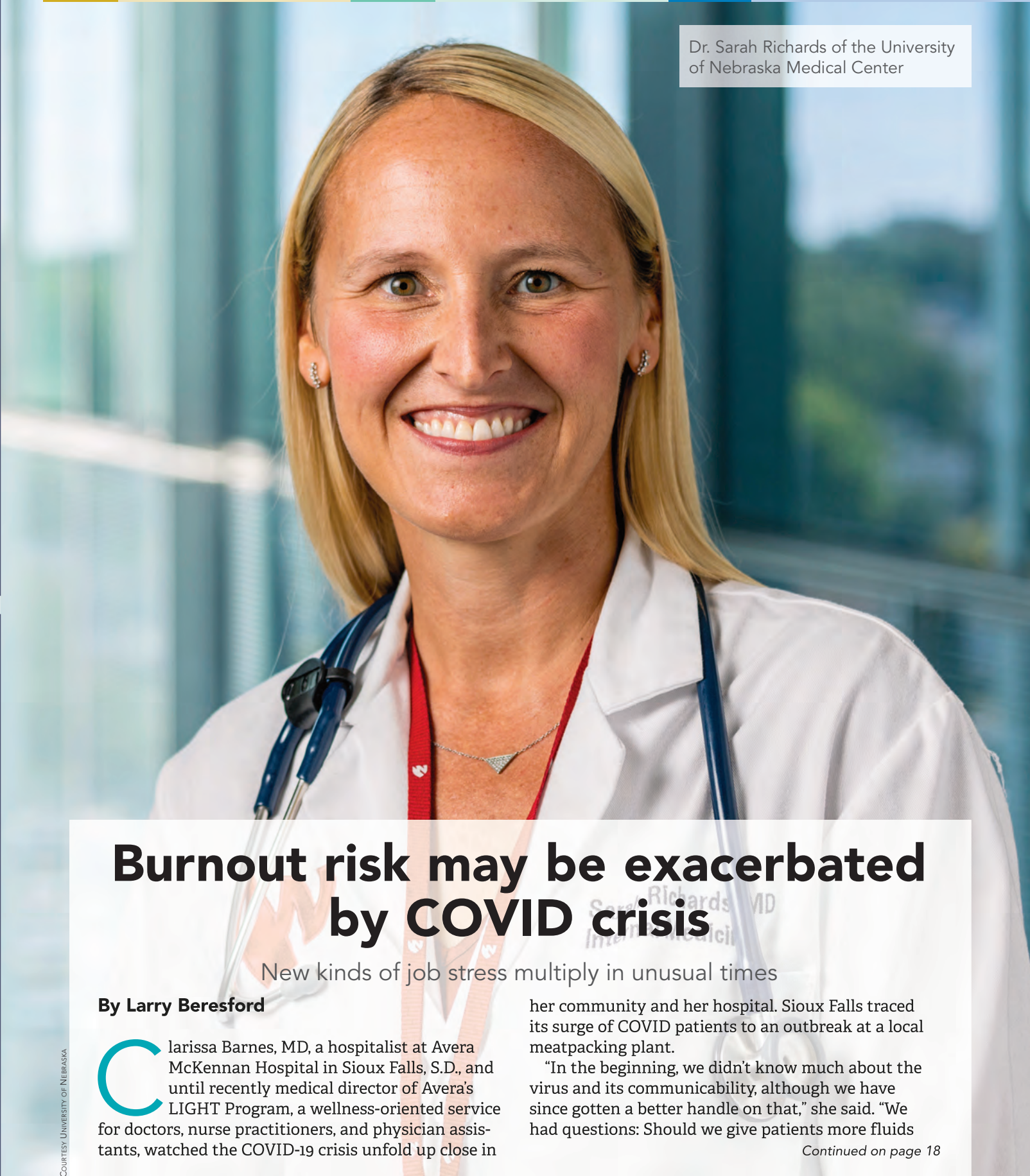


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Dr. Sarah Richards of the University of Nebraska Medical Center

Burnout risk may be exacerbated by COVID crisis

New kinds of job stress multiply in unusual times

By Larry Beresford

Clarissa Barnes, MD, a hospitalist at Avera McKennan Hospital in Sioux Falls, S.D., and until recently medical director of Avera's LIGHT Program, a wellness-oriented service for doctors, nurse practitioners, and physician assistants, watched the COVID-19 crisis unfold up close in

her community and her hospital. Sioux Falls traced its surge of COVID patients to an outbreak at a local meatpacking plant.

