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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

Dr. Ndidi Unaka, hospitalist and associate program director of the pediatric residency training program at Cincinnati Children’s Hospital



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SURVEY INSIGHTS

Sandra Gage, MD, PhD, SFHM, FAAP

p22 Pediatric highlights from the 2020 SoHM.

EDITOR’S DESK

Weijen Chang, MD, SFHM, FAAP

p26 Leading hospitalists during a pandemic.

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Hospitalist 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 Graduate 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.

Ezinne 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 420 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.



Dr. Steinberg



Dr. Sheehy

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**The
Hospitalist**

'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.



Dr. Sitammagari

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, videocon-



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ferencing gear, and a remote-monitoring kit that included a blood pressure cuff, a pulse oximeter, and a thermometer.

Dedicated hospitalists and nurses managed pa-

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

tients 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.

Few patients go to hospital

Overall, patients had a median length of stay of 11 days in the VOU or the VACU or both. The vast majority, 1,293 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 160 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-

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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. Sitamagari 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 VACU 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 case 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, iEnroll, 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 lifetime runner, with many analogies and applications to leadership.

Some people ask me why I run. “You must get a runner’s high.” The truth is, I have never had a runner’s high. I feel every step. In fact, the very nature of running makes a person feel like they are being pulled

under water. Runners are typically tachycardic and short of breath the whole time they are running. But running allows you to ignore some of the signals your body is sending, and completely focus on other things. I often have my most creative and innovative thoughts while running. Here are a few things that running and leadership have in common – and how lessons learned can translate between the two:

They are both really hard. As I mentioned above, running literally makes you feel like you are drowning. But when you finish running, it is amazing how easy everything else feels! Similar to leadership, it should 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



Dr. Scheurer is chief quality officer and professor of medicine at the Medical University of South Carolina, Charleston. She is president of SHM.

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 for 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.”

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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,¹⁻⁴ 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 deper-

sonalization, has shown good correlation with the full Maslach Burnout Inventory.⁷ 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,^{8,9} 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 outline 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 commitments⁵

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

Mapping the charter of well-being to Lean Management⁵

Societal commitments		
Charter principle	Lean philosophy	Division goal and intervention
Supportive culture and policies	"Kaizen," "Going to the Gemba"	Use Lean as a tool to optimize well-being in the division of hospital medicine
Organizational commitments		
Supportive systems	Sort, Set in order, Shine, Standardize, Sustain ("5S")	Optimize workspace using 5S with new workstations and power standing desks Improve communication and access to policies through mobile and cloud-based platforms
	Automated method to prevent any possible errors ("Mistake Proofing")	Optimize schedule to improve balance of predictability and flexibility Eliminate mandatory moonlighting and reduce clinical back-up pool activations through increased physician staffing
	Identifying areas of value-added time and waste, designing future state ("Value Stream")	Optimize workflow of clinical shifts to eliminate waste (waiting, minimizing nonclinical tasks, etc.)
	Standard work	Create a template for safe and efficient patient handoffs
Develop leadership engagement	Root-cause analysis and solutions ("A3 Thinking," "PDSA")	Create a transparent forum to discuss challenges and brainstorm solutions Guide academic growth of faculty by promoting faculty development
Optimizing highly functional interprofessional teams	Identifying value added time and waste, designing future state	Maximize efficiency and streamline communication in multidisciplinary rounds
Interpersonal and individual commitments		
Anticipate and respond to inherent challenges	No direct parallel	Provide a forum to discuss clinical and emotional aspects of caring for patients through case conferences, Schwartz rounds
Practice and promote self care	No direct parallel	Incorporate well-being topics into divisional meetings
Prioritize mental health	No direct parallel	Educate faculty about existing resources (Faculty and staff assistance program)

Source: Dr. Sanyal-Dey, Dr. Thomas, Dr. Chia

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thin staffing margin when expected personal leave and reductions in clinical effort occur. Furthermore, we revised scheduling principles to balance patient continuity and individual time-off requests while setting limits on the maximum duration of clinical stretches and instituting mandatory minimum time off between them.

