extremely negative connotations because there’s character judgment attached to it, but to say someone is racist or racially insensitive does not equate them with being a Klansman, said Dr. Johnson. “I think we as people have to acknowledge that, yes, it’s possible for me to be racist and I might not be 100% aware of it. It’s being open to the possibility – or rather probability – that you are and then taking steps to figure out how you can address that, so you can limit it. And that requires constant self-evaluation and work,” he said.

Racism in the medical environment

Institutional racism is evident before students are even accepted into medical school, said Areeba Kara, MD, SFHM, associate professor of clinical medicine at Indiana University School of Medicine and a hospitalist at IU Health Physicians.

Mean MCAT scores are lower for applicants traditionally underrepresented in medicine (UIM) compared to the scores of well-represented groups.1 “Lower scores are associated with lower acceptance rates into medical school,” Dr. Kara said. “These differences reflect unequal educational opportunities rooted in centuries of legal discrimination.”

Racism is apparent in both the hidden medical education curriculum and in lessons implicitly taught to students, said Ndidi Unaka, MD, MEd, associate program director of the pediatric residency training program at Cincinnati Children’s Hospital. “These lessons inform the way in which we as physicians see our patients, each other, and how we practice,” she said. “We reinforce race-based medicine and shape clinical decision-making through flawed guidelines and practices, which exacerbates health inequities. We teach that race – rather than racism – is a risk factor for poor health outcomes. Our students and trainees watch as we assume the worst of our patients from marginalized communities of color.”

Terms describing patients of color, such as “difficult,” “noncompliant,” or “frequent flyer” are thrown around and sometimes, instead of finding out why, “we view these states of being as static, root caus es for poor outcomes rather than symptoms of social conditions and obstacles that impact overall health and well-being,” Dr. Unaka said.

Leadership opportunities

Though hospital medicine is a growing field, Dr. Kara noted that the 2020 State of Hospital Medicine Report found that only 5.5% of hospital medical group leaders were Black, and just 2.2% were Hispanic/Latino.2 “I think these numbers speak for themselves,” she said.

Dr. Unaka said that the lack of UIM hospitalists and physician leaders creates fewer opportunities for “race-concordant mentorship relationships.” It also forces UIM physicians to shoulder more responsibilities – often obligations that do little to help them move forward in their careers – all in the name of diversity. And when UIM physicians are given leadership opportunities, Dr. Unaka said they are often unsure as to whether their appointments are genuine or just a hollow gesture made for the sake of diversity.

Dr. Johnson pointed out that Black and Latinx populations primarily get their care from hospital-based specialties, yet this is not reflected in the number of UIM practiced.

References

Continued from previous page

munities in leadership roles. He said race and ethnicity, as well as gender, need to be factors when individuals are evaluated for leadership opportuni-
ties – for the individual’s sake, as well as for the community he or she is serving.

“When we can evaluate for unconscionable bias and factor in that diverse groups tend to have better outcomes, whether it’s business or clinical outcomes, it’s one of the opportuni-
ties that we collectively have in the specialty to improve what we’re delivering for hospitals and, more im-
portantly, for patients,” he said.

Relationships with colleagues and patients

Racism creeps into interactions and relationships with others as well, whether it’s between clinicians, clinician to patient, or patient to cli-
nician. Sometimes it’s blatant; often it’s subtle.

A common, recurring example Dr. Unaka has experienced in the clinici-
an to clinician relationship is being confused with other Black physi-
cians, making her feel invisible. “The everyday verbal, nonverbal, and environ-
mental slights, snubs, or insults from colleagues are frequent and contribute to feelings of exclusion, isolation, and exhaustion,” she said.

Despite this, she is still expected to ‘address microaggressions and other forms of interpersonal racism and find ways to move through profes-
sional spaces in spite of the trauma, fear, and stress associated with my reality and lived experiences.” She said that clinicians who remain silent on the topic of racism participate in the violence and contribute to the disillusionment of UIM physicians.

Dr. Kara said that the discrimina-
tion from the health care team is the hardest to deal with. In the clinician to clinician relationship, there is a sense among UIM physicians that they’re being watched more closely and have “to prove themselves at ev-
every single turn.” Unfortunately, this comes from the environment, which tends to be adversarial rather than supportive and nurturing, she said.

“There are lots of opportunities for racism or racial insensitivity to crop up from clinician to clinician,” said Dr. Johnson. When he started his career as a physician after his train-
ing, Dr. Johnson was informed that his colleagues were watching him toward

Patients refusing care from UIM physicians or expressing disadvant-
aging – both verbal and nonverbal – of such care, happens all too often. “It’s easier for me to excuse patients and their families as we often meet them on their worst days,” said Dr. Kara. Still, “understanding my oath to care for people and do no harm, but at the same time, recognizing that this is an individual that is rejecting my care without having any idea of who I am as a physician is frustrating,” Dr. Johnson acknowledged.

Then there’s the complex clini-
cian to patient relationship, which research clearly shows contributes to health disparities. For one thing, the physician workforce does not reflect the patient population, Dr. Unaka said. “We cannot ignore the lack of race concordance between patients and clinicians, nor can the continued misplacement of blame for medical mistrust be at the feet of our patients,” she said.

Dr. Unaka feels that clinicians need to accept both that health inequities exist and that frontline physicians themselves contribute to the inequi-
ties. “Our diagnostic and therapeutic decisions are not immune to bias and are influenced by our deeply held beliefs about specific populations,” she said. “And the health care system that our patients navigate is no dif-
ferent than other systems, settings, and environments that are marred by racism in all its forms.”

Systemic racism greatly impacts patient care, said Dr. Kara. She point-
ed to several examples: research showing that race concordance be-
tween patients and providers in an emergency department setting led to better pain control with fewer anal-
egesics,6 the high maternal and infant mortality rates amongst Black wom-
en and children,7 evidence of poorer outcomes in sepsis patients with lim-
ited English proficiency,8 “There are plenty more,” she said. “We need to be asking ourselves what we are going to do about it.”

Work in progress

That racial biases are steeped so thoroughly into our culture and consciousness means that moving beyond them is a continual, purpose-
ful work in progress. But it is work that is critical for everyone, and cer-
tainly necessary for those who care for fellow human beings when they are in a vulnerable state.

Health care systems need to move toward equity – giving everyone what they need to thrive – rather than focusing on equality – giving everyone the same thing, said Jenny Baenzinger, MD, assistant professor of clinical medicine and pediatrics at Indiana University School of Medi-
cine and associate director of educa-
tion at IU Center for Global Health.

“We know that minoritized patients are going to need more attention, more advocacy, more sensitivity, and more creative solutions in or-
der to help them achieve health in a world that is often stacked against them,” she said.

“The unique needs of each pa-
tient, family unit, and/or population must be taken into consideration,” said Dr. Unaka. She said hospitals need to embrace creative approach-
es that can better serve the specific needs of patients. Equitable prac-
tices should be the default, which means data transparency, thorough-
ly dissectioning hospital processes to find existing inequities, giving stake-
holders – especially patients and families of color – a voice, and tearing down oppressive systems that contribute to poor health out-
comes and oppression, she said.

“It’s time for us to talk about rac-
ism openly,” said Dr. Kara. “Believe your colleagues when they share their fears and treat each other with respect. We should be actively learning about and celebrating our diversity.” She encourages finding out what your institution is doing on this front and getting involved.

