

Dr. Benji K. Mathews



HM20 course director influenced by POCUS, global health

Dr. Benji K. Mathews praises mentors for his SHM roles

By Richard Pizzi
MDedge News

Benji K. Mathews, MD, SFHM, CLHM, is chief of hospital medicine at Regions Hospital in Saint Paul, Minn., and director of point-of-care ultrasound (POCUS) for hospital medicine at HealthPartners. He is also the course director for the Society of Hospital Medicine's 2020 (HM20) annual conference, to be held April 15-18 in San Diego.

Dr. Mathews, an associate professor of medicine at the University of Minnesota, Minneapolis, is recognized by fellow hospitalists as a pioneer in the use of bedside ultrasound. In fact, his Certificate of Leadership in Hospital Medicine (CLHM) was completed with a focus on ultrasound in hospital medicine, and he is a Fellow in Diagnostic Safety through the Society to Improve Diagnosis in Medicine. "While a resident, I took an interest in the field of improving diagnosis and combined it with

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Hospitalist Movers and Shakers

By Matt Pesyna

Swati Mehta, MD, recently was honored as the lone hospitalist on the National Executive Physician Council for Beryl Institute (Nashville, Tenn.). Only 24 total physicians were selected to the council. Dr. Mehta also was named the 2019 Distinguished Physician Award winner at Vituity (Emeryville, Calif.), where she is the executive director of quality and performance.

A nocturnist at Sequoia Hospital (Redwood City, Calif.), Dr. Mehta is a member of the Society of Hospital Medicine's Patient Experience interest group.

Shannon Phillips, MD, SFHM, has been named to the National Quality Forum's Board of Directors for 2020. The chief patient experience officer at Intermountain Healthcare (Salt Lake City), she also is a recent member of the Performance Measurement and Reporting Committee.

Dr. Phillips, whose focus at Intermountain is on catalyzing safety, quality, and experience of care, was named a 2018 Becker's Hospital Review Hospital and Health System CXO to Know. Previously, she worked at the Cleveland Clinic, where she was its first patient safety officer and an associate chief quality officer.

Vineet Arora, MD, MHM, has been elected as a new member of the National Academy of Medicine, which honors pioneering scientific and professional achievements within the field.

An academic hospitalist at the University of Chicago, Dr. Arora specializes in improving the learning environment for her medical

trainees, as well as maintaining a high level of quality, safety, and care for patients. She also is considered an expert in using social media and other new technology to enhance medical education.

The National Academy of Medicine stated that Dr. Arora's honor was "for pioneering work to optimize resident fatigue and patient safety during long shifts."

Edmondo Robinson, MD, has been named senior vice president and chief digital innovation officer at Moffitt Cancer Center (Tampa). The chief digital innovation officer position is a newly created position that the veteran physician has assumed. Dr. Robinson has 16 years' experience in clinical and technological work.

In this new position, Dr. Robinson, a practicing academic hospitalist, will head Moffitt's digital innovation while looking to create and test new services, programs, partnerships, and technologies.

Dr. Robinson comes to Moffitt after serving as chief transformation officer and senior vice president at ChristianaCare (Wilmington, Del.). A teacher at Sidney Kimmel Medical College, Philadelphia, Dr. Robinson was the founding medical director of ChristianaCare Hospitalist Partners.

Relias Healthcare (Tupelo, Miss.) has begun providing hospitalist and emergency medicine services for North Mississippi Health Services' Gilmore-Amory Trauma Center. Relias, a multistate company that has partnered with more than 150 providers, now has a role at four different North Mississippi Health Services facilities.

Mednax (Sunrise, Fla.) has added Arcenio Chacon and Associated Pediatricians of Homestead (Fla.), a pediatric critical care and hospital practice, as an affiliate.

Chacon and Associated Pediatricians are based out of Miami and have served Baptist Health South Florida for more than 25 years. Established in 1979, Mednax is a health solutions company that provides subspecialty service in all 50 states.



Dr. Mehta



Dr. Robinson



Dr. Phillips



Dr. Arora

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Designing an effective onboarding program

It goes beyond welcoming and orientation

By Farzan Irani, MD, MBA,
MRCP, SFHM, FACP, CHCQM

As I gear up to welcome and onboard new hires to our hospitalist group, I could not help but reflect on my first day as a hospitalist. Fresh out of residency, my orientation was a day and a half long.

The medical director gave me a brief overview of the program. The program administrator handed me a thick folder of policies followed by a quick tour of the hospital and an afternoon training for the computerized order entry system (that was a time before EHRs). The next morning, I was given my full panel of patients, my new lab coat, and sent off into the battlefield.

I can vividly remember feeling anxious, a bit confused, and quite overwhelmed as I went through my day. The days turned into a week and the next. I kept wondering if I was doing everything right. It took me a month to feel a little more comfortable. It all turned out fine. Since nobody told me otherwise, I assumed it did.

Quite a bit has changed since then in hospital medicine. Hospital medicine groups, nowadays, have to tackle the changing landscape of payment reform, take on responsibility for an increasing range of hospital quality metrics, and juggle a swath of subspecialty comanagement agreements. Hospital medicine providers function from the inpatient to the post-acute care arena, all while continuing to demonstrate their value to the hospital administration. Simultaneously, they have to ensure their providers are engaged and functioning at their optimal level while battling the ever-increasing threat of burnout.

Thus, for new hires, all the above aspects of my orientation have become critical but alas terribly insufficient. Well into its third decade, the hospital medicine job market continues to boom but remains a revolving door. Hospital medicine groups continue to grow in size and integrate across hospitals in a given health system. The vast majority of the new hires tend to be fresh out of residency. The first year remains the most vulnerable period for a new hospitalist. Hospital medicine groups must design and implement

a robust onboarding program for their new hires. It goes beyond welcoming and orientation of new hires to full integration and assimilation in order to transform them into highly efficient and productive team members. Effective onboarding is table stakes for a successful and thriving hospital medicine group.

The content

An effective onboarding program should focus on three key dimensions: the organizational, the technical, and the social.¹

“It is quite common for new hires to feel like a stranger in a new land. A well-designed onboarding program provides new hires the space to forge relationships with each other and existing members of the hospital medicine team.”

1. The organizational or administrative aspect: The most common aspect of onboarding is providing new hires with information on the group's policies and procedures: what to do and how to do it. Equally essential is giving them the tools and contacts that will help them understand and navigate their first few months.

Information on how to contact consultants, sign on and off shifts, and so on can be easily conveyed through documents. However, having peers and the critical administrative staff communicate other aspects such as a detailed tour of the hospital, scheduling, and vacation policies is far more effective. It provides an excellent opportunity to introduce new hires to the key personnel in the group and vice versa as new hires get familiar with the unofficial workplace language.

Breaking down all this information into meaningful, absorbable boluses, spread over time, is key to avoiding information overload. Allowing new hires to assimilate and adapt to the group norms requires

follow-up and reinforcement. Group leaders should plan to meet with them at predetermined intervals, such as at 30, 60, 90 days, to engage them in conversations about the group's values, performance measurements, rewards, and the opportunities for growth that exist within the group and institution.

2. The technical or the clinical aspect: The majority of physicians and advanced providers hired to a hospital medicine group have come immediately from training. Transition into the autonomous role of an attending, or a semi-autonomous role for advanced providers, with a larger patient panel can be quite unnerving and stressful. It can be disorientating even for experienced providers transitioning into a new health system. A well-structured onboarding can allow providers to deploy their training and experience at your organization effectively.

Many onboarding programs have a clinical ramp-up period. The providers begin with a limited patient panel and gradually acclimatize into a full patient load. Many programs pair a senior hospitalist with the new hire during this period – a “buddy.” Buddies are available to help new hires navigate the health system and familiarize them with the stakeholders. They help new hires by providing context to understand their new role and how they can contribute to the group's success. In many instances, buddies help outline the unspoken rules of the group.

3. The social aspect – enculturation and networking: This is probably the most important of the three elements. It is quite common for new hires to feel like a stranger in a new land. A well-designed onboarding program provides new hires the space to forge relationships with each other and existing members of the hospital medicine team.

Groups can do this in myriad ways – an informal welcome social, a meet and greet breakfast or lunch, in-person orientation when designing the administrative onboarding, and assignment of buddies or mentors during their clinical ramp-up period. It is all about providing a space to establish and nurture lasting relationships between the new hires and the group.



Dr. Irani is a hospitalist affiliated with Baystate Health in Springfield, Mass. He would like to thank Joshua Lapps, Luke Heisenger, and all the members of the SHM Practice Management Committee for their assistance and input in drafting the guiding principles of onboarding and the case studies that have heavily inspired this article.

When done well, this helps transform a group into a community. It also lays the groundwork to avoid stress and loneliness, some of the culprits that lead to physician burnout. It is through these interpersonal connections that new hires adapt to a hospital medicine group's prevailing culture.

The personnel

Effective onboarding should be more than mere orientation. Group leaders should make an active attempt at understanding the core values and needs of the group. A good onboarding process assists new hires to internalize and accept the norms of the group. This process is not just a result of what comes from top management but also what they see and hear from the rank and file providers in the group. Hence it is critical to have the right people who understand

Continued on following page

Two decades of leadership

In recognition of Dr. Larry Wellikson's contributions to SHM

By Brian Harte, MD, MHM

It's already been a few years since I exited the Society of Hospital Medicine's Board of Directors (2 years, or maybe 3 – I've already lost count), and sitting in my proverbial rocking chair in the Old Hospitalists' Home, I heard, as many of you did, that Larry Wellikson, MD, MHM, the first and only chief executive officer in the Society's history, is stepping down soon.

With all the idle time that I find myself with these days, I have had

Dr. Win Whitcomb, and Dr. John Nelson established, he also has kept in touch with a vast network of hospitalists over the last 20-plus years.

Go to lunch with Larry, and be amazed at how much he knows about the goings-on of many of our colleagues. The fondness that Larry has for the people in his life is without parallel. These aren't just professional colleagues who have impacted him in some way – for Larry, every one of these is a true lifetime friendship, and he continues

Board over the years, or the *Journal of Hospital Medicine's* editorial staff, or of our committees, one sees a pattern – a commitment to continuously bringing on young leaders who are still on the early and ascending part of their career paths.