We initiated monthly operations meetings as a forum to discuss challenges, brainstorm solutions, and message new initiatives with group input. For example, as a result of these meetings, we designed and implemented an additional service line to address the high census, revised the distribution of new patient admissions to level-load clinical shifts, and established a maximum number of weekends worked per month and year.

This approach aligns with recommendations to use participatory leadership strategies to enhance physician well-being.¹⁰ Engaging both executive level and service level management to focus on burnout and other related well-being metrics is necessary for sustaining such work.

We revised multidisciplinary rounds with social work, utilization management, and physical therapy to maximize efficiency and streamline communication by developing standard approaches for each patient presentation.

Interpersonal, individual commitments⁵

Emotional challenges of physician work

Although these commitments did not have a direct corollary with Lean philosophy, some of these needs were identified by our physician group at

our annual retreats. As a result, we initiated a monthly faculty-led noon conference series focused on the clinical challenges of caring for vulnerable populations, a particular source of distress in our practice setting, and revised the division schedule to encourage attendance at the hospital's Schwartz rounds.

Mental health and self-care

We organized focus groups and faculty development sessions on provider well-being and burnout and dealing with challenging patients and invited the Faculty and Staff Assistance Program, our institution's mental health service provider, to our weekly division meeting.

Future directions

After using Lean Management as an approach to prospectively improve physician well-being, we were able to use the Charter on Physician Well-Being retrospectively as a "checklist" to identify additional gaps for targeted intervention to ensure all commitments are sufficiently addressed.

Overall, we found that, not surprisingly, Lean Management aligned best with the organizational commitments in the charter. Reviewing the organizational commitments, we found our biggest remaining challenges are in building supportive systems, namely ensuring sustainable workloads, offloading and delegating non-physician tasks, and minimizing the burden of



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documentation and administration.

Reviewing the societal commitments helped us to identify opportunities for future directions that we may not have otherwise considered. As a safety-net institution, we benefit from a strong sense of mission and shared values within our hospital and division. However, we recognize the need to continue to be vigilant to ensure that our physicians perceive that their own values are aligned with the division's stated mission. Devoting a Kaizen-style retreat to well-being likely helped, and allocating divisional resources

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Racism in medicine

Continued from page 1

"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."



Dr. Johnson

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 Ndid 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



Dr. Kara

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 causes 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 prac-

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to a well-being committee indirectly helped, to foster a culture of well-being; however, we could more deliberately identify local policies that may benefit from advocacy or revision. Although our faculty identified interventions to improve interpersonal and individual drivers of well-being, these charter commitments did not have direct parallels in Lean philosophy, and organizations may need to deliberately seek to address these commitments outside of a Lean approach. Specifically, by reviewing the charter, we identified opportunities to provide additional resources for peer support and protected time for mental health care and self-care.

Conclusion

Lean Management can be an effective strategy to address many of the organizational commitments outlined in the Charter on Physician Well-Being. This approach may be particularly effective for solving local challenges with systems and workflows. Those who use Lean as a primary method to approach systems improvement in support of the Quadruple Aim may need to use additional strategies to address soci-

etal and interpersonal and individual commitments outlined in the charter.

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

“When we can evaluate for unconscious bias and factor in that diverse groups tend to have better outcomes, whether it’s business or clinical outcomes, it’s one of the opportunities that we collectively have in the specialty to improve what we’re delivering for hospitals and, more importantly, 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 clinician. Sometimes it’s blatant; often it’s subtle.

A common, recurring example Dr. Unaka has experienced in the clinician to clinician relationship is being confused with other Black physicians, making her feel invisible. “The everyday verbal, nonverbal, and environmental 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 professional 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 discrimination 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 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 training, Dr. Johnson was informed that his colleagues were watching him because they were not sure about his clinical skills. The fact that he was a former chief resident and board certified in two specialties did not seem to make any difference.