Dr. Johnson believes that first and foremost, hospitalists need to be exposed to the data on health care disparities. “The next step is asking what we as hospitalists, or any other specialty, can do to intervene and improve in those areas,” he said. Fo-
cusing on unconscious bias training is important, he said, so clinicians can see what biases they might be bring-
ing into the hospital and to the bed-
side. Maintaining a diverse workforce and bringing UIM physicians into leadership roles to encourage diver-
sity of ideas and approaches are also critical to promoting equity, he said.

“You cannot fix what you cannot face,” said Dr. Unaka. Education on how racism impacts patients and col-
leagues is essential, she believes, as is advocacy for changing inequitable health system policies. Dr. Johnson recom-

dems expanding social and profes-
sional circles. “Diverse social groups allow us to consider the perspectives of others; diverse professional groups allow us to ask better research ques-
tions and practice better medicine.”

Start by developing the ability to question personal assumptions and pinpoint implicit biases, suggested Dr. Baenzinger. “Asking for feedback can be scary and difficult, but we should take a deep breath and do it anyway,” she said. “Simply ask your team. I’ve been thinking a lot about racial equity and disparities. How can I do better at my interactions with people of color? What are my blind spots?” Dr. Baenzinger said that “to help us remember how beautifully complicated and diverse people are,” all health care profes-
sionals need to watch Nigerian novelist Chimamanda Adichie’s TED talk “The Danger of a Single Story.”

Dr. Baenzinger also stressed the importance of conversations about ‘places where race is built into our clinical assessments, like eGFR,’” as well as being aware that many of the research studies that are used to support everyday clinical decisions didn’t include people of color. She also encouraged clinicians to consider hospitality, to find existing inequities, giving stakeholders – especially patients and families of color – a voice, and tearing down oppressive systems that contribute to poor health out-
comes and oppression, she said.

It’s time for us to talk about rac-
ism openly,” said Dr. Kara. “Believe your colleagues when they share their fears and treat each other with respect. We should be actively learning about and celebrating our diversity.” She encourages finding out what your institution is doing on this front and getting involved.

Dr. Johnson believes that first and foremost, hospitalists need to be exposed to the data on health care disparities. “The next step is asking what we as hospitalists, or any other specialty, can do to intervene and improve in those areas,” he said. Foc-
cusing on unconscious bias training is important, he said, so clinicians can see what biases they might be bring-
ing into the hospital and to the bed-
side. Maintaining a diverse workforce and bringing UIM physicians into leadership roles to encourage diver-
sity of ideas and approaches are also critical to promoting equity, he said.

“You cannot fix what you cannot face,” said Dr. Unaka. Education on how racism impacts patients and col-
leagues is essential, she believes, as is advocacy for changing inequitable health system policies. Dr. Johnson recom-

dems expanding social and profes-
sional circles. “Diverse social groups allow us to consider the perspectives of others; diverse professional groups allow us to ask better research ques-
tions and practice better medicine.”

References

1. Lucey CR, Sagui A. The consequences of structural racism on MCAT scores and medi-


4. Heins A, et al. Physician race/ethnicity predicts successful emergency department analge-


6. Jacobs ZG et al. The association between limited english proficiency and sepsis mortal-

tor.2014.16.6.eacc1-1406.
Social isolation at the time of social distancing

Implications of loneliness and suggested management strategies in hospitalized patients with COVID-19

By Yelena Burklin, MD, FHM, FACP, and Zanthia Wiley, MD

During a busy morning of rounds, our patient, Mrs. M., appeared distraught. She was diagnosed with COVID-19 2 weeks prior and remained inpatient because of medical-social reasons. Since admission she remained on the same ward, in the same room, cared for by the same group of providers donned in masks, gowns, gloves, and face shields. The personal protective equipment helped to shield us from the virus, but it also shielded Mrs. M. from us.

During initial interaction, Mrs. M. appeared anxious, tearful, and detached. It seemed that she recognized a new voice; however, she did not express much interest in engaging during the visit. When she realized that she was not being discharged, Mrs. M. appeared to lose further interest. She wanted to go home. Her outpatient dialysis arrangements were not complete, and that precluded hospital discharge. Prescribed anxiolytics were doing little to relieve her symptoms.

The next day, Mrs. M. continued to ask if she could go home. She stated that there was nothing for her to do while in the hospital. She was tired of watching TV, she was unable to call her friends, and was not able to see her family. Because of COVID-19 status, Mrs. M. was not permitted to leave her hospital room, and she was transported to the dialysis unit via stretcher, being unable to walk. The more we talked, the more engaged Mrs. M. had become. When it was time to complete the encounter, Mrs. M. started pleading with us to “stay a little longer; please don’t leave.”

Throughout her hospitalization, Mrs. M. had an extremely limited number of human encounters. Those encounters were fragmented and brief, centered on the infection mitigation. The chaplain was not permitted to enter her room, and she was unwilling to use the phone. The subspecialty consultants utilized telemedicine visits. As a result, Mrs. M. felt isolated and lonely. Social distancing in the hospital makes human interactions particularly challenging and contributes to the development of isolation, loneliness, and fear.

Reality of loneliness

Loneliness is the “subjective experience of involuntary social isolation.” As the COVID-19 pandemic began to entrap the world in early 2020, many people have faced new challenges—loneliness and its impact on physical and mental health. The prevalence of loneliness nearly tripled in the early months of the pandemic, leading to psychological distress and reopening conversations on ethical issues.

Ethical implications of loneliness

Social distancing challenges all four main ethical principles: autonomy, beneficence, nonmaleficence, and justice. How do we reconcile these principles from the standpoint of each affected individual, their caregivers, health care providers, and public health at large? How can we continue to mitigate the spread of COVID-19, but also remain attentive to our patients who are still in need of human interactions to recover and thrive?

Social distancing is important, but so is social interaction. What strategies do we have in place to combat loneliness? How do we help our hospitalized patients who feel connected to the “outside world”? Is battling loneliness worth the risks of additional exposure to COVID-19? These dilemmas cannot be easily resolved. However, it is important for us to recognize the negative impacts of loneliness and identify measures to help our patients.

In our mission to fulfill the beneficence and nonmaleficence principles of caring for patients affected by COVID-19, patients like Mrs. M. lose much of their autonomy during hospital admission. Despite our best efforts, our isolated patients during the pandemic remain alone, which further heightens their feeling of loneliness.

Clinical implications of loneliness

With the advancements in technology, our capabilities to substitute personal human interactions have grown exponentially. The use of telemedicine, video- and audio-conferencing communications have changed the landscape of our capacities to exchange information. This could be a blessing and a curse. While the use of digital platforms for virtual communication is tempting, we should preserve human interactions as much as possible, particularly when caring for patients affected by COVID-19. Interpersonal “connectedness” plays a crucial role in providing psychological and psychotherapeutic support, particularly when the number of human encounters is already limited.

Social distancing requirements have magnified loneliness. Several studies demonstrate that the perception of loneliness leads to poor health outcomes, including lower immunity, increased peripheral vascular resistance, and higher overall mortality. Loneliness can lead to functional impairment, such as poor social skills, and even increased inflammation.