Other organizations identify Board candidates at the peak of their careers, but at SHM, many of us were elected when we had just enough experience to contribute but then continued to grow in our careers after finishing our terms. I joined the Board of Directors in 2012 (I think) and while I would probably be a more seasoned and stately Board member if I joined at this point in my life, I would also have less new and novel to offer – and therefore be less effective for what the Society needs.

While the Society respects its past leaders, it does not revere them. Our past is important, but our present and future are more important. Larry brought that mentality to SHM.

Ironically, the one position within SHM which has not, until this year, been subject to that same kind of transition is the CEO position itself. And this year, that domino will fall as well. While transitions are hard, change is good – and I am confident that our Society's commitment to seeking out new, talented leaders, and making transitions at all levels – Board,



Dr. Harte is a past president of SHM, and president of Cleveland Clinic Akron (Ohio) General and the Southern Region. He formerly served as president of Cleveland Clinic Hillcrest Hospital and Cleveland Clinic South Pointe Hospital.

“The specialty of hospital medicine was, from its beginning, disruptive, and from his career as a physician executive, Larry understood and has brought to SHM an understanding of the necessity of disruption to encourage growth and fresh thinking.”

the opportunity to ruminate on what Larry has brought to SHM in his 2 decades of leadership. And among the many answers, two stand out for me.

The first is Larry's deep appreciation of the value of relationships that he has developed and nurtured, an attribute which he has imprinted on many of us who have worked with him over the years. Although Larry speaks of the camaraderie of the first years of SHM and the bonds that he, Dr. Bob Wachter,

to establish new ones every year. He makes each of his friends feel truly special to him.

The second is the critical value of and need for change and disruption. The specialty of hospital medicine was, from its beginning, disruptive, and from his career as a physician executive, Larry understood and has brought to SHM an understanding of the necessity of disruption to encourage growth and fresh thinking. If one steps back and looks at, for example, the composition of the

committees, chapters, speakers – with the intent of bringing new perspectives and creativity, is firmly entrenched in our culture.

Larry can join me in the rocking chair as we relive our common SHM experiences together – and create new memories as well. Congratulations, Larry, and thank you.

Continued from previous page

and embody these values at the planning table.

It is equally essential that necessary time and resources are devoted to building a program that meets the needs of the group. The practice management committee at SHM interviewed five different programs across a spectrum of settings. All of them had a designated onboarding program leader with a planning committee that included the administrative staff and senior frontline hospitalists.

The costs

According to one estimate, the cost of physician turnover is \$400,000-\$600,000 per provider.² Given such staggering costs, it is not difficult to justify the financial resources required to structure an effective

onboarding program. Activities such as a detailed facility tour, a welcome breakfast, and a peer buddy system cost virtually nothing. They go a

“Effective onboarding should be more than mere orientation. Group leaders should make an active attempt at understanding the core values and needs of the group.”

long way in building comradery, make new hires feel like they are part of a team, and reduce burnout and turnover.

Costs of an onboarding program are typically related to wages during shadowing and clinical ramp-up. However, all the programs we interviewed acknowledged that the costs associated with onboarding, in the broader context, were small and necessary.

The bottom line

An effective onboarding program that is well planned, well structured, and well executed is inherently valuable. It sends a positive signal to new hires, reassuring them that they made a great decision by joining the group. It also reminds the existing providers why they want to be a part of the group and its culture.

It is not about what is said or done during the onboarding process or how long it lasts. It need not be

overly complicated. It is how the process makes everyone feel about the group. At the end of the day, like in all aspects of life, that is what ultimately matters.

The SHM Practice Management Committee has created a document that outlines the guiding principles for effective onboarding with attached case studies.

Visit the SHM website for more information: <https://www.hospital-medicine.org>.

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The VA Hospitalist

The hospitalized post-bariatric surgery patient

What every hospitalist should know

By Jennifer C. Kerns, MD,
MSHS

With the prevalence of obesity worldwide topping 650 million people¹ and nearly 40% of U.S. adults having obesity,² bariatric surgery is increasingly used to treat this disease and its associated comorbidities.

The American Society for Metabolic & Bariatric Surgery estimates that 228,000 bariatric procedures were performed on Americans in 2017, up from 158,000 in 2011.³ Despite lowering the risks of diabetes, stroke, myocardial infarction, cancer, and all-cause mortality,⁴ bariatric surgery is associated with increased health care use. Neovius et al. found that people who underwent bariatric surgery used 54 mean cumulative hospital days in the 20 years following their procedures, compared with just 40 inpatient days used by controls.⁵

Although hospitalists are caring for increasing numbers of patients who have undergone bariatric surgery, many of us may not be aware of some of the things that can lead to hospitalization or otherwise affect inpatient medical care. Here are a few points to keep in mind the next time you care for an inpatient with prior bariatric surgery.

Pharmacokinetics change after surgery

Gastrointestinal anatomy necessarily changes after bariatric surgery and can affect the oral absorption of drugs. Because gastric motility may be impaired and the pH in the stomach is increased after bariatric surgery, the disintegration and dissolution of immediate-release solid pills or caps may be compromised.

It is therefore prudent to crush solid forms or switch to liquid or chewable formulations of immediate-release drugs for the first few weeks to months after surgery. Enteric-coated or long-acting drug formulations should not be crushed and should generally be avoided in patients who have undergone bypass procedures such as Roux-en-Y gastric bypass (RYGB) or biliopancreatic diversion with duodenal switch (BPD/DS), as they can

demonstrate either enhanced or diminished absorption (depending on the drug).

Reduced intestinal transit times and changes in intestinal pH can alter the absorption of certain drugs as well, and the expression of some drug transporter proteins and enzymes such as the CYP3A4 variant of cytochrome P450 – which is estimated to metabolize up to half of currently available drugs – varies



between the upper and the lower small intestine, potentially leading to increased bioavailability of medications metabolized by this enzyme in patients who have undergone bypass surgeries.

Interestingly, longer-term studies have reexamined drug absorption in patients 2-4 years after RYGB and found that initially increased drug plasma levels often return to preoperative levels or even lower over time,⁶ likely because of adaptive changes in the GI tract. Because research on the pharmacokinetics of individual drugs after bariatric surgery is lacking, the hospitalist should be aware that the bioavailability of oral drugs is often altered and should monitor patients for the desired therapeutic effect as well as potential toxicities for any drug administered to post-bariatric surgery patients.

Finally, note that nonsteroidal anti-inflammatory drugs (NSAIDs), aspirin, and corticosteroids should be avoided after bariatric surgery unless the benefit clearly outweighs the risk, as they increase the risk of ulcers even in patients without un-

derlying surgical disruptions to the gastric mucosa.

Micronutrient deficiencies are common and can occur at any time

While many clinicians recognize that vitamin deficiencies can occur after weight loss surgeries which bypass the duodenum, such as the RYGB or the BPD/DS, it is important to note that vitamin and mineral deficiencies occur commonly even in patients with intact intestinal absorption such as those who underwent sleeve gastrectomy (SG) and even despite regained weight due to greater volumes of food (and micronutrient) intake over time.

The most common vitamin deficiencies include iron, vitamin B₁₂, thiamine (vitamin B₁), and vitamin D, but deficiencies in other vitamins and minerals may be found as well. Anemia, bone fractures, heart failure, and encephalopathy can all be related to postoperative vitamin deficiencies. Most bariatric surgery patients should have micronutrient levels monitored on a yearly basis and should be taking at least a multivitamin with minerals (including zinc, copper, selenium and iron), a form of vitamin B₁₂, and vitamin D with calcium supplementation. Additional supplements may be appropriate depending on the type of surgery the patient had or whether a deficiency is found.

The differential diagnosis for abdominal pain after bariatric surgery is unique

While the usual suspects such as diverticulitis or gastritis should be considered in post-bariatric surgery patients just as in others, a few specific complications can arise after weight loss surgery.

Marginal ulcerations (ulcers at the surgical anastomotic sites) have been reported in up to a third of patients complaining of abdominal pain or dysphagia after RYGB, with tobacco, alcohol, or NSAID use conferring even greater risk.⁷ Early upper endoscopy may be warranted in symptomatic patients.

Small-bowel obstruction (SBO) may occur because of surgical adhesions as in other patients, but catastrophic internal hernias with



Dr. Kerns is a hospitalist and codirector of bariatric surgery at the Washington DC VA Medical Center.

associated volvulus can occur because of specific anatomical defects that are created by the RYGB and BPD/DS procedures. CT imaging is insensitive and can miss up to 30% of these cases,⁸ and nasogastric tubes placed blindly for decompression of an SBO can lead to perforation of the end of the alimentary limb at the gastric pouch outlet, so post-RYGB or BPD/DS patients presenting with signs of SBO should have an early surgical consult for expeditious surgical management rather than a trial of conservative medical management.⁹

Cholelithiasis is a very common postoperative complication, occurring in about 25% of SG patients and 32% of RYGB patients in the first year following surgery. The risk of gallstone formation can be significantly reduced with the postoperative use of ursodeoxycholic acid.¹⁰

Onset of abdominal cramping, nausea and diarrhea (sometimes accompanied by vasomotor symptoms) within 15-60 minutes of eating may be due to early dumping syndrome. Rapid delivery of food from the gastric pouch into the small intestine causes the release of gut peptides and an osmotic fluid shift into the intestinal lumen that can trigger these symptoms even in patients with a preserved pyloric sphincter, such as those who underwent SG. Simply eliminating sugars

and simple carbohydrates from the diet usually resolves the problem, and eliminating lactose can often be helpful as well.

Postprandial hyperinsulinemic hypoglycemia ("late dumping syndrome") can develop years after surgery

Vasomotor symptoms such as flushing/sweating, shaking, tachycardia/palpitations, lightheadedness, or difficulty concentrating occurring 1-3 hours after a meal should prompt blood glucose testing, as delayed hypoglycemia can occur after a large insulin surge.