Patients refusing care from UIM physicians or expressing disapproval – 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 clinician to patient relationship, which research clearly shows contributes to health disparities.³ 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 inequities. “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 different 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 pointed to several examples: research showing that race concordance between patients and providers in an emergency department setting led to better pain control with fewer analgesics;⁴ the high maternal and infant mortality rates amongst Black women and children;⁵ evidence of poorer outcomes in sepsis patients with limited English proficiency.⁶ “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, purposeful work in progress. But it is work that is critical for everyone, and certainly necessary for those who care for their 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 Medicine and associate director of education at IU Center for Global Health. “We know that minoritized patients are going to need more attention,



Dr. Baenzinger

more advocacy, more sensitivity, and more creative solutions in order 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 hospitalists need to embrace creative approaches that can better serve the specific needs of patients. Equitable practices should be the default, which means data transparency, thoroughly dissecting hospital processes to find existing inequities, giving stakeholders – especially patients and families of color – a voice, and tearing down oppressive systems that contribute to poor health outcomes and oppression, she said.

“It’s time for us to talk about racism 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. Focusing on unconscious bias training is important, he said, so clinicians can see what biases they might be bringing into the hospital and to the bedside. Maintaining a diverse workforce and bringing UIM physicians into leadership roles to encourage diversity 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 colleagues is essential, she believes, as is advocacy for changing inequitable health system policies. She recommends expanding social and professional circles. “Diverse social groups allow us to consider the perspectives of others; diverse professional groups allow us to ask better research questions 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 professionals 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 how and when they include race in their notes.⁷ “Is it really helpful to make sure people know right away that you are treating a ‘46-year-old Hispanic male’ or can the fact that he is Hispanic be saved for the social history section with other important details of his life such as being a father, veteran, and mechanic?” she asked.

“Racism is real and very much a part of our history. We can no longer be in denial regarding the racism that exists in medicine and the impact it has on our patients,” Dr. Unaka said. “As a profession, we cannot hide behind our espoused core values. We must live up to them.”

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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.



Dr. Burklin

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- Keep the patient’s cell or hospital phone within their reach.
- Adequately manage pain and prevent insomnia.
- Communicate frequently, utilizing audio- and visual-teleconferencing platforms that simultaneously include the patient and their loved ones.
- For patients who continue to exhibit feelings of loneliness despite the above interventions, consider consultations with psychiatry to offer additional coping strategies.
- Ensure a multidisciplinary approach when applicable – proactive consultation with the members of a palliative care team, ethics, spiritual health, and social and ancillary services.

It is important to recognize how vulnerable our patients are. Diagnosed with COVID-19, and caught in the midst of the current pandemic, not only do they suffer from the physical effects of this novel disease, but they also have to endure prolonged confinement, social isolation, and uncertainty – all wrapped in a cloak of loneliness and fear.

With our main focus being on the management of a largely unknown viral illness, patients’ personal experiences can be easily overlooked. It is vital for us as health care providers on the front lines to recognize, reflect, and reform to ease our patients’ journey through COVID-19.

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

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: 10.1080/07853890.2020.1836566).

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.

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Clinician reviews of HM-centric research

By Krishna A. Chokshi, MD; Andrew Chung, MD; Ariel Y. Elyahu, MD; Rex Hermansen, MD; Michael Herscher, MD; Andrew Kim, MD; Amit S. Narayan, MD; David Portnoy, MD; Elizabeth Yoo, MD

Division of Hospital Medicine, Mount Sinai Health System, New York

IN THIS ISSUE

1. Bedside frailty assessment can determine when CPR will be nonbeneficial
2. Tranexamic acid does not reduce risk of death in GI bleed
3. Antibiotics vs. placebo in acute uncomplicated diverticulitis
4. Apixaban noninferior to low-molecular-weight heparin in cancer-associated VTE
5. Compression therapy prevents recurrence of cellulitis
6. Timing of initiation of renal-replacement therapy in acute kidney injury
7. Apixaban a reasonable alternative to warfarin in patients with severe renal impairment
8. Anticoagulant choice in antiphospholipid syndrome-associated thrombosis
9. Oral step-down therapy for infective endocarditis

By Krishna A. Chokshi, MD

1 Bedside frailty assessment can determine when CPR will be nonbeneficial

CLINICAL QUESTION: How does frailty impact survival after inpatient 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 retroactively applied based on available chart data. The patients' median age was 77 years old, and 71% were male. The initial cardiac rhythm was nonshockable in 82% of cases, and overall in-hospital mortality was 86%. Frailty was independently associated with increased mortality when controlling

for age, comorbidities, and rhythm. No frail patients survived to hospital discharge, while 26% of patients with CFS greater than 4 survived. Although patients with a shockable rhythm had a better chance of survival overall, compared with those with a nonshockable rhythm (92% vs. 23%, P less than .001), 15% of frail patients had a shockable rhythm, and none survived to discharge. Limitations of the study include relatively small sample size and the possibility of confounding variables, such as comorbid conditions.