The negative emotional impact of SARS-CoV-2 echoes the experiences of patients affected by the severe acute respiratory syndrome (SARS) outbreak in 2003. However, with COVID-19, we are witnessing the amplified effects of loneliness on a global scale. The majority of affected patients during the 2003 SARS outbreak in Canada reported loneliness, fear, aggression, and boredom. They had concerns about the impacts of the infection on loved ones, and psychological support was required for many patients with mild to moderate SARS disease.

Nonpharmacological management strategies for battling loneliness

Utilization of early supportive services has been well described in literature and includes extending additional resources such as books, newspapers, and most importantly, additional in-person time to our patients. Maintaining rapport with patients’ families is also helpful in reducing anxiety and fear. The following measures have been suggested to prevent the negative impacts of loneliness and should be considered when caring for hospitalized patients diagnosed with COVID-19:

• Screen patients for depression and delirium and utilize delirium prevention measures throughout the hospitalization.
• Educate patients about the signs and symptoms of loneliness, fear, and anxiety.
• Extend additional resources to patients, including books, magazines, and newspapers.

For a complete list of the references for this article, please see the online version at www.the-hospitalist.org.

January 2021  16  The Hospitalist
Blood glucose predicts COVID-19 severity

By Miriam E. Tucker

Hyperglycemia at hospital admission – regardless of diabetes status – is a key predictor of COVID-19–related death and severity among noncritical patients, new research finds.

The observational study, the largest to date to investigate this association, was published in Annals of Medicine by Francisco Javier Carrasco-Sánchez, MD, PhD, and colleagues (doi: 10.1080/07853890.2020.1836565).

Among more than 11,000 patients with confirmed COVID-19 from March to May 2020 in a nationwide Spanish registry involving 109 hospitals, admission hyperglycemia independently predicted progression from noncritical to critical condition and death, regardless of prior diabetes history.

Those with abnormally high glucose levels were more than twice as likely to die from the virus than those with normal readings (41.4% vs 15.7%). They also had an increased need for a ventilator and ICU admission.

"These results provided a simple and practical way to stratify risk of death in hospitalized patients with COVID-19. Hence, admission hyperglycemia should not be overlooked, but rather detected and appropriately treated to improve the outcomes of COVID-19 patients with and without diabetes," Dr. Carrasco-Sánchez and colleagues wrote.

The findings confirm those of previous retrospective observational studies, but the current study ‘has, by far, the biggest number of patients involved in this kind of study [to date]. All conclusions are consistent to other studies,’ Dr. Carrasco-Sánchez, of University Hospital Juan Ramón Jiménez, Huelva, Spain, said in an interview.

However, a surprising finding, he said, "was how hyperglycemia works in the nondiabetic population and [that] glucose levels over 140 [mg/dL] increase the risk of death."

Even mild hyperglycemia on admission may affect outcome

The study also differs from some of the prior observational ones in that it examines outcome by admission glycemia rather than during the hospital stay, therefore eliminating the effect of any inpatient treatment, such as dexamethasone.

Although blood glucose measurement at admission is routine for all patients in Spain, as it is in the United States and elsewhere, a mildly elevated level in a person without a diagnosis of diabetes may not be recognized as important.

"In patients with diabetes we start the protocol to control and treat hyperglycemia during hospitalization. However, in nondiabetic patients blood glucose levels under 180 [mg/dL] and even greater, are usually overlooked. This means there is not a correct follow-up of the patients during hospitalization. After this study we learned that we need to pay attention to this population who develop hyperglycemia from the beginning," he said.

The study was limited in that patients who had previously undiagnosed diabetes couldn’t always be distinguished from those with acute ‘stress hyperglycemia.’

Progress to critical care higher with hyperglycemia

The retrospective, multicenter study was based on data from 11,312 adult patients with confirmed COVID-19 in 109 hospitals participating in Spain’s SEMI-COVID-19 registry as of May 29, 2020. They had a mean age of 67 years, 57% were male, and 19% had a diagnosis of diabetes. A total of 20% (n = 2,289) died during hospitalization.

Overall all-cause mortality was 41.1% among those with admission blood glucose levels above 180 mg/dL, 33.0% for those with glucose levels 140-180 mg/dL, and 15.7% for levels below 140 mg/dL. All differences were significant (P < .0001), but there were no differences in mortality rates within each blood glucose category between patients with or without a previous diagnosis of diabetes.

After adjustment for confounding factors, elevated admission blood glucose level remained a significant predictor of death.

A version of this article originally appeared on Medscape.com.
**CLINICAL QUESTION:** How does frailty impact survival after in-patient cardiac arrest in older adults?

**BACKGROUND:** Although average survival after in-hospital cardiac arrest is 17%-20%, many clinicians feel that survival is lower in older patients or patients with multiple comorbidities. The Clinical Frailty Scale (CFS) is a simple bedside visual tool that encapsulates patients’ mobility and functional status, with a score greater than 4 indicating frailty. How this measure of frailty correlates with outcomes after in-hospital cardiac arrest is unknown.

**STUDY DESIGN:** Retrospective review.

**SETTING:** Tertiary referral center in England.

**SYNOPSIS:** The study included patients over 60 years old who received CPR between May 2017 and December 2018. CFS was retroactive-ly applied based on available chart data. The patients’ median age was 77 years old, and 71% were male.

**RESULTS:** The patients’ median age was 77 years old, and 71% were male.

**BACKGROUND:** TXA is an anti-fibrinolytic agent that decreases surgical bleeding and reduces death resulting from bleeding in trauma and postpartum hemorrhage. A 2012 Cochrane review suggested a reduction in mortality with use of TXA in patients with GI bleed, but previous trials were small with a high risk of bias.

**STUDY DESIGN:** Randomized, double-blind, placebo-controlled trial.

**SETTING:** 164 hospitals in 15 countries.

**SYNOPSIS:** A total of 12,009 patients presenting with suspected significant upper or lower GI bleeding were randomized to receive either high-dose TXA or placebo. Death resulting from bleeding within 5 days (primary outcome) was similar in the two groups (3.7% with TXA and 3.8% with placebo; relative risk, 0.99; 95% confidence interval, 0.82-1.18). All-cause mortality at 28 days was also similar (9.5% with TXA and 9.2% with placebo; RR, 1.03; 95% CI, 0.92-1.16).

There was an increase in venous thromboembolism (VTE; deep vein thrombosis or pulmonary embolism) in the TXA group versus the placebo group (0.8% with TXA and 0.4% with placebo; RR, 1.85; 95% CI, 1.15-2.98), as well as an increase in seizure events (0.6% with TXA and 0.4% with placebo; RR, 1.73; 95% CI, 1.03-2.93).

**BOTTOM LINE:** TXA did not reduce mortality risk in patients with upper or lower GI bleeding and should not be used in the routine management of GI bleed.


**By Krishna A. Chokshi, MD**

**1 Bedside frailty assessment can determine when CPR will be nonbeneficial**

**CLINICAL QUESTION:** How does frailty impact survival after in-patient cardiac arrest in older adults?

**BACKGROUND:** Although average survival after in-hospital cardiac arrest is 17%-20%, many clinicians feel that survival is lower in older patients or patients with multiple comorbidities. The Clinical Frailty Scale (CFS) is a simple bedside visual tool that encapsulates patients’ mobility and functional status, with a score greater than 4 indicating frailty. How this measure of frailty correlates with outcomes after in-hospital cardiac arrest is unknown.