Most commonly seen after RYGB, late dumping syndrome, like early dumping syndrome, can often be managed by eliminating sugars and simple carbohydrates from the diet. The onset of late dumping syndrome has been reported as late as 8 years after surgery,¹¹ so the etiology of symptoms can be elusive. If the diagnosis is unclear, an oral glucose tolerance test may be helpful.

Alcohol use disorder is more prevalent after weight loss surgery

Changes to the gastrointestinal anatomy allow for more rapid

absorption of ethanol into the bloodstream, making the drug more potent in postop patients. Simultaneously, many patients who undergo bariatric surgery have a history of using food to buffer negative emotions. Abruptly depriving them of that comfort in the context of the increased potency of alcohol could potentially leave bariatric surgery patients vulnerable to the development of alcohol use disorder, even when they did not misuse alcohol preoperatively.

Of note, alcohol misuse becomes more prevalent after the first postoperative year.¹² Screening for alcohol misuse on admission to the hospital is wise in all cases, but perhaps even more so in the post-bariatric surgery patient. If a patient does report excessive alcohol use, keep possible thiamine deficiency in mind.

The risk of suicide and self-harm increases after bariatric surgery While all-cause mortality rates decrease after bariatric surgery compared with matched controls, the risk of suicide and nonfatal self-harm increases.

About half of bariatric surgery patients with nonfatal events have

substance misuse.¹³ Notably, several studies have found reduced plasma levels of SSRIs in patients after RYGB,⁶ so pharmacotherapy for mood disorders could be less effective after bariatric surgery as well. The hospitalist could positively impact patients by screening for both substance misuse and depression and by having a low threshold for referral to a mental health professional.

As we see ever-increasing numbers of inpatients who have a history of bariatric surgery, being aware of these common and important complications can help today's hospitalist provide the best care possible.

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Hospital Medicine HM20 Mathews

Continued from page 1

the 21st-century innovative tool of bedside ultrasound,” he said. “Now, I continue to teach clinicians, educators, and learners.”

In addition to his interest in POCUS and medical education, Dr. Mathews also has a passion for global health, rooted in a commitment to reducing health care disparities both locally and globally. He has worked with medical missions, nongovernmental organizations, and orphanages in Nepal, India, Bolivia, Honduras, and Costa Rica. This led him to complete the global health course at the University of Minnesota.

Dr. Mathews spent a few minutes with *The Hospitalist* to discuss his background and his new role of course director of the HM20 annual conference.

Can you describe your journey to becoming a hospitalist?

I’ve been a hospitalist for most of the last decade. I was fortunate to be a part of a great residency program at the University of Minnesota Medical School, which started a hospital medicine pathway that had several nationally recognized hospital medicine leaders as mentors. I was lucky to work with several of them through the HealthPartners organization in Saint Paul, and that developed in me a further desire to practice hospital medicine. The

group and mentors provided opportunities to develop further niches in my practice, like bedside ultrasound.

How did you first get involved with SHM?

I entered SHM through the influence of mentors at HealthPartners,



Dr. Burke Kealey

especially Burke Kealey, MD, SFHM, senior medical director for hospital specialties at HealthPartners Medical Group in Bloomington, Minn., and a past president of the Society, who encouraged me to participate on SHM committees. I eventually applied for the Annual Conference Committee, and somehow was accepted.

At that time, I was a community hospitalist among a lot of academic

hospitalists. I thought that my voice could probably diversify the conversation, and bring the perspective of an early-career hospitalist to the discussion around educational offerings at the Annual Conference. I benefited from good mentorship on that committee, and with that experience I started getting involved with our local chapter in Minnesota. That was very important. I became our local chapter president and was able to combine my efforts with SHM nationally with our regional initiatives.

You have a particular interest in point-of-care ultrasound for hospitalists. How did that make its way into your involvement with SHM?

Point-of-care ultrasound and diagnostic error work really took off when I was a resident. My interest in that funneled naturally into the base curriculum of the Annual Conference, where once a year I could come together with 18 of my best hospitalist friends from across the nation to discuss curriculum. We talk about what content is applicable for front-line clinicians, what is right for early learners, and what innovations are coming in the future. Toward that last point, I was always involved as a judge or volunteer for the Research, Innovations, and Clinical Vignettes – or RIV – competition at the Annu-

al Conference. That’s the scientific abstract and poster competition at the conference. My interest grew to a point at which I decided to apply for one of the leadership roles in the RIV. I had the opportunity to serve as an Innovations Lead at RIV one year, and then chaired the overall RIV competition. Those opportunities helped me better understand the cutting-edge research that hospitalists should be aware of and which researchers and clinicians we should be in conversation with.

All these roles together have led me to my service as HM20 course director. I see myself as a lucky guy who has benefited from great mentorship, and I want to take advantage of my opportunities to serve.

We’ve been told that your elementary school-age children have learned to use ultrasound!

Well, they’ve learned how to use handheld ultrasound devices on each other. They’re able to find their siblings’ kidneys and hearts. I often show an image of this to encourage hospitalists that, if children can pick it up, highly educated providers can do the same and more.

To register for the Society of Hospital Medicine’s 2020 Annual Conference, please visit the HM20 Registration page at <https://shmanualconference.org/register>.

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- A live podcast with Mark Shapiro, MD, featuring discussions with hospital medicine thought leaders in an informal setting (*preregistration required*)

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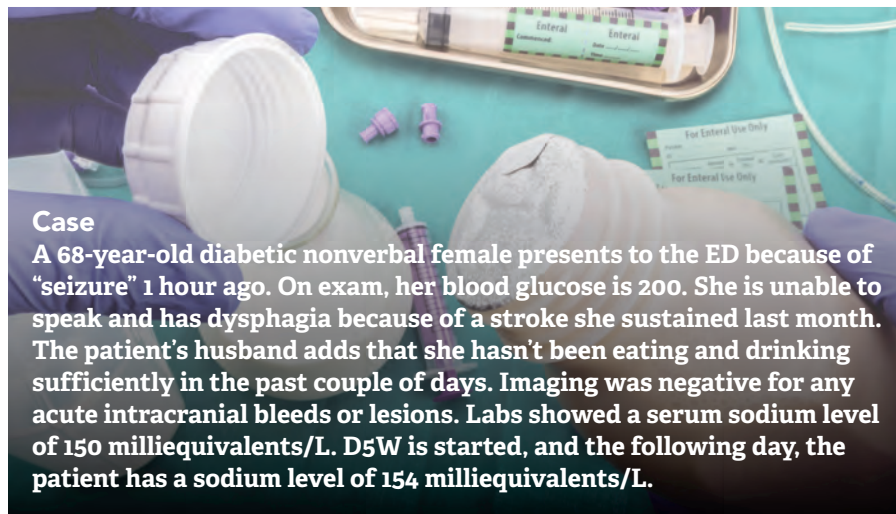
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Key Clinical Question

Which tube placement is best for a patient requiring enteral nutrition?

Comparative advantages of EN tubes

By Bibhusan Basnet, MD; Cory Gallivan, OMS III; and Carla Tayes, OMS III



Case

A 68-year-old diabetic nonverbal female presents to the ED because of "seizure" 1 hour ago. On exam, her blood glucose is 200. She is unable to speak and has dysphagia because of a stroke she sustained last month. The patient's husband adds that she hasn't been eating and drinking sufficiently in the past couple of days. Imaging was negative for any acute intracranial bleeds or lesions. Labs showed a serum sodium level of 150 milliequivalents/L. D5W is started, and the following day, the patient has a sodium level of 154 milliequivalents/L.

Brief overview

Many hospitalized patients are unable to maintain hydration and/or nutritional status by mouth and will need enteral nutrition (EN).

Variables such as past medical history, swallowing ability, history of aspiration, prognosis, and functional capacity of each gastrointestinal segment will determine the best

option for enteral nutrition for each patient. Each type of enteral tube feeding has advantages, disadvantages, and complications.

Overview of the data

Enteral nutrition should be started within 24-48 hours in a critically ill patient who is unable to maintain intake according to the American Society of Parenteral and Enteral Nutrition.¹ This can be provided through a nasogastric (NG) tube, percutaneous endoscopic gastrostomy (PEG) tube, PEG tube with jejunal extension (PEG-J), or a percutaneous endoscopic jejunal (PEJ) tube.¹

NG tubes are often the first method deployed because of their low cost and convenience. They are also suitable for the patient who requires this type of feeding for less than 4 weeks. However, NG tubes do require some patient cooperation (to place and maintain) and are contraindicated in some patients with orofacial trauma, upper GI tumors, inadequate lower esophageal sphincter tone, and gastroparesis.²

Another option is a PEG tube, which is a good alternative for patients who are sedated; are ventilated; or have neurodegenerative processes, stroke with dysphagia, or head and neck cancers. These are typically recommended when enteral nutrition will be needed for more than 4 weeks. Disadvantages of PEG



Dr. Basnet

Dr. Basnet is the hospitalist program director for Apogee Physicians Group at Eastern New Mexico Medical Center in Roswell.