BOTTOM LINE: When adjusted for age and rhythm, no frail patients older than 60 who received CPR for cardiac arrest survived to hospital discharge. Clinicians should discuss the limited chance of survival and potential burdens of resuscitation with frail patients and their families to avoid inappropriate CPR at the end of life. **CITATION:** Ibitoye SE et al. Frailty status predicts futility of cardiopulmonary resuscitation in older adults. *Age Ageing*. 2020 Jun 5;[e-pub]. doi: doi.org/10.1093/ageing/afaa104.

Dr. Chokshi is a hospitalist in the Division of Hospital Medicine, Mount Sinai Health System, New York.

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.

CITATION: Roberts I et al. Effects of a high-dose 24-h infusion of tranexamic acid on death and thromboembolic events in patients with acute gastrointestinal bleeding (HALT-IT): an international randomised, double-blind, placebo-controlled trial. *Lancet*. 2020;395(10241):1927-1936. doi: 10.1016/S0140-6736(20)30848-5.

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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 1a 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 (40.0 hours) and placebo (45.8 hours) groups were not significantly different (5.9 hours difference between groups; 95% CI, -3.7 to 15.5; $P = .2$). 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



Dr. Chung



Dr. Elyahu



Dr. Chokshi

raises concerns regarding the generalizability of the results.

BOTTOM LINE: Antibiotic therapy does not decrease length of hospital stay when compared with placebo for patients with acute uncomplicated diverticulitis.

CITATION: Jaung R et al. Antibiotics do not reduce length of hospital stay for uncomplicated diverticulitis in a pragmatic double-blind randomized trial. *Clin Gastroenterol Hepatol.* 2020 Mar;S1542-3565(20):30426-2. doi: 10.1016/j.cgh.2020.03.049.

Dr. Elyahu is a hospitalist in the Division of Hospital Medicine, Mount Sinai Health System, New York.

By Rex Hermansen, MD

4 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. Relatively 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.

CITATION: Agnelli G et al. Apixaban for the treatment of venous thromboembolism associated with cancer. *N Engl J Med.* 2020 Apr 23;382:1599-607. doi: 10.1056/NEJMoa1915103.

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By Michael Herscher, MD

5 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.

CITATION: Webb E et al. Compression therapy to prevent recurrent cellulitis of the leg. *N Engl J Med.*

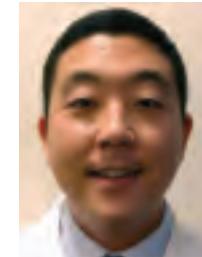
2020;383(7):630-9. doi:10.1056/NEJMoa1917197.

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By Andrew Kim, MD

6 Timing of initiation of renal-replacement therapy in acute kidney injury

CLINICAL QUESTION: In critically ill patients, does early renal-replacement therapy



Dr. Kim

(RRT), compared with standard therapy, improve death from any cause at 90 days? **BACKGROUND:** Acute kidney injury (AKI) is a common complication that occurs

in seriously ill patients admitted to the ICU, and many of these patients eventually require RRT. When complicated by major metabolic disorders, it is usually clear when therapy should be initiated. However, when these complications are absent, the most appropriate time to initiate

Continued on following page



Dr. Hermansen



Dr. Herscher

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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: 168 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; $P = .92$). 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.

CITATION: Bagshaw SM et al. Timing of initiation of renal-replacement therapy in acute kidney injury. *N Engl J Med.* 2020;383:240-51. doi: 10.1056/NEJMoa2000741.

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By Amit S. Narayan, MD

7 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



Dr. Narayan

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.

CITATION: Hanni C et al. Outcomes associated with apixaban vs. warfarin in patients with renal dysfunction. *Blood Adv.* 2020;4(11):2366-71. doi: 10.1182/bloodadvances.2019000972.