**STUDY DESIGN:** Retrospective review.

**SETTING:** Tertiary referral center in England.

**SYNOPSIS:** The study included patients over 60 years old who received CPR between May 2017 and December 2018. CFS was retroactive-ly applied based on available chart data. The patients’ median age was 77 years old, and 71% were male.

**RESULTS:** The patients’ median age was 77 years old, and 71% were male.

**BACKGROUND:** TXA is an anti-fibrinolytic agent that decreases surgical bleeding and reduces death resulting from bleeding in trauma and postpartum hemorrhage. A 2012 Cochrane review suggested a reduction in mortality with use of TXA in patients with GI bleed, but previous trials were small with a high risk of bias.

**STUDY DESIGN:** Randomized, double-blind, placebo-controlled trial.

**SETTING:** 164 hospitals in 15 countries.

**SYNOPSIS:** A total of 12,009 patients presenting with suspected significant upper or lower GI bleeding were randomized to receive either high-dose TXA or placebo. Death resulting from bleeding within 5 days (primary outcome) was similar in the two groups (3.7% with TXA and 3.8% with placebo; relative risk, 0.99; 95% confidence interval, 0.82-1.18). All-cause mortality at 28 days was also similar (9.5% with TXA and 9.2% with placebo; RR, 1.03; 95% CI, 0.92-1.16).

There was an increase in venous thromboembolism (VTE; deep vein thrombosis or pulmonary embolism) in the TXA group versus the placebo group (0.8% with TXA and 0.4% with placebo; RR, 1.85; 95% CI, 1.15-2.98), as well as an increase in seizure events (0.6% with TXA and 0.4% with placebo; RR, 1.73; 95% CI, 1.03-2.93).

**BOTTOM LINE:** TXA did not reduce mortality risk in patients with upper or lower GI bleeding and should not be used in the routine management of GI bleed.


**By Andrew Chung, MD**

**2 Tranexamic acid does not reduce risk of death in GI bleed**

**CLINICAL QUESTION:** In patients with GI bleeding, does high-dose tranexamic acid (TXA) reduce the risk of death?

**BACKGROUND:** TXA is an anti-fibrinolytic agent that decreases surgical bleeding and reduces death resulting from bleeding in trauma and postpartum hemorrhage. A 2012 Cochrane review suggested a reduction in mortality with use of TXA in patients with GI bleed, but previous trials were small with a high risk of bias.

**STUDY DESIGN:** Randomized, double-blind, placebo-controlled trial.

**SETTING:** 164 hospitals in 15 countries.

**SYNOPSIS:** A total of 12,009 patients presenting with suspected significant upper or lower GI bleeding were randomized to receive either high-dose TXA or placebo. Death resulting from bleeding within 5 days (primary outcome) was similar in the two groups (3.7% with TXA and 3.8% with placebo; relative risk, 0.99; 95% confidence interval, 0.82-1.18). All-cause mortality at 28 days was also similar (9.5% with TXA and 9.2% with placebo; RR, 1.03; 95% CI, 0.92-1.16).

There was an increase in venous thromboembolism (VTE; deep vein thrombosis or pulmonary embolism) in the TXA group versus the placebo group (0.8% with TXA and 0.4% with placebo; RR, 1.85; 95% CI, 1.15-2.98), as well as an increase in seizure events (0.6% with TXA and 0.4% with placebo; RR, 1.73; 95% CI, 1.03-2.93).

**BOTTOM LINE:** TXA did not reduce mortality risk in patients with upper or lower GI bleeding and should not be used in the routine management of GI bleed.


**By Ariel Y. Elyahu, MD**

**3 Antibiotics vs. placebo in acute uncomplicated diverticulitis**

**CLINICAL QUESTION:** Does antibiotic therapy decrease length of hospital stay for patients with acute uncomplicated diverticulitis?

**BACKGROUND:** Antibiotic therapy is considered the standard of care for acute uncomplicated diverticulitis. Over the past decade, randomized clinical trials have suggested that treatment with antibiotics may be noninferior to observation with supportive care; however, there have not been any blinded, placebo-controlled trials to provide high-quality evidence.

**STUDY DESIGN:** Placebo-controlled, double-blinded, randomized noninferiority trial.

**SETTING:** Four centers in New Zealand and Australia.

**SYNOPSIS:** Researchers randomized 180 patients hospitalized for acute uncomplicated diverticulitis with Hinchey Ia CT findings (i.e., phlegmon without abscess) into two groups treated with either antibiotics (intravenous cefuroxime and oral metronidazole followed by oral amoxicillin/clavulanic acid) or placebo for 7 days. Median lengths of stay between the antibiotic (60.0 hours) and placebo (45.8 hours) groups were not significantly different (5.9 hours difference between groups; 95% CI, -3.7 to 15.5; P = 0.2). Additionally, there were no significant differences in the secondary outcomes of readmission at 7 days and 30 days or in need for procedural intervention, mortality, pain scores at 24 hours, or change in white blood cell count.

Notably though this study was adequately powered to detect differences in length of stay, it was not powered to detect differences in clinical outcomes, including death or the need for surgery. The exclusion of patients with language barriers...
By Rex Hermansen, MD

**Apixaban noninferior to low-molecular-weight heparin in cancer-associated VTE**

**CLINICAL QUESTION:** Is oral apixaban as safe and effective as subcutaneous dalteparin in treating venous thromboembolism (VTE) in patients with underlying cancer?

**BACKGROUND:** VTE is common in patients with cancer and can lead to serious complications and death. Recently, the use of edoxaban or rivaroxaban was recommended by major guidelines for the treatment of cancer-associated VTE. Previous studies have demonstrated a higher risk of major bleeding when compared with low-molecular-weight heparin. Whether oral apixaban can be safely used in this setting is unknown.

**STUDY DESIGN:** Randomized, controlled, open-label, noninferiority clinical trial.

**SETTING:** Multinational study with patients enrolled in nine European countries, Israel, and the United States.

**SYNOPSIS:** Adult patients with confirmed cancer who had a new diagnosis of proximal lower-limb deep vein thrombosis or pulmonary embolism were enrolled in the trial. Of those enrolled, 1,170 patients underwent randomization to receive either oral apixaban twice daily or subcutaneous dalteparin once daily. The primary outcome was recurrent deep vein thrombosis or pulmonary embolism. The principal safety outcome was major bleeding. Researchers followed patients for 7 months after randomization. The primary outcome occurred in 32 of 576 patients (5.6%) in the apixaban group and 46 of 579 patients (7.9%) in the dalteparin group (hazard ratio, 0.63; 95% CI, 0.37-1.07). Major bleeding occurred in 22 patients (3.8%) in the apixaban group and 23 patients (4.0%) in the dalteparin group (HR, 0.82; 95% CI, 0.40-1.69). Limitations were the open-label trial design, the exclusion of patients with primary brain tumors, cerebral metastases, or acute leukemia, and the sample size being powered for the primary outcome, rather than to allow definitive conclusions about bleeding. Additionally, long-term data are needed as patients were followed for only 7 months.

**BOTTOM LINE:** Apixaban was noninferior to subcutaneous dalteparin for the treatment of VTE in patients with cancer and did not increase bleeding.


By Michael Herscher, MD

**Compression therapy prevents recurrence of cellulitis**

**CLINICAL QUESTION:** Do compression garments prevent recurrent cellulitis in patients with lower-extremity edema?

**BACKGROUND:** Recurrent cellulitis is a common condition in patients with lower-extremity edema. Although some clinicians recommend compression garments as a preventative treatment, there are no data evaluating their efficacy for this purpose.