Ms. Gallivan

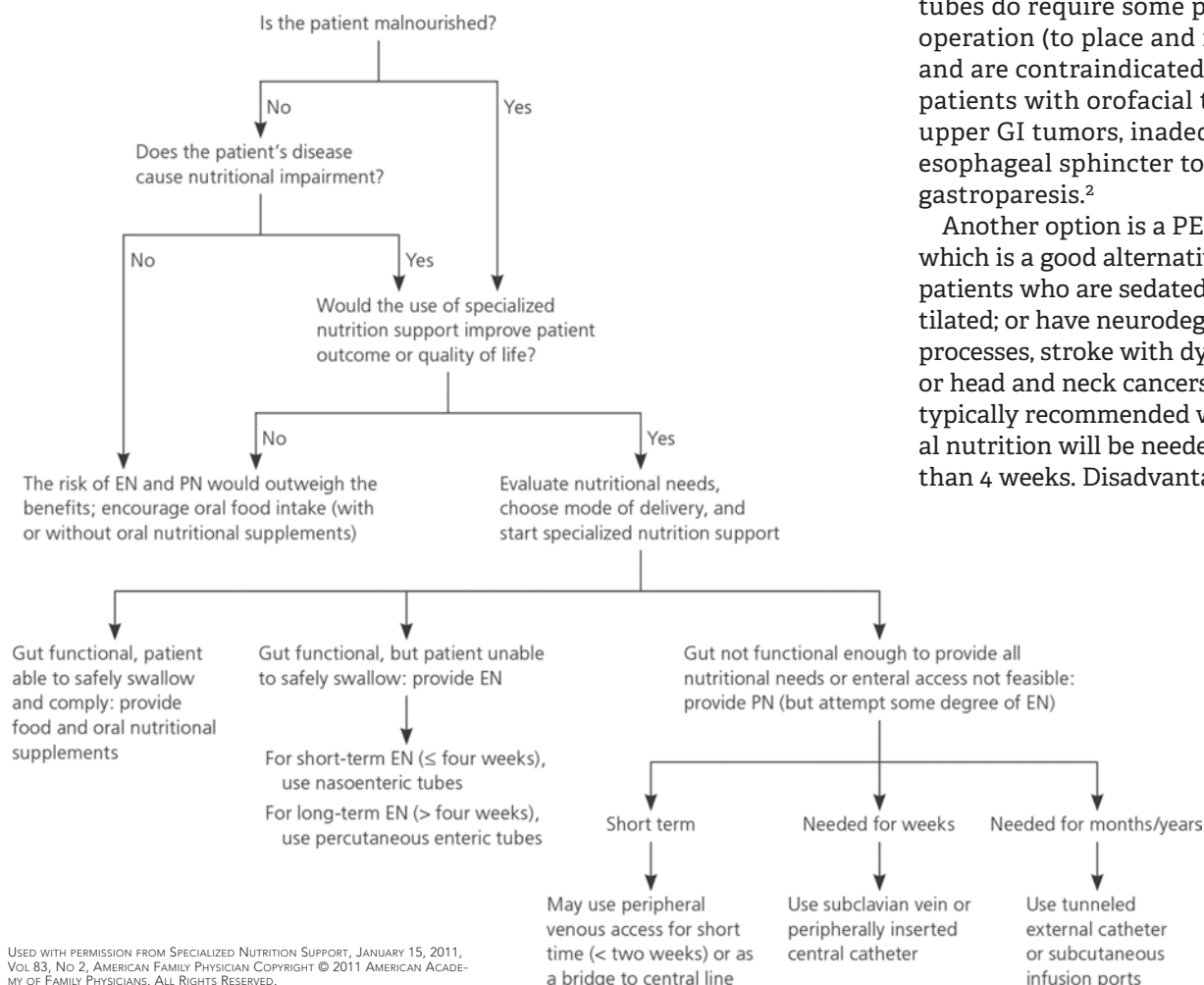


Ms. Tayes

Ms. Gallivan is a third-year medical student at Burrell College of Osteopathic Medicine, in Las Cruces, N.M., with interests in cardiothoracic surgery, general surgery, and internal medicine.

Ms. Tayes is a third-year medical student at Burrell College of Osteopathic Medicine with interests in surgery, internal medicine, and emergency medicine.

Figure 1: Implementation of specialized nutrition support



tubes include tube obstruction or displacement, gastroesophageal reflux, and leakage of gastric content around the percutaneous site or into the peritoneum.

PEG-J tubes, PEJ tubes, or jejunostomy tubes are best suited for patients with GI dysmotility, patients who have unsuccessfully undergone the aforementioned methods, patients with histories of partial gastrectomies, or patients with gastric or pancreatic cancers/multiple traumas. The PEG-J tube extends into the distal duodenum; because it is longer and more narrow, it is more likely to coil and occlude the flow of nutrients during feedings.^{2,3} Jejunal feeding methods incorporate a continuous pump

controlled infusion; if set too rapidly, this could cause dumping syndrome. A benefit of jejunal nutrition is a lower risk of aspiration, compared with other enteral tubes.⁴

It is best to appraise the selected method for its efficacy and patient preference. The American College of Gastroenterology recommends starting with orogastric or nasogastric feeds, and switching to postpyloric or jejunal feeds for those intolerant to or at high risk for aspiration.⁵ The most important aspect is early enteral nutrition in hospitalized patients unable to maintain oral nutrition.

Application of the data to the original case

This is a severely hypernatremic diabetic patient unable to swallow. On day 2 of her hospitalization, the clinical team provided the patient with an NG tube for increased free-water intake to gradually decrease her serum sodium. By hospital day 4, the patient's sodium had normalized. Because of the patient's long-term prognosis and dysphagia, discus-

sions were held with the patient and husband for PEG tube placement. The patient received a PEG tube and was subsequently discharged 2 days later.

Bottom line

Enteral nutrition is a common need among hospitalized patients. Modality of enteral nutrition will depend on the patient's past medical

history, anticipated duration, and preferences.

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Table 1. Evidence-Based Indications for Specialized Nutrition Support

Indication	Effect on patient outcome	SORT evidence rating*
Acute severe pancreatitis	EN has been shown to reduce length of hospitalization and infection rates compared with PN; no effect on mortality ¹	B
Bone marrow transplantation	PN may prevent weight loss, but is associated with increased risk of infections related to intravenous line ²	B
Burns	EN appears to be beneficial in improving patient outcomes, although the best time to start is not clear; early EN (within 24 hours of injury) vs. delayed EN (greater than 24 hours) may blunt the hypermetabolic response to thermal injury, but there are insufficient data to provide clear guidelines for practice ³	B
Cancer	EN may improve nutritional status in some patients with cancer (e.g., those who are malnourished or at risk of becoming malnourished during cancer treatment; those with a potentially curable disease; those with a long disease-free period after cancer treatment); no effect on survival; no benefit demonstrated in clinical trials of patients undergoing chemotherapy for advanced cancer; PN associated with increased rate of complications in patients undergoing chemotherapy ⁴	B
Critically ill	EN in patients who are critically ill and unable to maintain voluntary nutritional intake reduces mortality and length of stay in the ICU (most clinical trials included surgical patients in the ICU with trauma, burns, peritonitis, and pancreatitis) ¹⁸	A
	In critically ill patients requiring EN, formulas designed to improve immune function have been shown to reduce length of hospitalization, infection rate, and time spent on mechanical ventilation, but increase mortality in patients with sepsis ¹⁹	B
	There is no evidence that PN improves important outcomes in critically ill patients ¹⁷	B
Crohn disease	Supplementary EN may be effective for maintenance of Crohn disease remission; there are insufficient data to recommend elemental vs. polymeric formulas ¹	B
Cystic fibrosis	Observational studies suggest improved nutritional status and stabilization of lung function in patients with cystic fibrosis who are receiving EN ²⁰ ; PN has been shown to promote weight gain, but with a higher rate of sepsis ²¹ ; oral nutrition support does not confer additional benefits in moderately malnourished children than the use of dietary advice and monitoring alone ¹	B
Dementia	Patients with dementia and poor oral intake do not benefit from specialized nutrition support; percutaneous endoscopic gastrostomy tubes have been associated with poor prognosis ²²	B
Gastrointestinal surgery	Early (within 24 hours) feeding (i.e., food intake, oral nutrition support, or EN) has been shown to reduce mortality, risk of postsurgical complications, and length of hospitalization compared with no feeding ¹⁹	A
Head injury	Early feeding has been associated with a trend toward better survival and disability outcomes; further trials are required ²³	B
Liver transplant	PN and EN have been associated with shorter ICU stays and improved nutritional status compared with no nutrition support ²⁴	B
Necrotizing enterocolitis	There are insufficient data to inform clinical practice on the effect of delayed (at least 96 hours after birth) vs. earlier enteral feedings on necrotizing enterocolitis in infants ²⁵	C
Older patients, malnourished	Oral nutrition support has been shown to produce a small but consistent weight gain in older patients who are malnourished; potential beneficial effect on complications and mortality, but confirmation is needed; no evidence of functional improvement ^{26,27}	B
Short bowel syndrome	Five-year survival with PN is better than that with grafting after small bowel transplantation; therefore, PN is the treatment of choice in patients with short bowel syndrome when EN is not possible; potential candidates for small bowel transplantation include those with liver failure associated with PN or those with recurrent catheter sepsis and lack of venous access ⁵	B
Stroke (dysphagic)	Early placement of an enteral feeding tube (within the first week) has not been shown to improve long-term survival, complication rates, or length of hospitalization ⁶	B
Very low-birth-weight infants	There is no evidence that early feeding affects feeding tolerance or growth rates in very low-birth-weight infants ⁷	B

EN = enteral nutrition; ICU = intensive care unit; PN = parenteral nutrition.
*—A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to <http://www.aafp.org/afpsort.xml>.
Information from references 1 through 7, and 17 through 27.

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A match made in medicine: Match Day 2020

By Caitlin Cowan

Match Day is the celebration of the National Resident Matching Program® (NRMP®) results, which seals the fate not only of future medical professionals, but of the program placements dedicated to supporting their careers.

Daniel Ricotta, MD, FHM, an academic hospitalist at Beth Israel Deaconess Medical Center (BIDMC) in Boston, and an active SHM member since 2013 – including his current role as a Physicians in Training Committee member – offers unique insight into the value of understanding both sides of this interview table.

As an associate program director of BIDMC's Internal Medicine Residency Program and the director of Simulation Education at the Carl J. Shapiro Center for Education & Research, Dr. Ricotta is able to act on his passions for medical education and clinical care.

"I knew I wanted to do academic medicine and education," Dr. Ricotta said. "I was able to get involved by working with students and residents early on in my career."

A natural fit for his current roles, Dr. Ricotta has gained a unique perspective on the match process and how it has evolved since he began his residency 9 years ago.

Preparing for Match Day includes an extensive checklist of life-altering to-dos that shape your career trajectory. Medical students must have noteworthy CV points, scholarly recommendations, stand-out interviews, and a thoughtful rank list – among many other things to consider through the course of the match. Dr. Ricotta said that, while this application process has generally remained the same since his participation, he has noticed that the students themselves have changed.

"Students going into residency are more mature and further along professionally," he explained. "I've seen more students go on to do something else for a while and have gained more experience."

Amidst what can feel like a free-for-all, Dr. Ricotta reminds his students that the match process is a two-sided relationship.