"In the beginning, we didn't know much about the virus and its communicability, although we have since gotten a better handle on that," she said. "We had questions: Should we give patients more fluids

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HM20 Virtual: What did we learn?

By Daniel I. Steinberg, MD, SFHM, FACP

The last session of each SHM Annual Conference is traditionally a short presentation titled “What Have We Learned?” that is delivered by next year’s course director (and this year, that was me!). It’s a way to celebrate all the great things about the meeting and get people excited about next year. And this was most certainly a year where we learned a lot.

We’ve learned that, by making the heartbreaking decision to cancel the HM20 in-person conference and convert to a virtual platform, SHM leadership is not afraid to do the right thing to protect the health of its members and staff, even when such a decision comes at significant cost to the organization. We’ve learned that the SHM staff are flexible and innovative and are masters of logistics – their ability to pivot so quickly into a virtual format on such short notice is nothing short of amazing. On the Annual Conference Committee, we already knew that Benji Mathews, MD, the HM20 course director, was an outstanding leader. True to form, despite facing unprecedented uncertainty and tremendous disappointment, Benji continued to lead with the steady, eloquent presence and poise he’s known for, delivering an outstanding HM20 Virtual.

We’ve learned that SHM members can enjoy and engage meaningfully in a virtual format, as evidenced by well-attended sessions, including robust Q&A exchanges that took place during HM20 Virtual’s simulive offerings. Not seeing each other in person this year has reminded us how much the sense of community we enjoy through SHM means to so many of us. I missed catching up with so many colleagues that have become true friends over the years, and I know you did as well.

We also saw how SHM does not hesitate to provide a platform to shine a spotlight on the critical issues of the day. The double pandemic of COVID-19 and structural racism that we face was addressed head-on by expert faculty in sessions such



as “Structural Racism and Bias in Hospital Medicine During Two Pandemics,” “The Immigrant Hospitalist: Navigating the Uncertain Terrain During COVID-19,” and “When Grief and Crises Intersect: Perspectives of a Black Physician in the Time of Two Pandemics.” Sessions on different aspects of COVID-19 enabled our members to stay up to date on the continually evolving knowledge base of this new disease.



Dr. Steinberg

We are so excited as we look ahead to SHM Converge in 2021. There will be content on COVID-19 ... but not too much COVID. The ACC is mindful that our members come to the Annual Conference to hear experts speak on a broad range of clinical topics, and

SHM Converge will be sure to deliver. An innovative new track on Diagnostic Safety will address this critical aspect of high-quality care. We will also debut a new leadership track. The ACC is also proud to introduce a dedicated track that will include sessions that address diversity, disparities, and equity. And if what happens in Vegas cannot stay in Vegas, and a virtual element needs to be part of SHM Converge, we will utilize a sophisticated and highly functional platform that will provide some things that our HM20 Virtual platform didn’t.

Couldn’t make HM20 Virtual? Don’t worry! You can still experience the in-depth, immersive education courtesy of some of the most knowledgeable faculty in the field through HM20 Virtual On Demand.

It has indeed been a year in which we have learned a lot. Most importantly, we have learned that we are resilient and are stronger together. That SHM and the Annual Conference – be it virtual or in person – is a place where we value, respect, and support each other. Have a great year. I look forward to welcoming you to SHM Converge in May 2021!

Dr. Steinberg is associate chair for education and residency program director in the department of medicine at Mount Sinai Beth Israel, New York, and course director of SHM Converge.

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COVID-19 pandemic amplifies uncertainty for immigrant hospitalists

H-1B visa program needs improvement

By Kari Oakes

MDedge News

Statistics tell the tale of immigrants in the American health care workforce in broad strokes. In an interview, though, one hospitalist shared the particulars of his professional and personal journey since arriving in the United States from India 15 years ago.

Mihir Patel, MD, MPH, FHM, came to the United States in 2005 to complete a Master's in Public Health. Fifteen years later, he is still waiting



Dr. Mihir Patel wears PPE.

for the green card that signifies U.S. permanent residency status. The paperwork for the application, he said, was completed in 2012. Since then, he's been renewing his H-1B visa every 3 years, and he has no expectation that anything will change soon.

"If you are from India, which has a significant backlog of green cards – up to 50 years ... you just wait forever," he said. "Many people even die waiting for their green card."

Arriving on a student visa, Dr. Patel completed his MPH and began an internal medicine residency in 2008, holding a J-1 visa for the 3 years of his U.S. residency program.