**STUDY DESIGN:** Participants were randomized to receive either education alone or education plus compression therapy. Neither the participants nor the assessors were blinded to the treatment arm.

**SETTING:** Single-center study in Australia.

**SYNOPSIS:** Participants with cellulitis who also had at least two previous episodes of cellulitis in the previous 2 years and had lower-extremity edema were enrolled. Of participants, 84 were randomized. Both groups received education regarding skin care, body weight, and exercise, while the compression therapy group also received compression garments and instructions for their use. The primary outcome was recurrent cellulitis. Patients in the control group were allowed to cross over after an episode of cellulitis. The trial was stopped early for efficacy. At the time the trial was halted, 17 of 43 (40%) participants in the control group had recurrent cellulitis, compared with only 6 of 41 (15%) in the intervention (hazard ratio, 0.23; 95% CI, 0.09-0.59; P = .002). Limitations include the lack of blinding, which could have introduced bias, although the diagnosis of recurrent cellulitis was made by clinicians external to the trial. This study supports the use of compression garments in preventing recurrent cellulitis in patients with lower-extremity edema.

**BOTTOM LINE:** Compression garments can be used to prevent recurrent cellulitis in patients with edema.

continued from previous page

RRT is unclear. There are potential advantages to performing early RRT in patients with severe AKI, such as restoring acid-base balance, preventing fluid accumulation, and preventing major electrolyte disturbances.

**STUDY DESIGN:** Multinational, randomized, controlled trial.

**SETTING:** 188 hospitals in 15 countries.

**SYNOPSIS:** Eligible patients were adults admitted to an ICU with severe AKI. Patients were randomly assigned to an accelerated strategy of RRT (initiated within 12 hours, 1,465 patients) or a standard strategy of RRT (held until conventional indications developed or AKI lasted more than 72 hours, 1,462 patients). RRT was performed in 1,418 (96.8%) in the accelerated group and 903 (61.8%) in the standard group. At 90 days, 643 deaths (43.9%) occurred in the accelerated group and 639 deaths (43.7%) occurred in the standard group (RR, 1.00; 95% CI, 0.93-1.09). Among survivors at 90 days, 85 out of 814 accelerated patients (10.4%) and 49 of 815 standard patients (6.0%) continued to require RRT (RR, 1.75; 95% CI, 1.24-2.43), suggesting the possibility of increased dependence on long-term RRT if introduced early. Limitations include use of clinical equipoise to confirm full eligibility, introducing possible patient heterogeneity into the trial. In addition, broad discretion was given to clinicians on when to start RRT in the standard group resulting in variable initiation times.

**BOTTOM LINE:** In critically ill patients with severe AKI, earlier RRT did not result in lower mortality at 90 days compared with standard therapy and increased the risk of requiring RRT at 90 days.


---

**By Amit S. Narayan, MD**

**Apixaban a reasonable alternative to warfarin in patients with severe renal impairment**

**CLINICAL QUESTION:** Is apixaban a safe alternative to warfarin in patients with severe renal impairment?

**BACKGROUND:** Over 6 million Americans are prescribed anticoagulation; however, available anticoagulation options for patients with concomitant renal impairment are limited. Until recently, warfarin was the only recommended option because of a lack of data to support the use of alternative agents in such patients. This study evaluates the safety and effectiveness of apixaban, compared with warfarin, in patients with severe renal dysfunction.

**STUDY DESIGN:** Multicenter retrospective cohort study.

**SETTING:** Seven hospitals in Michigan between January 2013 and December 2015 and including adult patients with CrCl less than 25 cc/min who were newly initiated on apixaban or warfarin.

**SYNOPSIS:** Patients in the apixaban group (n=128) had a higher rate of heart failure, atrial fibrillation, stent placement, and hyperlipidemia, while the warfarin group (n=733) had a higher rate of prior venous thromboembolism. The primary outcome was time to first bleeding or thrombotic event. Apixaban was associated with a lower risk of thrombotic or bleeding events, compared with warfarin (HR, 0.47). Post-hoc analysis controlling for patient differences showed similar results. There was no statistical difference in the severity of events or overall mortality. Further subgroup analysis showed that 5 mg B.I.D. dosing was not associated with higher risk of bleeding than 2.5 mg B.I.D.

The main limitation is the retrospective observational design, which may have introduced confounding variables that were not accounted for in the analyses. The study also did not account for patient nonadherence to medication.

**BOTTOM LINE:** Apixaban is a reasonable alternative to warfarin in patients with severe renal impairment.


---

**By Elizabeth Yoo, MD**

**Oral step-down therapy for infective endocarditis**

**CLINICAL QUESTION:** What is oral step-down therapy’s relative clinical effectiveness, compared with prolonged IV antibiotics for infective endocarditis (IE)?

**BACKGROUND:** The standard of care for IE has been a prolonged course of IV antibiotics. Recent literature has suggested that oral antibiotics might be a safe and effective step-down therapy for IE.

**STUDY DESIGN:** Systematic review.

**SETTING:** Literature review in October 2019, with update in February 2020, consisting of 3 randomized controlled trials.

**SYNOPSIS:** Three RCTs and 21 observational studies were reviewed, with a focus on the effectiveness of antibiotics administered orally for part of the therapeutic course for IE patients. Patients included in the study had left- or right-sided IE. Pathogens included viridans streptococci, staphylococci, and enterococci, with a minority of patients infected with methicillin-resistant Staphylococcus aureus. Treatment regimens included beta-lactams, linezolid, fluoroquinolones, trimethoprim-sulfamethoxazole, or clindamycin, with or without rifampin.

In studies wherein IV antibiotics alone were compared with IV antibiotics with oral step-down therapy, there was no difference in clinical cure rate. Those given oral step-down therapy had a statistically significant lower mortality rate than patients who received only IV therapy.

Limitations include inconclusive data regarding duration of IV lead-in therapy, with the variance before conversion to oral antibiotics amongst the studies ranging from 0 to 24 days. The limited number of patients with MRSA infections makes it difficult to draw conclusions regarding this particular pathogen.

**BOTTOM LINE:** Highly orally bioavailable antibiotics should be considered for patients with IE who have cleared bacteremia and achieved clinical stability with IV regimens.

Spanish survey of COVID-19 patients suggests that upper gastrointestinal bleeding (UBG) does not affect in-hospital mortality. It also found that fewer COVID-19–positive patients underwent endoscopies, but there was no statistically significant difference in in-hospital mortality outcome as a result of delays.

"In-hospital mortality in COVID-19 patients with upper GI bleeding seemed to be more influenced by COVID-19 than by upper GI bleeding, and that’s something I think is important for us to know," Gyanprakash Ketwaroo, MD, associate professor at Baylor College of Medicine, Houston, said in an interview. Dr. Ketwaroo was not involved in the study.

The results weren’t a surprise, but they do provide some reassurance. "Initially, we thought there might be some COVID-19–related [GI] lesions, but that didn’t seem to be borne out. So we thought the bleeding was related to [the patient] being in a hospital or the typical reasons for bleeding. It’s also what I expected that less endoscopies would be performed in these patients, and even though fewer endoscopies were performed, the outcomes were still similar. I think it’s what most people expected," said Dr. Ketwaroo.