"I certainly didn't realize how much work goes into recruitment when I was a student," Dr. Ricotta

admitted. "What students don't think about is the amount of care that goes into trying to match students who share personal values, support of the mission, or are a good cultural fit."

He went on to emphasize the importance of environmental compatibility.

"Go where you feel you will thrive," he said. "Go somewhere that has a mission that resonates with your mission and think about your fellow applicants and potential mentorship. Could you see yourself being their classmate? Does this program have people there who can help you to achieve your goals?"

In part because of hospital medicine's scheduling flexibility and hands-on learning opportunities, more students are interested in exploring this specialty.

"What is amazing about hospital medicine is the ample opportunity for you to get involved earlier in your career and build from that," he said. "There is more face time with patients, more training for medical students available, countless academic opportunities in research and scholarships, and even conferences."

Because of the multiple career pathways available in hospital medicine, SHM aims to provide students and residents with professional tools and opportunities as early as possible to allow them to get a preview of what they can expect as a hospitalist.

"SHM is about getting involved," said Dr. Ricotta. "SHM encourages residents to become actively incorporated into the community through chapters, conferences, and other networking opportunities on both local and national levels."

Are you a student interested in exploring a career in hospital medicine? SHM supports educational and professional needs at all stages of your career. When you join SHM during your residency training, you receive access to programs, resources, and opportunities that will enhance your skills and raise your professional profile. For more information about our Residents & Fellows membership opportunity, please visit: hospitalmedicine.org/residents.

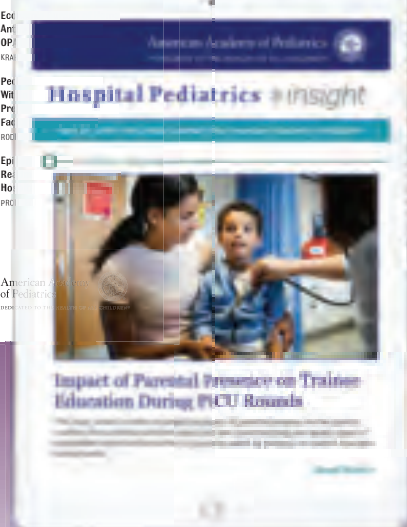
Ms. Cowan is a marketing communications specialist at SHM.



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Clinician reviews of HM-centric research

By Nausheen Ahmed, MD; Ritu Garg, MD; Sameer Qazi, MD;
Krishna Raghavan, MD; Edwin Santa, MD; Margaret Tsien, MD

Loyola University Medical Center, Maywood, Ill.

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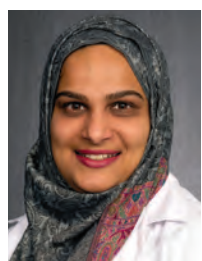
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3. Assessing the efficacy and safety of dapagliflozin in patients with HFrEF
4. Lower target LDL-C cuts risk of CV events in ischemic stroke patients
5. Efficacy and safety of daily low-dose colchicine after recent MI
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10. Torsemide vs. furosemide in heart failure patients

By Nausheen Ahmed, MD

1 Correlating hospitalist work schedules with patient outcomes

CLINICAL QUESTION: How do hospitalist schedules correlate with patient care outcomes?

BACKGROUND: Studies show better outcomes, decreased length of stay, increased patient satisfaction, improved quality, and decreased readmission rates when hospitalist services are used. This study looks at how hospitalist



Dr. Ahmed

schedules affect these outcomes.

STUDY DESIGN: Retrospective cohort study.

SETTING: 229 hospitals in Texas.

SYNOPSIS: This cohort study used 3 years of Medicare data from 229 hospitals in Texas. It included 114,777 medical admissions of patients with a 3- to 6-day length of stay. The study used the percentage of hospitalist working days that were blocks of 7 days or longer. ICU stays and patients requiring two or more E&M codes were excluded since they are associated with greater illness severity.

The primary outcome was mortality within 30 days of discharge and secondary outcomes were 30-day readmission rates, discharge destination, and 30-day postdischarge costs.

Patients receiving care from hos-

pitalists working several days in a row had better outcomes. It is postulated that continuity of care by one hospitalist is important for several reasons. Most importantly, the development of rapport with patient and family is key to deciding the plan of care and destination post discharge as it is quite challenging to effectively transfer all important information during verbal or written handoffs.

BOTTOM LINE: Care provided by hospitalists working more days in a row improved patient outcomes. A variety of hospitalist schedules are being practiced currently; however, these findings must be taken into account as schedules are designed.

CITATION: Goodwin JS et al. Association of the work schedules of hospitalists with patient outcomes of hospitalization. *JAMA Intern Med.* 2020;180(2):215-22. doi: 10.1001/jamainternmed.2019.5193.

2 Early palliative care consultation in the medical ICU

CLINICAL QUESTION: Does early palliative care consultation in critically ill patients lead to early establishment of code status and positively impact care?

BACKGROUND: Mortality rates in critically ill patients remain in excess of 20% in many institutions. In the last 2 decades, palliative care has become a core component of ICU care. Current literature recommends a palliative care consult in the ICU setting; however, implementing this

recommendation in a meaningful way has been challenging. The purpose of this study is to evaluate whether consulting palliative care in ICU earlier improves patient outcomes.

STUDY DESIGN: Single-center cluster randomized crossover trial.

SETTING: Two medical ICUs at Barnes Jewish Hospital, St. Louis.

SYNOPSIS: 199 patients were enrolled using palliative care criteria to identify patients at high risk for morbidity and mortality. In the intervention arm patients received a palliative care consultation from an inter-professional team led by board-certified palliative care providers within 48 hours of ICU admission.

The primary outcome of this study was a change in code status to Do Not Resuscitate/Do Not Intubate (DNR/DNI), which was significantly higher in the intervention group (50.5% vs. 23.4%; *P* less than .0001). The intervention group also had more hospice discharges, fewer ventilated days, a lower rate of tracheostomy, and fewer hospital readmissions. However, mortality and ICU/hospital length of stay were not significantly different between the two arms. Limitations of this study include using a single academic center and the fact that establishing a DNR/DNI may not measure quality of life or patient/family satisfaction. Further studies are needed to focus on clinical outcomes as well as patient and family satisfaction.

BOTTOM LINE: Early goal-directed palliative care consults with experienced clinicians board certified in palliative care influences goals of care, code status, and discharge plans for the critically ill and can improve medical resource utilization.

CITATION: Ma J et al. Early palliative care consultation in the medical ICU: A cluster randomized crossover trial. *Crit Care Med.* 2019 Dec;47:1707-15.

Dr. Ahmed is assistant professor in the division of hospital medicine, Loyola University Medical Center, Maywood, Ill.

By Ritu Garg, MD

3 Assessing the efficacy and safety of dapagliflozin in patients with HFrEF

CLINICAL QUESTION: Can the use of dapagliflozin, in addition to guideline-directed medical therapy, improve patient-reported outcomes and health-related quality of life in patients with heart failure and reduced ejection fraction (HFrEF)?

BACKGROUND: Guideline-directed medical therapy (use of beta-blockers, ACE inhibitor/angiotensin recep-

tor blockers, and mineralocorticoid antagonists) provides clear benefits on mortality and morbidity in patients with HFrEF. Dapagliflozin (Farxiga) belongs to a class



Dr. Garg

of sodium-glucose transporter 2 (SGLT2) inhibitors that inhibits reabsorption of sodium and glucose in the kidney and treats type 2 diabetes. This new class of drugs is emerging as an effective tool in the management of HFrEF based on the recent publication of the primary results of the DAPA-HF trial (Study to Evaluate the Effect of Dapagliflozin on the Incidence of Worsening Heart Failure or Cardiovascular Death in Patients with Chronic Heart Failure). It demonstrated substantial benefits in terms of heart failure symptoms, hospitalizations, and mortality when added to triple therapy for patients with chronic HFrEF regardless of the presence of diabetes.

STUDY DESIGN: Randomized, controlled double-blind trials.

SETTING: 410 participating institutions in 20 countries.

SYNOPSIS: Men and women aged 18 years and older with HFrEF who had New York Heart Association (NYHA) functional class II or higher, and optimally treated with pharmacologic and device therapy for HF were randomized to receive dapagliflozin or placebo. A total of 4,744 patients, aged 22-94 years were enrolled in the study.

- Dapagliflozin showed a clinically significant benefit on health status (symptoms, physical function, and quality of life). Improved health-related quality of life (as measured by the well-validated Kansas City Cardiomyopathy Questionnaire score) with dapagliflozin in comparison with placebo was sustained for more than 8 months.
- Dapagliflozin reduced the risk of death and worsening heart failure and improved symptoms across the broad spectrum of ages studied in DAPA-HF. There was no significant imbalance in tolerability or safety events between dapagliflozin and placebo, even in elderly individuals.

BOTTOM LINE: Follow-up DAPA-HF studies further support the role of SGLT2 inhibitor dapagliflozin in improving mortality, reducing hospitalization, and improving the quality of life in patients with HFrEF and is considered a safe option across all age groups.

CITATIONS: Kosiborod MN et al. Effects of dapagliflozin on symptoms, function, and quality of life in patients with heart failure and reduced ejection fraction: Results from the DAPA-HF trial. *Circulation*. 2020 Jan 14;141(2):90-9. Martinez FA et al. Efficacy and safety of dapagliflozin in heart failure with reduced ejection fraction according to age. *Insights from DAPA-HF*. *Circulation*. 2020 Jan 14;141:100-11.

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4 Lower target LDL-C cuts risk of CV events in ischemic stroke patients

CLINICAL QUESTION: Is a target LDL cholesterol (LDL-C) level of less than 70 mg/dL superior to a target LDL-C level of 90-110 mg/dL in prevention of future cardiovascular (CV) events in patients with a prior stroke of atherosclerotic origin or transient ischemic attack (TIA)?

BACKGROUND: The beneficial role of high-intensity statins in secondary prevention of recurrent atherosclerotic stroke is well established. It is uncertain whether the observed benefit was from a reduction in the cholesterol level or to other pleiotropic effects of atorvastatin. The ideal target cholesterol level for secondary prevention is unclear. This trial was conducted to help determine an ideal target LDL-C level in the prevention of CV events following ischemic stroke.