Dr. Narayan is a hospitalist in the Division of Hospital Medicine, Mount Sinai Health System, New York.

By David Portnoy, MD

8 Anticoagulant choice in antiphospholipid syndrome-associated thrombosis

CLINICAL QUESTION: Are direct oral anticoagulants (DOACs) as effi-

cient and safe as vitamin K antagonists (VKAs) in treating thrombosis secondary to antiphospholipid syndrome (APS)?

BACKGROUND: DOACs have largely replaced VKAs as first-line therapy



Dr. Portnoy

for venous thromboembolism in patients with adequate renal function. However, there is concern in APS that DOACs may have higher rates of recurrent thrombosis than VKAs when treat-

ing thromboembolism.

STUDY DESIGN: Randomized non-inferiority trial.

SETTING: Six teaching hospitals in Spain.

SYNOPSIS: Of adults with thrombotic APS, 190 were randomized to receive rivaroxaban or warfarin. Primary outcomes were thrombotic events and major bleeding. Follow-up after 3 years demonstrated new thromboses in 11 patients (11.6%) in the DOAC group and 6 patients (6.3%) in the VKA group ($P = .29$). Major bleeding occurred in six patients (6.3%) in the DOAC group and seven patients (7.4%) in the VKA group ($P = .77$). By contrast, stroke occurred in nine patients in the DOAC group while the VKA group had zero events, yielding a significant relative RR of 19.00 (95% CI, 1.12-321.90) for the DOAC group.

The DOAC arm was not proven to be noninferior with respect to the primary outcome of thrombotic events. The higher risk of stroke in this group suggests the need for caution in using DOACs in this population.

BOTTOM LINE: DOACs have a higher risk of stroke than VKAs in patients with APS without a significant difference in rate of a major bleed.

CITATION: Ordi-Ros J et al. Rivaroxaban versus vitamin K antagonist in antiphospholipid syndrome. *Ann Intern Med.* 2019;171(10):685-94. doi: 10.7326/M19-0291.

Dr. Portnoy is a hospitalist in the Division of Hospital Medicine, Mount Sinai Health System, New York.

By Elizabeth Yoo, MD

9 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.



Dr. Yoo

STUDY DESIGN: Systematic review.

SETTING: Literature review in October 2019, with update in February 2020, consisting of 21 observational studies and 3 ran-

domized 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 viridians 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.

CITATION: Spellberg B et al. Evaluation of a paradigm shift from intravenous antibiotics to oral step-down therapy for the treatment of infective endocarditis: a narrative review. *JAMA Intern Med.* 2020;180(5):769-77. doi: 10.1001/jamainternmed.2020.0555.

Dr. Yoo is a hospitalist in the Division of Hospital Medicine, Mount Sinai Health System, New York.

Upper GI bleeds in COVID-19 not related to increased mortality

By Jim Kling

MDedge News

A Spanish survey of COVID-19 patients suggests that upper gastrointestinal bleeding (UGB) 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 retrospectively 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, 34.255; 95% confidence interval, 12.752-92.021), 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, those 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, 11.719-102.572) 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).

UGB 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.



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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

sponse team (38.4%) coverage. In addition, most PHM programs have a role in comanagement of a wide variety of patient populations, with the greatest presence among the



surgical specialties. Approximately 90% of programs report some role in the care of patients admitted to general surgery, orthopedic surgery, and other surgical subspecialties.

“Pediatric hospitalist programs continue to provide a wide variety of services beyond care on inpatient wards.”

2020 *SoHM* Report the most meaningful ever 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 taken 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 re-

The role for comanagement with medical specialties remains diverse, with PHM programs routinely having some 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% instituted a hiring freeze felt likely to be permanent. As PHM programs gear up for the next viral