The study was published online in the Journal of Clinical Gastroenterology (2020 Nov. doi: 10.1097/MCG.0000000000001465), and led by Rebeca González González, MD, of Severo Ochoa University Hospital in Leganés, Madrid, and Pascual Piñera-Salmerón, MD, of Reina Sofia University General Hospital in Murcia, Spain. The researchers retrospective-ly analyzed data on 71,904 COVID-19 patients at 62 emergency departments in Spain, and compared 83 patients who had COVID-19 and UGB to two control groups: 249 randomly selected COVID-19 patients without UGB, and 249 randomly selected non-COVID-19 patients with UGB.

They found that 1.11% of COVID-19 patients presented with UGB, compared with 1.78% of non–COVID-19 patients at emergency departments. In patients with COVID-19, risk of UGB was associated with hemoglobin values <10 g/L (odds ratio, 3.455, 95% confidence interval, 1.275-9.202), abdominal pain (OR, 11.4; 95% CI, 5.092-25.944), and systolic blood pressure <90 mm Hg (OR, 11.096; 95% CI, 2.975-41.390).

Compared with non–COVID-19 patients with UGB, COVID-19 patients with UGB were more likely to have interstitial lung infiltrates (OR, 66.42; 95% CI, 15.364-287.223) and ground-glass opacities (OR, 21.27; 95% CI, 9.720-46.567) in chest radiograph, as well as fever (OR, 34.67; 95% CI, 11.740-102.572) and cough (OR, 26.4; 95% CI, 8.845-78.806).

Gastroscopy and endoscopic procedures were lower in patients with COVID-19 than in the general population (gastroscopy OR, 0.269; 95% CI, 0.160-0.453; endoscopy OR, 0.26; 95% CI, 0.165-0.623). There was no difference between the two groups with respect to endoscopic findings. After adjustment for age and sex, the only significant difference between COVID-19 patients with UGB and COVID-19 patients without UGB was a higher rate of intensive care unit admission (OR, 2.98; 95% CI, 1.16-7.65). Differences between COVID-19 patients with UGB and non–COVID-19 patients with UGB included higher rates of ICU admission (OR, 3.29; 95% CI, 1.28-8.47), prolonged hospitalizations (OR, 2.02; 95% CI, 1.15-3.55), and in-hospital mortality (OR, 2.05; 95% CI, 1.09-3.86).

UBG development was not associated with increased in-hospital mortality in COVID-19 patients (OR, 1.14; 95% CI, 0.59-2.19).

A limitation to the study is that it was performed in Spain, where endoscopies are performed in the emergency department, and where there are different thresholds for admission to the intensive care unit than in the United States.
Pediatric HM highlights from the 2020 State of Hospital Medicine Report

By Sandra Gage, MD, PhD, SFHM, FAAP

To improve the pediatric data in the State of Hospital Medicine (SoHM) Report, the Practice Analysis Committee (PAC) developed a pediatric task force to recommend content specific to pediatric practice and garner support for survey participation. The pediatric hospital medicine (PHM) community responded with its usual enthusiasm, resulting in a three-fold increase in PHM participation (99 groups), making the data from new PHM tasks more meaningful for pediatric practices.

However, data collection for the 2020 SoHM Report concluded in February, just before the face of medical practice and hospital care changed dramatically. A recent report at the virtual Pediatric Hospital Medicine meeting stated that pre-COVID-19 hospital operating margins had already shown a significant decline (from 5% to 2%-3%), putting pressure on pediatric programs in community settings that typically do not generate much revenue. After COVID-19, hospital revenues took an even greater downturn, affecting many hospital-based pediatric programs. While the future direction of many PHM programs remains unclear, the robust nature of the pediatric data in the 2020 SoHM Report defines where we were and where we once again hope to be.

In addition, the PAC conducted a supplemental survey designed to assess the impact of COVID-19 on the practice of hospital medicine. Here’s a quick review of PHM highlights from the 2020 SoHM Report, with preliminary findings from the supplemental survey.

Diversity of service and scope of practice: Pediatric hospitalist programs continue to provide a wide variety of services beyond care on inpatient wards, with the most common being procedure performance (56.6%), care of healthy newborns (51.5%), and rapid response team (38.4%) coverage. In addition, most PHM programs have a role in care of patients admitted to general surgery, orthopedic surgery, and other surgical subspecialties.

The role for comanagement with medical specialties remains diverse, with PHM programs routinely having a role in caring for patients hospitalized for neurologic, gastroenterological, cardiac concerns, and others (see graphic below). With the recent decline in hospital revenues affecting PHM practices, one way to ensure program value is to continue to diversify. Based on data from the 2020 SoHM report, broadening of clinical coverage will not require a significant change in practice for most PHM programs.

PHM board certification: With the first certifying exam for PHM taking place just months before SoHM data collection, the survey sought to establish a baseline percentage of providers board certified in PHM. With 98 groups responding, an average of 26.4% of PHM practitioners per group were reported to be board certified. While no difference was seen based on academic status, practitioners in PHM programs employed by a hospital, health system, or integrated delivery system were much more likely to be board certified than those employed by a university or medical school (31% vs. 20%). Regional differences were noted as well, with the East region reporting a much higher median proportion of PHM-certified physicians. It will be interesting to watch the trend in board certification status evolve over the upcoming years.

Anticipated change of budgeted full-time equivalents in the next year/post-COVID-19 analysis: Of the PHM programs responding to the SoHM Survey, 46.5% predicted an increase in budgeted full-time equivalents in the next year, while only 5.1% anticipated a decrease. Expecting this to change in response to COVID-19, the supplemental survey sought to update this information. Of the 30 PHM respondents to the supplemental survey, 41% instituted a temporary hiring freeze because of COVID-19, while 8.3% reported a hiring freeze felt likely to be permanent. As PHM programs gear up for the next viral season, we wait to see whether the impact of COVID-19 will continue to be reflected in the volume and variety of patients admitted. It is clear that PHM programs will need to remain nimble to stay ahead of the changing landscape of practice in the days ahead. View all data by obtaining access to the 2020 SoHM Report at hospitalmedicine.org/sohm.

Many thanks to pediatric task force members Jack Percelay, MD; Vivien Kon-Ea Sun, MD; Marcos Mestre, MD; Ann Allen, MD; Dimple Khona, MD; Jeff Grill, MD; and Michelle Marks, MD.
MASSACHUSETTS
Hospitalist Position Available

Come join our well established hospitalist team of dedicated hospitalist at Emerson Hospital located in historic Concord, Massachusetts. Enjoy living in the suburbs with convenient access to metropolitan areas such as Boston, New York and Providence as well as the mountains, lakes and coastal areas.

Opportunities available for part-time nocturnist and moonlighting positions, just 25 minutes from Boston.

A great opportunity to join a well established program.