STUDY DESIGN: Randomized, paral-

lel-group, event-driven trial.

SETTING: Conducted in France and South Korea.

SYNOPSIS: In this study, patients with an ischemic stroke within the last 3 months or TIAs within 15 days were randomly assigned to receive statins with or without ezetimibe (Zetia) to achieve a higher-target LDL-C level (90-110 mg/dL) vs. lower-target LDL-C (less than 70 mg/dL). The composite primary endpoint was a major cardiovascular event, which included ischemic stroke, MI, new symptoms leading to urgent coronary or carotid revascularization, or death from CV causes.

There were 2,860 patients enrolled, 1,430 were assigned to each target group. At the end of 3.5 years, the primary endpoint occurred in 8.5% of patients in the lower target group, compared with 10.9% in the higher target group (hazard ratio, 0.78; 95% confidence interval, 0.61-0.98; $P = .04$). Unfortunately, the trial was stopped early because of a lack of funding.

BOTTOM LINE: Using medications including statins to lower the LDL-C to less than 70 mg/dL leads to better cardiovascular outcomes following ischemic stroke.

CITATION: Amarenco P et al. A comparison of two LDL cholesterol targets after ischemic stroke. *N Engl J Med*. 2020 Jan 2;382:9-19.

Dr. Garg is assistant professor in the division of hospital medicine, Loyola University Medical Center, Maywood, Ill.

By Sameer Qazi, MD

5 Efficacy and safety of daily low-dose colchicine after recent MI

CLINICAL QUESTION: Can giving low-dose colchicine to patients after

a recent myocardial infarction reduce future ischemic cardiovascular events, compared with placebo?

BACKGROUND: Clinical evidence supports the role of inflammation



Dr. Qazi

in atherosclerosis and its complications. Colchicine (Colcrys) is an orally administered potent anti-inflammatory that is currently used to treat gout and pericarditis.

STUDY DESIGN: Randomized,

Continued on following page

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Continued from previous page

double-blind, placebo-controlled, investigator-initiated trial.

SETTING: Funded by Canadian Institute of Health and Research, 167 centers in 12 different countries. Centers were predominately located in Canada, South America, and Europe.

SYNOPSIS: In this study, 4,745 patients with a MI within the last 30 days and treated according to national guidelines were enrolled. There were multiple exclusion criteria including severe heart, renal, and/or hepatic failure. The mean age of patients was 60.6 years. Patients were followed for a median of 22.6 months. The primary endpoint was a composite of death from cardiovascular causes, resuscitated cardiac arrest, MI, stroke, or urgent hospitalization for angina leading to coronary revascularization.

The primary endpoint occurred in 5.5% of patients in the colchicine group and 7.1% of those in the placebo group (hazard ratio, 0.77). This was largely because of a decreased incidence of stroke in the colchicine group compared to placebo (0.2% vs 0.8%) and decreased urgent hospitalizations for unstable angina leading to revascularization (1.1% vs 2.1%).

Nausea was more common in the colchicine group as well as pneumonia which was reported as a serious adverse event (0.9% compared to 0.4% in placebo).

Limitations included short follow-up and significant exclusion criteria.

BOTTOM LINE: In patients following a recent myocardial infarction, the use of low-dose colchicine at 0.5 mg daily led to a significantly lower percentage of ischemic cardiovascular events compared to placebo.

CITATION: Tardif JC et al. Efficacy and safety of low-dose colchicine after myocardial infarction. *N Engl J Med.* 2019 Dec 26;381:2497-505.

Dr. Qazi is assistant professor in the division of hospital medicine, Loyola University Medical Center, Maywood, Ill.

By Krishna Raghavan, MD

6 Thyroid hormone analogues can reverse NASH

CLINICAL QUESTION: In patients with nonalcoholic steatohepatitis (NASH) and stages 1-3 fibrosis, does the thyroid hormone receptor beta-agonist, resmetirom reduce hepatic steatosis compared with placebo?

BACKGROUND: Fat toxicity results in inflammation of the liver and eventual hepatic fibrosis and cirrhosis. Thyroid hormones can greatly reduce this hepatic steatosis by restoring metabolic pathways in damaged liver, prevent fibrosis progression, and have broad atherogenic lipid-lowering actions by activating hepatic thyroid beta-receptors.

However, hyperthyroidism also leads to osteoporosis, tachyarrhythmias, muscle wasting, and psychiatric side effects, mediated by the alpha-thyroid receptor. Resmetirom (MGL-3196) is a novel, highly selective thyroid beta-agonist, with a minimal side-effect profile, which avoids the alpha-side effects.

STUDY DESIGN: Randomized, double-blind, placebo-controlled study.

SETTING: 25 centers in the United States.

SYNOPSIS: Of 125 adults with NASH fibrosis 1-3 and greater than 10% hepatic fat, 84 received resmetirom and 41 received placebo. Resmetirom resulted in a nearly 30% decrease over placebo in hepatic fat, compared with baseline, significant improvement in lipid profile, improvement in liver enzymes, fibrosis markers, and histologic resolution of NASH in some patients.

While the study showed resolution of inflammation, the 36-week study was likely not long enough to show improvement of fibrosis. The relatively small sample size also limited results. Placebo patients who lost significant weight also showed improvement and were discarded from analysis, suggesting that weight loss itself is also an excellent alternative to reverse NASH. Resmetirom use in NASH is now moving into a large phase 3 trial.

BOTTOM LINE: Resmetirom results in major liver and cardiovascular benefits in patients with NASH.

CITATION: Harrison SA et al. Resmetirom (MGL-3196) for the treatment of nonalcoholic steatohepatitis: A multicentre, randomised, double-blind, placebo-controlled, phase 2 trial. *Lancet.* 2019 Nov 11;394(10213):2012-24.

7 IV drug users: The new face of candidemia

BACKGROUND: Intravenous drug use is an increasingly common risk factor for candidemia as the opioid crisis worsens. This study quantifies this change and characterizes the

changing epidemiology of candidemia.

STUDY DESIGN: A cross-sectional study.

SETTING: Health departments in nine states.

SYNOPSIS: IV drug users typically have a very distinctive phenotype among all patients with candidemia: They are younger (35 vs. 63 years), are more likely to be homeless, are not black, are smokers; they have hepatitis C, have no malignancies, have polymicrobial bacteremia, and have acquired the infection outside of the hospital. They are much less likely to die of the infection (8.6% vs 27.5%), compared with the non-IV drug users. In four states, the proportion of candidemia associated with IV drug use more than doubled, from 7% to 15% during 2014-2017, representing a possible shift in the epidemiology of candidemia.

The study did not quantify or address complications that many hospitalists see, such as endocarditis, endophthalmitis, and osteomyelitis. The study looked at only nine states, so results may not be generalizable. Nevertheless, the robust analysis suggests an alarming, increasing trend.

BOTTOM LINE: As the opioid crisis worsens, hospitalists should consider candidemia in hospitalized IV drug users and should evaluate patients with candidemia for IV drug use.

CITATION: Zhang AY et al. The changing epidemiology of candidemia in the United States: Injection drug use as an increasingly common risk factor – Active surveillance in selected sites, United States, 2014-2017. *Clin Infect Dis.* 2019 Nov 2. doi: 10.1093/cid/ciz1061.

Dr. Raghavan is assistant professor in the division of hospital medicine, Loyola University Medical Center, Maywood, Ill.

By Edwin Santa, MD

8 FMT cuts risk of bloodstream infections in patients with recurrent CDI

CLINICAL QUESTION: In patients with recurrent *Clostridioides difficile* infections (CDI), does fecal microbiota transplantation (FMT) decrease the risk of bloodstream infection (BSI) and related complications including hospital length of stay and death?

BACKGROUND: After a first episode of CDI, almost 20% of patients will have a recurrence. Recurrent CDI (rCDI) is more likely

to be associated with life-threatening complications including toxic megacolon, perforation, bloodstream infections, and death. Most BSIs are caused by intestinal microbes. Some evidence suggests that vancomycin therapy creates conditions that favor intestinal colonization by health care-associated pathogens. FMT aims to restore the normal composition of gut microbiota, is superior to vancomycin, and might decrease the incidence of BSI and related complications including death.

STUDY DESIGN: Prospective cohort study.

SETTING: Fondazione Policlinico Universitario Agostino Gemelli in Rome.

SYNOPSIS: In this study, 290 patients with rCDIs were randomized to FMT (109 patients) or antibiotic

therapy (181 patients). Only patients with their first rCDIs were included. The primary outcome was the development of primary BSI after treatment of rCDI and within a 90-day

follow-up period. Secondary outcomes were length of hospitalization and overall survival at 90 days.

Five patients in the FMT group and 40 in the antibiotic group (16% of total patients) developed BSIs during the 90-day follow-up. Because of baseline characteristic differences in the patients treated with FMT versus antibiotics, comparative analyses were limited to the matched cohort. Risk for BSIs was 23% lower in the FMT group (95% confidence interval, 10%-35%); the FMT group also had 14 fewer days of hospitalization (95% CI, 9-20 fewer days) and a 32% increase in overall survival (95% CI, 16%-47%), compared with the antibiotic group. Limitations of the study include its observational nature, single-center design, and differences in several baseline characteristics between the groups remaining after the match.

BOTTOM LINE: Patients with rCDI who received FMT were less likely to develop primary BSIs and related complications, including hospital length of stay and death when compared with patients who received antibiotics.

CITATION: Ianiro G et al. Incidence of bloodstream infections, length of hospital stay, and survival in patients

Continued on page 19



Dr. Santa



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Predictors of bacteremia in children hospitalized with community-acquired pneumonia

Children with blood pathogens had longer lengths of stay

By Anika Kumar, MD

CLINICAL QUESTION: Are blood cultures warranted in specific subsets of children hospitalized with community-acquired pneumonia (CAP)?

BACKGROUND: Guidelines from the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America recommend obtaining blood cultures in children hospitalized with moderate to severe community-acquired pneumonia. This group of authors recently published a study showing the prevalence of bacteremia of 2.5% in a cohort of generally healthy children hospitalized with CAP who had blood cultures obtained, with only 0.4% harboring a pathogen not susceptible to penicillin. They found low yield for blood cultures in children hospitalized with CAP.