"Post-residency, I started working in a rural hospital in an underserved area of northeast Tennessee as a hospitalist," thus completing the 3 years of service in a rural underserved area that's a requirement for J-1 visa holders, said Dr. Patel. "I loved this rural community hospital so much that I ended up staying there for 6 years. During my work

at this rural hospital, I was able to enjoy the autonomy of managing a small ICU, doing both critical care procedures and management of intubated critical patients while working as a hospitalist," he said. Dr. Patel served as chief of staff at the hospital for 2 years, and also served on the board of directors for his 400-physician medical group.

"I was a proud member of this rural community – Rogersville," said Dr. Patel. Although he and his wife, who was completing her hospitalist residency, lived in Johnson City, Tenn., "I did not mind driving 120 miles round trip every day to go to my small-town hospital for 6 years," he said.

Spending this time in rural Tennessee allowed Dr. Patel to finish the requirements necessary for the Physician National Interest Waiver and submit his application for permanent residency. The waiver, though, doesn't give him priority status in the waiting list for permanent residency status.

After a stint in northern California to be closer to extended family, the pull of "beautiful northeast Tennessee and the rural community" was too strong, so Dr. Patel and his family moved back to Johnson City in 2018.

Now, Dr. Patel is a hospitalist at Ballad Health System in Johnson City. He is the corporate director of Ballad's telemedicine program and is also the medical director of the COVID-19 Strike Team. He co-founded and is president of the Blue Ridge Chapter of the Society of Hospital Medicine. Under another H-1B visa, Dr. Patel works part-time from home as a telehospitalist, covering six hospitals in four different states.

Even in ordinary circumstances, the H-1B visa comes with constraints. Although Dr. Patel's 6-year-old daughter was born in the United States and is a citizen, Dr. Patel and his wife have to reapply for their visas every 3 years. "If we travel outside the U.S., we have to get our visas stamped. We cannot change jobs easily due to fear of visa denial, especially with the recent political environment," said Dr. Patel. "It feels like we are essential health care workers but nonessential immigrants."



Dr. Patel is a private pilot, and flies with his daughter.

Having recently completed a physician executive MBA program, Dr. Patel said he'd like to start a business of his own using Lean health care principles and telemedicine to improve rural health care. "But while on an H-1B I cannot do anything outside my sponsored employment," he said.

Ideally, health care organizations would have high flexibility in how and where staff are deployed when a surge of COVID-19 patients hits. Dr. Patel made the point that visa restrictions can make this much harder: "During this COVID crisis, this restriction can cause significant negative impact for small rural hospitals, where local physicians are quarantined and available physicians are on a visa who cannot legally work outside their primary facilities – even though they are willing to work," he said. "One cannot even work using telemedicine in the same health system, if that is not specifically mentioned during H-1B petition filling. More than 15,000 physicians who are struck by the green card backlog are in the same situation all over U.S.," he added.

These constraints, though, pale before the consequences of a worst-case pandemic scenario for an immigrant family, where the physician – the primary visa-holder – becomes disabled or dies. In this case, dependent family members must self-deport. "In addition, there would not be any disability or Social Security benefits for the physician or dependents, as they are not citizens or green card



Dr. Patel appears on a telehealth monitor at Ballad Health System.

holders and they cannot legally stay in the U.S.," noted Dr. Patel. "Any hospitalist working during the COVID-19 pandemic can have this fate due to our high exposure risk."

SHM has been advocating to improve the H-1B visa system for years, Dr. Patel said. The Fairness for High-Skilled Immigrants Act passed the U.S. House with bipartisan support, and the Society is advocating for its passage in the Senate.

The Fairness for High-Skilled Immigrants Act (S. 386) simplifies the employment-based immigration system by removing per-country caps, converting the employment-based immigration system into a "first-come, first-served" system that does not discriminate on country of origin. The act will also help alleviate the green card and permanent residency application backlogs.

Dr. Patel emphasized the importance of action by Congress to reauthorize the physician visa waiver program and expediting physician permanent residency. "This is a crisis and we are all physicians who are ready to serve, regardless of our country of origin. Please let us help this great nation by giving us freedom from visa restrictions and providing security for our families.

"During wartime, all frontline soldiers are naturalized and given citizenship by presidential mandate; this is more than war and we are not asking for citizenship – but at least give us a green card which we have already satisfied all requirements for. If not now, then when?" he asked.