- Manageable daily census
- Flexible scheduling to ensure work life balance
- Dedicated nocturnist program
- Intensivists coverage of critical care unit
- Competitive compensation and bonus structure
- Access to top specialty care

For more information please contact:
Diane M Forte, Director of Physician Recruitment and Relations
978-287-3002, dforte@emersonhosp.org

Not a J of H opportunity
Ochsner Health is seeking physicians to join our hospitalist team. BC/BE Internal Medicine and Family Medicine physicians are welcomed to apply. Highlights of our opportunities are:

- Hospital Medicine was established at Ochsner in 1992.
- We have a stable 50+ member group.
- 7 on 7 off block schedule with flexibility
- Dedicated nocturnists cover nights
- Base plus up to 40 K in incentives
- Average census of 14-18 patients
- E/ICU intensivist support with open ICUs at the community hospitals
- EPIC medical record system with remote access capabilities
- Dedicated RN and Social Work Clinical Care Coordinators
- Community based academic appointment
- The only Louisiana Hospital recognized by U.S. News and World Report Distinguished Hospital for Clinical Excellence award in 3 medical specialties
- Co-hosts of the annual Southern Hospital Medicine Conference
- We are a medical school in partnership with the University of Queensland providing clinical training to third and fourth year students.
- Leadership support focused on professional development, quality improvement, and academic committees & projects
- Opportunities for leadership development, research, resident and medical student teaching
- Skilled nursing and long term acute care facilities seeking hospitalists and mid-levels with an interest in geriatrics
- Paid malpractice coverage and a favorable malpractice environment in Louisiana
- Generous compensation and benefits package

Ochsner Health is a system that delivers health to the people of Louisiana, Mississippi and the Gulf South with a mission to Serve, Heal, Lead, Educate and Innovate. Ochsner Health is a not-for-profit committed to giving back to the communities it serves through preventative screenings, health and wellness resources and partnerships with innovative organizations that share our vision. Ochsner Health healed more than 876,000 people from across the globe in 2019, providing the latest medical breakthroughs and therapies, including digital medicine for chronic conditions and telehealth specialty services. Ochsner Health is a national leader, named the top hospital in Louisiana and a top children’s hospital by U.S. News & World Report. As Louisiana’s leading healthcare educator, Ochsner Health and its partners educate thousands of healthcare professionals annually. Ochsner Health is innovating healthcare by investing in new technologies and research to make world-class care more accessible, affordable, convenient and effective. Ochsner’s team of more than 26,000 employees and 4,500 providers are working to reinvent the future of health and wellness in the region. To learn more about Ochsner Health, please visit www.ochsner.org. To transform your health, please visit www.ochsner.org/healthyyou.

Interested physicians should apply to:

Sorry, no opportunities for J1 applications.

Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law.
Hospitalist Opportunities

Gorgeous Lakes, Ideal Climate, Award-winning Downtown

Inspire health. Serve with compassion. Be the difference.

Prisma Health-Upstate employs 16,000 people, including 1,200+ physicians on staff. Our system includes clinically excellent facilities with 1,627 beds across 8 campuses. Additionally, we host 19 residency and fellowship programs and a 4-year medical education program: University of South Carolina School of Medicine–Greenville, located on Prisma Health-Upstate’s Greenville Memorial Medical Campus. Prisma Health-Upstate also has developed a unique Clinical University model in collaboration with the University of South Carolina, Clemson University, Furman University, and others to provide the academic and research infrastructure and support needed to become a leading academic health center for the 21st century.

Greenville, South Carolina is a beautiful place to live and work and is located on the I-85 corridor between Atlanta and Charlotte and is one of the fastest growing areas in the country. Ideally situated near beautiful mountain ranges, beaches and lakes, we enjoy a diverse and thriving economy, excellent quality of life and wonderful cultural and educational opportunities. Check out all that Greenville, SC has to offer! #yeahTHATgreenville

Ideal Candidates:

- BC/BE Internal Medicine Physicians
- IM procedures highly desired, but not required. Simulation center training & bedside training available if needed.
- Comfort managing critically ill patients.

Details Include:

- Group comprised of career hospitalists with low turnover
- Relocation allowance available
- EPIC Electronic Medical Record system
- 7 on/7 off schedule with 1 week of vacation per year
- Additional shifts paid at a premium

Available Opportunities:

Nocturnist, Laurens County Hospital
- $360K base salary with $10K incentive bonus and a yearly $5K CME stipend
- Up to $50K sign on bonus for a 4 year commitment

Nocturnist, Baptist Easley Hospital
- $340K base salary with $10K incentive bonus and CME stipend
- Up to $40K sign on bonus

Nocturnist or Traditional Hospitalist, Oconee Memorial Hospital
- $278K base salary with 40K incentive bonus and CME stipend for Traditional Hospitalist
- $340K base salary with $10K incentive bonus and CME stipend for Nocturnist
- Up to $40K sign on bonus

*Public Service Loan Forgiveness (PSLF) Program Qualified Employer*
Please submit a letter of interest and CV to:
Natasha Durham, Physician Recruiter,
Natasha.Durham@PrismaHealth.org, ph: 864-797-6114

To learn more, visit www.the-hospitalist.org and click “Advertise” or contact
Heather Gonroski • 973-290-8259 • hgonroski@mdedge.com or
Linda Wilson • 973-290-8243 • lwilson@mdedge.com
Leading hospitals during a pandemic

By Weijen W. Chang, MD, SFHM, FAAP

As I write this, we are entering the third surge of the COVID-19 pandemic, with new cases, hospitalizations, and deaths from COVID-19 skyrocketing around the country. Worst of all, this surge has been most severely affecting areas of the nation least prepared to handle it (rural) and populations already marginalized by the health care system (Latinx and Black). Despite the onslaught of COVID-19, “pandemic fatigue” has begun to set in amongst colleagues, friends, and family, leading to challenges in adhering to social distancing and other infection-control measures, both at work and home.

In the face of the pandemic’s onslaught, hospitalists — who have faced the brunt of caring for patients with COVID-19, despite the absence of reporting about the sub-specialty’s role — are faced with muddling the grit to respond with resolve, coordinated action, and empathy. Luckily, hospitalists are equipped with the very characteristics needed to lead teams, groups, and hospitals through the crisis of this pandemic. Ask yourself, why did you become a hospitalist? If you wanted steady predictability and control, there were many office-based specialties you could have chosen. You chose to become a hospitalist because you seek the challenges of clinical variety, problem-solving, systems improvement, and you are a natural team leader, whether you have been designated as such or not. In the words of John Quincy Adams, “if your actions inspire others to dream more, learn more, do more, and become more, you are a leader.”

As a leader, how can you lead your team through the series of trials and tribulations that this year has thrown at you? From COVID-19 to racism directed against Black and Latinx people to the behavioral health crisis, 2020 has likely made you feel as if you’re stuck in a ghoulish carnival fun house without an exit.

Yet this is where some leaders hit their stride, in what Bennis and Thomas describe as the “crucible of leadership.” There are many types of “crucibles of leadership,” according to Bennis and Thomas, and this year has thrown most of these at us: prejudice/bias, physical fatigue and illness, sudden elevation of responsibility to lead new processes, not to mention family stressors. Leaders who succeed in guiding their colleagues through these challenges have manifested critical skills: engaging others in shared meaning, having a distinctive and compelling voice, displaying integrity, and having adaptive capacity.

What exactly is adaptive capacity, the most important of these, in my opinion? Adaptive capacity requires understanding the new context of a crisis and how it has shifted team members’ needs and perceptions. It also requires what Bennis and Thomas call “hardiness” and what I call grit — the ability to face adversity, get knocked down, get up, and do it again.