STUDY DESIGN: Retrospective Cohort Study.

SETTING: Pediatric Health Information System Plus (PHIS+) database (six institutions).

SYNOPSIS: Secondary analysis of prior study of children aged 3 months to 18 years hospitalized with CAP between 2007 to 2011. For the second-

ary analysis only children in whom a blood culture was obtained on the initial or second day of hospitalization were studied. CAP was defined by a primary ICD-9 discharge diagnosis code for pneumonia or a primary ICD-9 discharge diagnosis code for pleural effusion with a secondary diagnosis code for pneumonia. Children transferred into the study institution and children with complex chronic conditions were excluded from the study. The primary outcome was the presence of bacteremia based on pathogen detection in the initial blood culture. Bacteria were labeled as pathogens or contaminants.

A total of 7,509 children were included in the initial study. Of them, 2,568 (34.2%) had a blood culture obtained on the initial or second day of hospitalization; 65 (2.5%) of the children with blood cultures obtained on admission had bacteremia. The most common penicillin-susceptible blood pathogen isolated was *Streptococcus pneumoniae* (n = 47). Eleven children (0.4%) had bacteremia with a pathogen not susceptible to penicillin. Children with bacteremia had a higher median admission white blood cell (WBC)



Dr. Kumar is a pediatric hospitalist at Cleveland Clinic Children's. She is a clinical assistant professor of pediatrics at Case Western Reserve University, Cleveland, and serves as the Pediatrics Editor for *The Hospitalist*.

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count than did those without bacteremia (17.5×10^3 cells per mL vs. 12.4×10^3 cells per mL; $P < .01$) and definite radiographic pneumonia on admission chest radiograph ($P < .01$). C-reactive protein and erythrocyte sedimentation rate were also higher in children with bacteremia but were obtained only in 35% and 15% of patients, respectively. Children with bacteremia had a higher prevalence of complicated pneumonia on admission ($P = .06$) than did children without bacteremia. Children with bacteremia

had longer lengths of stay (4 days vs. 2 days; $P < .01$) and were more likely to be admitted to an ICU ($P < .01$) than were children without bacteremia.

This study is limited by its sample because all of the patients were cared for at tertiary care hospitals. It is also limited by its timing; the PHIS+ data set spans the introduction of the 13-valent pneumococcal vaccine, and so the current prevalence of bacteremia in CAP may be lower than that found in the study.

BOTTOM LINE: The prevalence of bacteremia was low among a cohort of generally healthy children hospitalized with CAP, and no features strongly predicted the presence of bacteremia. The authors recommend that blood cultures in children with CAP should be limited to patients admitted to the ICU.

CITATION: Lipsett SC et al. Predictors of bacteremia in children hospitalized with community-acquired pneumonia. *Hosp Pediatr*. 2019 Oct;9(10):770-8.

Continued from page 16

with recurrent *Clostridioides difficile* infection treated with fecal microbiota transplantation or antibiotics: A prospective cohort study. *Ann Intern Med*. 2019, Nov 5;171:695-702.

9 Ruling out PE in patients with low C-PTP and D dimer of less than 1,000 ng/mL

CLINICAL QUESTION: Can we rule out pulmonary embolism (PE) in patients with a low clinical pretest probability (C-PTP) and a D dimer of less than 1,000 ng/mL?

BACKGROUND: A pulmonary embolism can be considered ruled out if patients have a low C-PTP for PE and a D-dimer level of less than 500 ng/mL. However, this occurs in approximately 30% of outpatients only. By increasing the D-dimer threshold used to define a negative test to 1,000 ng/mL in patients with a low C-PTP, we might be able to rule out a larger segment of patients and avoid chest imaging.

STUDY DESIGN: Prospective study. **SETTING:** University-based clinical centers in Canada.

SYNOPSIS: This study enrolled 2,017 patients presenting with symptoms of PE. The Wells' criteria was used to categorize the patient's C-PTP as low (0-4.0), moderate (4.5-6.0), or high (6.5 or more). Patients with a low or moderate C-PTP had a D dimer drawn. Those with a low C-PTP and D dimer of less than 1,000 ng/mL or moderate C-PTP and a D dimer of less than 500 ng/mL underwent no further testing. Outcomes were assessed at 90 days. Of the 1,325 patients with a low C-PTP or moderate C-PTP and a negative D-dimer test (less than 1,000 or 500 ng/mL, respectively), none had venous thromboembolism during follow-up (95% confidence interval, 0.00-0.29). This strategy resulted in the use of chest imaging in only 34.3% of patients versus 51.9% using the prior criteria of a D-dimer level of less than 500 ng/mL (difference, -17.6 percentage points; 95% CI, -19.2 to -15.9). One limitation of the study is that almost all patients

enrolled were outpatients (only one inpatient).

BOTTOM LINE: A combination of a low C-PTP and a D-dimer level of less than 1,000 ng/mL identified a group of patients at low risk for pulmonary embolism during follow-up. **CITATION:** Kearon C et al. Diagnosis of pulmonary embolism with D-dimer adjusted to clinical probability. *N Engl J Med* 2019 Nov 28;381:2125-34.

Dr. Santa is assistant professor in the division of hospital medicine, Loyola University Medical Center, Maywood, Ill.

By Margaret Tsien, MD

10 Torsemide vs. furosemide in heart failure patients

CLINICAL QUESTION: Does the use of torsemide improve clinical outcomes when compared with furosemide?

BACKGROUND: Treatment goals of heart failure include improvement in quality of life, prevention of hospitalization, and decreases in mortality. Loop diuretics can improve these goals. Furosemide (Lasix) is the most widely used diuretic in heart failure patients. Torsemide

(Demadex) has a better pharmacokinetic and pharmacodynamic profile than does furosemide, with greater bioavailability, a longer half-life, and higher potency. In addition, there is a suggestion that torsemide has a vasodilatory effect and a possible antialdosterone effect that may contribute to its efficacy. However, it is not known if that better profile leads to differences or improvements in primary treatment goals.

STUDY DESIGN: Systematic review and meta-analysis.

SETTING: 19 published randomized, controlled trials (RCTs) or observational studies in the English language.

SYNOPSIS: 19 RCTs and observational studies comparing furosemide and torsemide were analyzed to identify differences in New York Heart Association functional classification, side effects, hospitalizations for heart failure, cardiac mortality, and all-cause mortality. More than 19,000 patients were included with a mean follow-up of 15 months. Torsemide was associated with a significant improvement in functional status with a number

needed to treat of five. In addition, there were lower numbers of hospitalizations from heart failure

and a lower risk of cardiac death in the torsemide arm though these differences disappeared when RCTs were analyzed alone. There were no differences in all-cause mortality

or medication side effects between furosemide and torsemide.

BOTTOM LINE: The use of torsemide is associated with significant improvement in functional status. It is also – though less significantly – associated with lower hospitalization rates for heart failure and lower cardiac mortality.

CITATION: Abraham B et al. Meta-analysis comparing torsemide versus furosemide in patients with heart failure. *Am J Cardiol*. 2020 Jan 1;125: 92-9.

Dr. Tsien is assistant professor in the division of hospital medicine, Loyola University Medical Center, Maywood, Ill.



Dr. Tsien

SHORT TAKES

New antibiotic for complicated UTIs

Fetroja (cefiderocol) is a newly approved antibacterial drug for treatments of patients aged 18 years or older with complicated urinary tract infections and otherwise limited treatment options. Safety and efficacy were demonstrated in a study of 448 patients although there was also a higher all-cause mortality rate in critically ill patients with multidrug-resistant gram-negative bacterial infections.

CITATION: FDA approves new antibacterial drug to treat complicated urinary tract infections as part of ongoing efforts to address antimicrobial resistance. FDA News Release. 2019 Nov 14

Drug of choice for patients with status epilepticus refractory to benzodiazepines

In a prospective, randomized, double-blind, adaptive comparative effectiveness trial involving 384 patients with benzodiazepine-refractory convulsive status epilepticus, the anticonvulsant drugs levetiracetam, fosphenytoin, and valproate each led to seizure cessation and

improved alertness by 60 minutes in approximately half the study population. The three drugs were associated with similar incident of adverse events.

CITATION: Kapur J et al. Randomized trial of three anticonvulsant medications for status epilepticus. *N Engl J Med*. 2019 Nov 28;381:2103-13.

Invasive strategy vs. conservative treatment for stable ischemic heart disease

5,179 participants with stable ischemic heart disease and evidence of moderate to severe ischemia on stress testing were randomized to optimal medical therapy versus optimal medical therapy plus routine cardiac catheterization, followed by intervention in order to evaluate the primary outcome of cardiovascular death and secondary outcomes of stroke and all-cause mortality.

CITATION: Hochman JS. ISCHEMIA Research Group. Late-Breaking Science II: Results for the ISCHEMIA Trials: To intervene or not to intervene. AHA scientific sessions. 2019 Nov 16. Session LBS.02.



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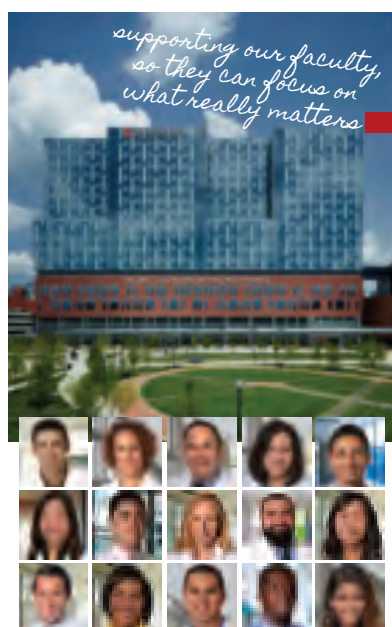
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Survey Insights

Hospital medicine physician leaders

The right skills and time to develop them

By Mihir Patel, MD

“When you get someone who knows what quality looks like and pair that with curiosity about new ways to think about leading, you end up with the people who are able to produce dramatic innovations in the field.”¹

In medicine, a physician is trained to take charge in emergent situations and make potentially lifesaving efforts. However, when it comes to leading teams of individuals, not only must successful leaders have the right skills, they also need time to dedicate to the work of leadership.