PHOTOS COURTESY DR. MIHIR PATEL

The pandemic experience through the eyes of APPs

The evolution of hospitalist advanced practice providers

By Sarah Ludwig Rausch

MDedge News

Throughout the chaos of the COVID-19 pandemic, advanced practice providers (APPs) – physician assistants (PAs) and nurse practitioners (NPs) – have become an integral component of the hospitalist response. As many physicians began shifting into telemedicine and away from direct patient care, APPs have been eagerly jumping in to fill the gaps. Their work has been changing almost as dramatically and quickly as the pandemic itself, bringing with it expected challenges but bestowing hugely satisfying, often unanticipated, rewards.

APPs on the rise

As the coronavirus pandemic evolves, the role of APPs is evolving right alongside it. With the current relaxation of hospital bylaw restrictions on APPs, their utilization has increased, said Tracy Cardin, ACNP-BC, SFHM, a nurse practitioner and vice president of advanced practice providers at Sound Physicians. “We have not really furloughed any advanced practice providers,” Ms. Cardin said. “In fact, I consider them to be, within hospital medicine, a key lever to finding more cost-effective care delivery models.”

Ms. Cardin said APPs have been working more independently since COVID-19 started, seeing patients on their own and using physician consultation and backup via telemedicine or telephone as needed. With the reduction in elective surgeries and patient volumes at many hospitals, APP-led care also saves money. Because one of the biggest costs is labor, Ms. Cardin said, offering this high-quality care delivery model using APPs in collaboration with physician providers helps defray some of that cost. “We’re hoping that advanced practice providers are really a solution to some of these financial pressures in a lot of different ways,” she said.

“COVID ... forced us to expedite conversations about how to maximize caseloads using APPs,” said Alicia Sheffer, AGAC-AGPC NP, a nurse practitioner and Great Lakes regional director of advanced practice providers at Sound Physicians in Cincinnati. Some of those staffing model changes have included using APPs while transitioning ICUs and med-surg units to COVID cohort units, APP-led COVID cohorts, and APP-led ICUs.

“At first the hospital system had ideas about bringing in telemedicine as an alternative to seeing patients, rather than just putting APPs on the front lines and having them go in and see patients,” said Jessica Drane, APRN, PhD, DNP FNP-C, a nurse practitioner and regional director of advanced practice provider services and hospital medicine at Sound Physicians in San Antonio. In Texas at the beginning of the pandemic, hospital numbers were so low that Dr. Drane did not work at all in April. “We were all afraid we were

going to lose our jobs,” she said. Then the state got slammed and APPs have been desperately needed.

Iliaria Gadalla, DMSc, PA-C, a PA at Treasure Coast Hospitalists in Port St. Lucie, Fla., and the PA program director at South University, West Palm Beach, Fla., noted that many of her APP colleagues have pivoted fluidly from other specialties to the hospitalist realm as the need for frontline workers has increased. “Hospitalists have shined through this and their value has

“Advanced practice providers are ... willing to go into those COVID units. They’re willing to be in the front lines. They are dedicated. They’re just intensely inspirational to me.”

been recognized even more than previously as a result of COVID-19,” Dr. Gadalla said.

“I don’t think it’s any surprise that hospitalists became a pillar of the COVID pandemic,” said Bridget McGrath, PA-C, a physician assistant and director of the NP/PAs service line for the section of hospital medicine at the University of Chicago. “There are just some innate traits that hospitalists have, such as the ability to be flexible, to problem solve, and to be the solution to the problem.”

Team camaraderie

Ms. Cardin says that the need for APPs has led to an evolving integration between physicians and APPs. The growing teamwork and bonding between colleagues have been some of the most rewarding aspects of the pandemic for Dr. Gadalla. “We rely even more on each other and there isn’t really a line of, ‘I’m a physician versus an NP or PA or nurse.’ We’re all working together with the same goal,” she said.

Ms. McGrath said she has been learning what it means to lead a team during a challenging time. It has been gratifying for her to watch mentors get down to the bare bones of patient care and see everyone unify, putting aside roles and titles and coming together to care for their patients in innovative ways.

“This pandemic has really opened up a lot of doors for us because up until now, we were used almost like scribes for physicians,” Dr. Drane said. She has seen even the most resistant hospital systems beginning to rely on APPs as the pandemic has progressed. “They have become pleasantly surprised at what an APP can do.”