There is probably no better example of a crisis leader with extraordinary adaptive capacity than Anglo-Irish explorer Sir Ernest Shackleton. Bitten by the bug of exploration, Shackleton failed at reaching the South Pole (1908-1909) but subsequently attempted to cross the Antarctic, departing South Georgia Island on Dec. 5, 1914..Depressingly for Shackleton, his ship, the Endurance, became stuck in sea ice on Jan. 19, 1915, before even reaching the continent. Drifting with the ice floe, his crew had set up a winter station hoping to be released from the ice later, but the Endurance was crushed by the pressure of sea ice and sank on Nov. 21, 1915. From there, Shackleton hoped to drift north to Paulet Island, 350 miles away, but eventually was forced to take his crew on lifeboats to the nearest land, Elephant Island, 346 miles from where the Endurance sank. He then took five of his men on an open boat, 828-mile journey to South Georgia Island. Encountering hurricane-force winds, the team landed on South Georgia Island 15 days later, only to face a climb of 32 miles over mountainous terrain to reach a whaling station. Shackleton eventually organized his men’s rescue on Elephant Island, reaching them on Aug. 30, 1916, 4½ months after he had set out for South Georgia Island. His entire crew survived, only to have two of them killed later in World War I.

You might consider Shackleton a failure for not even coming close to his original goal, but his success in saving his crew is regarded as the epitome of crisis leadership. As Harvard Business School professor Nancy F. Koehn, PhD, whose case study of Shackleton is one of the most popular at HBS, stated, “He thought he was going to be an entrepreneur of exploration, but he became an entrepreneur of survival.” Upon realizing the futility of his original mission, he pivoted immediately to the survival of his crew. “A man must shape himself to a new mark directly the old one goes to ground,” wrote Shackleton in his diary.

Recognizing that preserving his crew’s morale was critical, he maintained the crew’s everyday activities, despite the prospect of dying on the ice. He realized that he needed to keep up his own courage and confidence as well as that of his crew. Despite his ability to share the strategic focus of getting to safety with his men, he didn’t lose sight of day-to-day needs, such as keeping the crew entertained. When he encountered crew members who seemed problematic to his mission goals, he assigned them to his own tent.

Despite the extreme cold, his decision-making did not freeze — he acted decisively. He took risks when he thought appropriate, twice needing to abandon his efforts to drag a lifeboat full of supplies with his men toward the sea. “You can’t be afraid to make smart mistakes,” says Dr. Koehn. “That’s something we have no training in.” Most importantly, Shackleton took ultimate responsibility for his men’s survival, never rest-

References
The importance of community pediatric hospital medicine

By Gregory Welsh, MD, FAAP

According to data from the American Academy of Pediatrics, over 2,000 physicians – or approximately 70% of all physicians practicing pediatric hospital medicine – do so in a community hospital. Like all areas of hospital medicine, community pediatric hospital medicine (CPHM) strives to fulfill one of our field’s central tenets – providing high-quality, evidence-based care to our patients.

A phrase often used among CPHM practitioners is that, “if you’ve seen one CPHM program, you’ve seen one CPHM program.” Every CPHM program is different. While this phrase may seem rather simplistic, it quite accurately portrays a unique aspect of our place in the hospital medicine field. CPHM programs usually require their practitioners to perform a broader range of roles and responsibilities than our colleagues who practice in university or children’s hospitals. Typically, these roles are aligned with the unique needs of each hospital within which we practice and the communities we serve. Factors such as the distance to a tertiary care referral center, access to subspecialists, availability and expertise of ancillary services for children, and the particular needs of each community further shape the role that CPHM practitioners may be asked to play.

In 2014, the American Academy of Pediatrics section on hospital medicine’s subcommittee on community hospitalists surveyed all CPHM programs to understand the unique roles that practitioners play within their institutions. Under the leadership of Clota Snow, MD, and Jacques Corriveau, MD, the aim was to contact every hospital in the country using the American Hospital Directory to see if they had a PHM program and to identify what roles the program was responsible for within their hospital. Of the 535 programs identified, the primary responsibilities included inpatient care (85%), ED consultations (76%), and newborn nursery care (73%). Other common roles not typically associated with a university-based hospitalist’s responsibilities included delivery room attendance/neonatal resuscitations (44%), neonatal ICU management (47%), and subspecialty or surgical comanagement (52%). In some communities, even pediatric ICU management, sedation, and patient transport are part of our role. Because of the large breadth of roles that a CPHM practitioner may cover, we have often been referred to as “pediatric hospital-based generalists.”

“A career in CPHM provides physicians with the opportunity to work together with a close-knit group to provide exceptional care for children and to advocate for the medical needs of children in their hospital and their community.”

Ideally, the presence of a pediatric hospitalist in a community hospital allows children to obtain high-quality, evidence-based care within their home communities. Most hospitalized children do not require direct access to subspecialists or all the pediatric-specific resources only available within a university or children’s hospital. Thus, if these resources are not required for the child’s care, CPHM practitioners can provide the care that a child needs in a setting that is less disruptive to the family and typically more cost effective.

CPHM physicians are often drawn to a career in a community hospital because it allows them to use their entire skill set to care for children with a wide variety of conditions. As they are often the only physicians in an adult hospital with a full understanding of the unique aspects of care that children require, it is important that they be comfortable in their role of managing the majority of pediatric care independently. Yet they also need to understand the limitations of their own ability, as well as their institution’s level of expertise in pediatric-specific care. They must be confident and vocal advocates for pediatric-specific needs throughout their institution and its numerous committees, and form close working relationships with colleagues and administrators in the different fields with whom we share care of our patients (e.g., ED, obstetrics, radiology, trauma, and other medical and surgical subspecialties).

CPHM physicians are particularly well suited to partner with local outpatient providers as well as tertiary care physicians to provide coordinated transitions between the inpatient and outpatient management of a child’s illness. In addition, a CPHM physician can often bring a unique and valuable perspective of the particular ethnic, cultural, and socioeconomic diversity of their community, as well as its available resources, to facilitate a greater level of engagement with the child’s needs and ultimate success of their care.

The 2014 survey of CPHM programs identified several major challenges to recruitment and career satisfaction as a CPHM physician. These include a lack of access to subspecialists, a lack of pediatric-specific ancillary services and the perception that our importance as community hospital providers was not valued as much in the PHM community as PHM physicians working in a university/children’s hospital setting. With the recent recognition of PHM as an official subspecialty by the American Board of Pediatrics, the concern has intensified within our field that a two-tiered system will develop with some PHM physicians being board certified and others not.

While the development of board subspecialization was not meant to limit the pool of providers available to staff community hospital sites, there is nowhere near the number of fellowship-trained physicians to provide an adequate workforce to staff CPHM programs. This means that many CPHM physicians will not be board certified in pediatric hospital medicine but does not mean that CPHM programs will be unable to provide high-quality local care that benefits children and their families, including safe care for children who require the skills that an immediately available CPHM physician can provide.

Many pediatric residency programs do not currently provide their trainees with exposure to community hospital medicine. Further, with increased sub-specialization throughout pediatrics, fewer residents are developing the necessary skill set to perform roles integral to a caring for children in community hospitals such as stabilization of a critically ill child prior to transport and complex neonatal resuscitation.

A career in CPHM provides physicians with the opportunity to work together with a close-knit group to provide exceptional care to children and to advocate for the medical needs of children in their hospital and their community. The AAP’s subcommittee has made it a priority to continue educating training programs about why a career in CPHM is exciting, fulfilling and a great life, as well as continuing to educate training programs at every level – as well as the larger PHM community – about why CPHM is a valuable and important part of pediatric medicine.
This advertisement is not available for the digital edition.