To better understand current approaches to dedicated hospital

medicine group (HMG) leadership time, let’s examine the 2018 *State of Hospital Medicine (SoHM) Report*.² The survey, upon which the *Report* was based, examined two aspects of leadership: 1) how much dedicated time a leader receives to manage the group; and 2) how the leader’s time is compensated. Looking closely at the data displayed in graphs from the *SoHM Report* (Figures 1, 2, and 3), we can see that dedicated administrative time is directly proportional to the size of the group.

In my current role as a regional medical director in the Dallas–Fort Worth market, I oversee some programs where the size is greater than 30 full-time equivalents (FTEs), and requires a full-time administrative physician leader to manage the group. Their daily administrative

duties include, but are not limited to, addressing physician performance and behaviors, managing team performance metrics, dealing with consultants’ expectations, attending and leading various committee meetings at the hospital or the system level, attending and presenting performance reviews, and leading and preparing for team meetings, as well as addressing and being innovative in leading new initiatives from the hospital partner system.

Although physician leaders are paid more for their work, the 2018 *SoHM Report* reveals a decline in the premium year over year. One of the reasons for the payment decline that I have encountered in various groups is that their incentives for leading the group are based on performance, as opposed to receiving a fixed stipend. Another reason is the presence of dedicated administrative support or the inclusion of a performance improvement staffer, such as an additional nurse or advanced practice provider, in the group.

Evidence suggests that organizations and patients benefit when physicians take on leadership roles. Physician leaders play critical roles in providing high-quality patient care. How can the Society of Hospital Medicine help? Management degrees and leadership workshops have become a common pathway for many physicians, including myself. SHM provides one of the most thorough and relevant experi-



Dr. Patel is a regional medical director with Sound Physicians. He manages more than 100 FTE hospitalists and advanced-practice providers (APPs) within multiple health systems and hospitals in the Texas market. He also serves as a member of the SHM Practice Analysis Committee and as a vice president of SHM North Texas Chapter.

ences through the SHM Leadership Academy. The focus of the Leadership Academy is on developing a broad set of additional leadership competencies across a spectrum of experience.⁴ As hospitalist physicians are often expected to fulfill a broader leadership void, we must pay attention to developing the leadership skills depicted in Figure 3. Hospital medicine is an ideal “proving ground” for future physician

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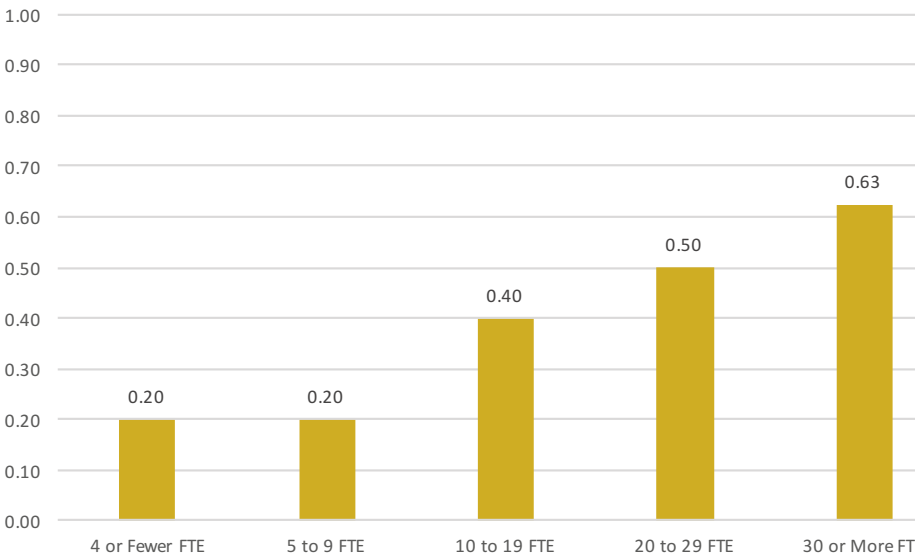


Figure 1: Portion of FTE dedicated for Administrative duties of Lead Physician, by group size.²

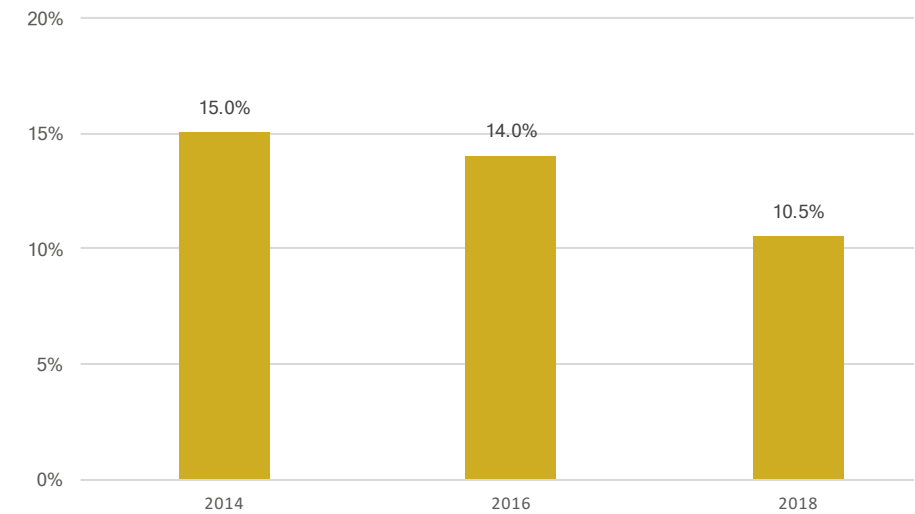


Figure 2: Compensation Premium for Lead Physician compared to hospitalists by year.²

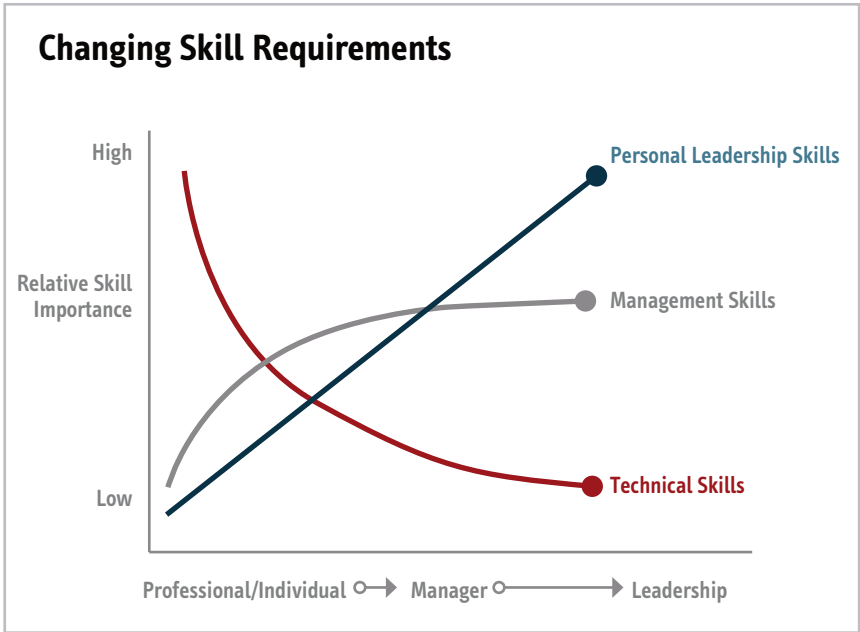


Figure 3: Changing Professional Skill Requirements³

Medicare study evaluates impact of U.S. hospital readmissions program

By Doug Brunk
MDedge News

Among Medicare beneficiaries admitted to the hospital between 2008 and 2016, there was an increase in postdischarge 30-day mortality for patients with heart failure, but not for those with acute myocardial infarction or pneumonia.

The finding comes from an effort to evaluate the use of services soon after discharge for conditions targeted in the U.S. Hospital Readmissions Reduction Program (HRRP), and patients' outcomes.

"The announcement and implementation of the HRRP were associated with a reduction in readmissions within 30 days of discharge for heart failure, acute myocardial infarction, and pneumonia, as shown by a decrease in the overall national



Dr. Khera

rate of readmissions," wrote Rohan Khera, MD, and colleagues in a study published in the *British Medical Journal* (doi:10.1136/bmj.l6831).

"Concerns existed that pressures to reduce readmissions had led to the evolution of care patterns that may have adverse consequences through

reducing access to care in appropriate settings. Therefore, determining whether patients who are seen in acute care settings, but not admitted to hospital, experience an increased risk of mortality is essential."

The study strongly suggests that the HRRP "did not lead to harm through inappropriate triage of patients at high risk to observation units and the emergency department, and therefore provides evidence against calls to curtail the program owing to this theoretical concern (see *JAMA* 2018;320:2539-41)," the researchers concluded.

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executives and leaders, as they often share the same characteristics required for success.

The leadership paths available in my organization, Sound Physicians, were recently highlighted in a *New York Times* article.⁵ Sound Physicians employs more than 3,000 physicians across the country, and has a pipeline for doctors to advance through structured rungs of leadership – emphasizing a different mix of clinical, strategic, and business skills at each stage, from individual practitioner to the C-suite. The training includes in-person and online courses, as well as an annual conference, to help doctors develop management and leadership competencies, and learn how to apply these skills within their organizations. Since introducing its leadership development program, the company reports less turnover, higher morale, and better growth. I personally have gone through the leadership training provided by Sound Physicians, and reflecting back, it has been a transformational experience for me. Leadership is a journey, not a destination, and as physicians we should strive to learn

more from the health care leaders around us.

The administrative workload for hospital-based physician leaders will increase with the arrival of value-based programs and alternative payment models promoted by the Centers for Medicare & Medicaid Services. Lead hospitalist duties are not limited to daily operations, but can extend to leading the strategic vision of the hospital or health system. The 2020 *SoHM Report* will reflect these changes, as well as provide further information about how to manage and set expectations for physician leaders, based on group size and employment model.

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