Work challenges

Obviously, challenges abound. Dr. Gadalla listed hers as visiting restrictions that invariably lead to slower patient visits thanks to obligatory phone calls, constantly fluctuating patient censuses,

sporadic elective surgeries, watching colleagues become furloughed, and trying to balance external perceptions with what’s actually happening in the hospital.

Overall, though, “There have been a lot more rewards than barriers,” added Dr. Drane.

One of the biggest obstacles for health care workers navigating a pandemic is balancing work and home life, not to mention having time to unwind while working long hours. “Finding time for my family has been very limited. My kids feel really neglected,” said Dr. Gadalla. Some days, she gets up extra early to exercise to help clear her head, but other times she’s just too exhausted to even move.



Ms. Cardin

Dr. Drane agreed that the work can get overwhelming. “We’re changing the way we practice almost every week, which can make you doubt yourself as an educator, as a practitioner. You constantly feel like you’re not sure what you’re doing, and people trust you to heal them,” she said. “Today is my first day off in 24 days. I only got it off because I said I needed a moment.”

Ms. Sheffer’s crazy days were at the beginning of the pandemic when she had to self-quarantine from her family and was working nonstop. “I would come home and sleep and work and wake up in the middle of the night and double-check and triple-check and go back to sleep and work, and that consumed me for several months,” she said.

The biggest challenge for Ms. Sheffer has been coping with public fear. “No matter how logical our medical approach has been, I think the constant feeling of the public threat of COVID has had this insidious effect on how patients approach their health,” she said. “We’re spending a lot more time shaping our approach to best address their fears first and not to politicize COVID so we can actually deal with the health issue at hand.”

Complications of COVID

With all the restrictions, caring for patients these days has meant learning to interact with them in different ways that aren’t as personal, Ms. McGrath said. It has been difficult to lose “that humanity of medicine, the usual ways that you interact with your patients that are going through a vulnerable time,” she noted.

Additionally, students in the medical field are being held back from graduation because they cannot participate in direct patient care. This is particularly problematic for PAs and medical students who must touch patients to graduate, Dr. Gadalla said. “All of this is slowing down future providers. We’re going to have trouble catching up. Who’s going to relieve us? That’s a huge problem and no one is finding solutions for that yet,” she said.



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At the University of Chicago, Ms. McGrath explained, they created virtual rotations so that PA students could continue to do them at the university. Not only has the experience reminded Ms. McGrath how much she loves being a medical educator and fighting for the education of PA students, but she was surprised to find that her patients came to appreciate the time they spent with her students on the virtual platform as well.

“It’s isolating for patients to be in the hospital in a vulnerable state and with no support system,” she said. “I think being a part of [the PA students] education gave some meaning to their hospitalization and highlighted that collaboration and connection is a human need.”

Despite everything, there’s a noticeable emphasis on the flowering buds of hope, unity, compassion, and pride that have been quietly blooming from the daily hardships. As Ms. Cardin puts it, “It’s so cliché to say that there’s a crisis. The other word is ‘opportunity,’ and it’s true, there are opportunities here.”



Dr. Gadalla

Peer Networks

Creating resources for providers has been a priority at the University of Chicago, according to Ms. McGrath. “As hospitalists, we’re used to taking care of a variety of patients, but our section leadership and providers on the front lines quickly realized that COVID patients are more akin to trauma patients with their quick changes in health, as well as their isolation, fear, and unexpected deterioration,” she said. Her facility has implemented wellness initiatives to help prevent burnout and mental health problems in COVID providers so they can continue to give the best care to their patients.

Both Ms. Sheffer and Dr. Drane say that they have a peer network of APPs at Sound Physicians to call on for questions and support. And it’s encouraging to know you’re not alone and to keep

tabs on how colleagues in other states are doing, Ms. Sheffer noted.

“The peer support system has been helpful,” Dr. Drane said. “This job, right now, takes pieces of you every day. Sometimes it’s so emotional that you can’t put it into words. You just have to cry and get it out so that you can go be with your family.”

Back to basics

The changes in patient care have turned into something Ms. McGrath said she appreciates.

It has been difficult to lose “that humanity of medicine, the usual ways that you interact with your patients that are going through a vulnerable time.”

“This pandemic has really stripped away the extra fluff of medicine and brought us back to the reason why many of us have gotten into the field, because it became about the patients again,” she says. “You quickly learn your strengths and weaknesses as a provider and as a leader, and that flows into the decisions you’re making for your team and for your patients.”

Ms. Sheffer acknowledged that it is difficult to deal with patients’ family members who don’t understand that they can’t visit their sick relatives, but she said the flip side is that frontline workers become surrogate family members, an outcome she considers to be an honor.