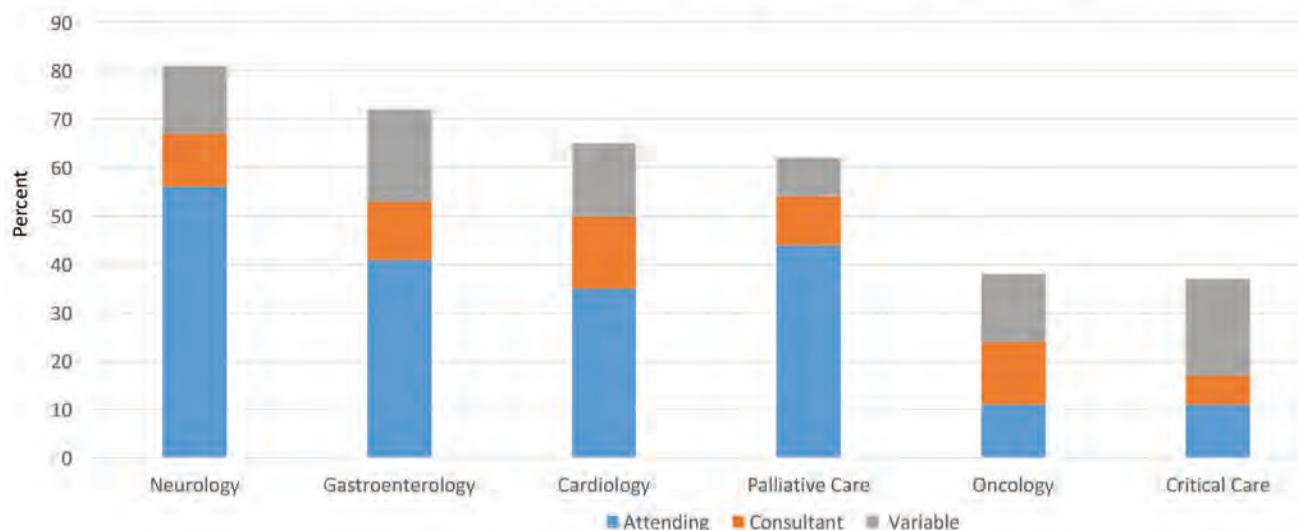


Dr. Gage is director of faculty development, pediatric hospital medicine, at Phoenix Children's Hospital, and associate professor of pediatrics at the University of Arizona, Phoenix.

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.

Percent of Programs with Pediatric Hospitalist Co-Management Roles by Medical Sub-specialty





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309510

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https://ochsner.wd1.myworkdayjobs.com/en-US/OchsnerPhysician/job/New-Orleans-New-Orleans-Region-Louisiana/Hospital-Medicine-Sourcing-Requisition-all-regions_REQ_00022186

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Leading hospitalists 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.



Endurance final sinking in Antarctica, November 1915. The dogs were later shot to conserve supplies.

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 subspecialty's role – are faced with mustering 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, prob-

lem-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.”¹ 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, 250 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.”² 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.³

Realizing 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.”⁴ Most importantly, Shackleton took ultimate responsibility for his men's survival, never rest-



Dr. Chang is chief of pediatric hospital medicine at Baystate Children's Hospital in Springfield, Mass., and associate professor of pediatrics at the University of Massachusetts, also in Springfield.

ing until they had all been rescued. And he modeled a culture of shared responsibility for one another⁵ – he had once offered his only biscuit of the day on a prior expedition to his fellow explorer Frank Wild.

As winter arrives in 2020 and deepens into 2021, we will all be faced with leading our teams across the ice and to the safety of spring, and hopefully a vaccine. Whether we can get there with our entire crew depends on effective crisis leadership. But we can draw on the lessons provided by Shackleton and other crisis leaders in the past to guide us in the present.

Author disclosure: I studied the HBS case study “Leadership in Crisis: Ernest Shackleton and the Epic Voyage of the *Endurance*” as part of a 12-month certificate course in Safety, Quality, Informatics, and Leadership (SQIL) offered by Harvard Medical School.

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Community PHM

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 to 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 pro-



Dr. Welsh is a clinical associate professor of pediatrics at the Stanford (Calif.) University in the division of pediatric hospital medicine. He has practiced community pediatric hospital medicine for over 27 years in Washington state and the San Francisco Bay Area. He is the chair of the working group of the Future of Community Pediatric Hospital Medicine for the AAP section on hospital medicine's subcommittee on community hospitalists.

grams 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 engage physicians during all parts of their pediatric training 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.

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