“You step into the emotion with the family or with the patient because you’re all they have. That is a beautiful, honorable role, but it’s also tremendously emotional and sometimes devastating,” she said. “But to me, it’s one of the most beautiful things I’ve been able to offer in a time where we don’t even know what to do with COVID.”

Limited resources mixed with a healthy dose of fear can stifle creativity, Dr. Drane said. Right

away, she noticed that, despite the abundance of incentive spirometers at her hospital, they were not being utilized. She came in 2 hours early for 3 days to pass one out to every patient under investigation or COVID-positive patient and enlisted the help of her chief nursing officer, CEO, and regional medical director to get everyone on board.

Dr. Drane’s out-of-the-box thinking has enabled people to go home without oxygen 2 days earlier and cut the hospital’s length of stay by 5%. “It’s something so small, but it has such a great end reward,” she said. “I’m proud of this project because it didn’t take money; it was getting creative with what we already have.”

Renewed pride and passion

Dr. Drane is intensely proud of being an NP and working on the front lines. She sees that the pandemic has encouraged her and other APPs to expand their horizons.

“For me, it’s made me work to get dual certified,” she said. “APPs can be all-inclusive. I feel like I’m doing what I was meant to do and it’s not just a job anymore.”

Ms. McGrath is even more passionate about being a hospitalist now, as she has realized how valuable their unique skill sets are. “I think other people have also been able to realize that our ability to see the patient as a whole has allowed us to take care of this pandemic, because this disease impacts all organ systems and has a trickle-down effect that we as hospitalists are well versed to manage,” she said.

Ms. Cardin’s work involves communicating with APPs all around the country. Recently she had a phone exchange with an APP who needed to vent.

“She was weeping, and I thought she was going to say, ‘I can’t do this anymore. I need to go home,’” said Ms. Cardin. “Instead, she said, ‘I just want to make a difference in one of these people’s lives.’ And that is who the advanced practice providers are. They’re willing to go into those COVID units. They’re willing to be in the front lines. They are dedicated. They’re just intensely inspirational to me.”

SHM chapter innovations: A provider exchange program

BY Krystle D. Apodaca, DNP, FHM; Amith Skandhan, MD, FHM

The SHM Annual Conference is more than an educational event. It also provides an opportunity to collaborate, network, and create innovative ideas to improve the quality of inpatient care.

During the 2019 Annual Conference (HM19) – the last “in-person” Annual Conference before the COVID pandemic – SHM chapter leaders from the New Mexico chapter (Krystle D. Apodaca, DNP, FHM) and the Wiregrass chapter (Amith Skandhan, MD, FHM), which covers the counties of Southern Alabama and the Panhandle of Florida, met during a networking event.

As we talked, we realized the unique differences and similarities our practice settings shared. We debated the role of clinician well-being, quality of medical education, and faculty development on individual hospital medicine group (HMG) practice styles.

Clinician well-being is the prerequisite to the Triple Aim of improving the health of populations, enhancing the patient experience, and reducing the cost of care. Engagement in local SHM chapter activities promotes the efficiency of practice, a culture of wellness, and personal resilience. Each HMG faces similar challenges but approaches to solving them vary. Professional challenges can affect the well-being of individual clinicians. During our discussion we realized that an inter-institutional exchange program could provide a platform to exchange ideas and establish mentors.

The quality of medical education is directly linked to the quality of faculty development. Improving the quality of medical education requires a multifaceted approach by highly developed faculty. The complex factors affecting medical education and faculty development are further complicated by geographic location, patient characteristics, and professional growth opportunities.

Overcoming these obstacles requires an innovative and collaborative approach. Although faculty exchanges are common in academic medicine, they are not commonly attempted with HMGs. Hospitalists

are responsible for a significant part of inpatient training for residents, medical students, and nurse practitioners/physician assistants (NPs/PAs) but their faculty training can vary based on location.

As a young specialty, hospital medicine is still evolving and incorporating NPs/PAs and physician hospitalists in varied practice models. Each HMG addresses common obstacles differently based on their culture and practice styles. As chapter leaders we determined that an exchange program would afford the opportunity for visiting faculty members to experience these differences.

We shared the idea of a chapter-level exchange with SHM’s Chapter Development Committee and obtained chapter development funds to execute the event. We also requested that an SHM national board member visit during the exchange to provide insight and feedback. We researched the characteristics of individual academic HMGs and structured a faculty exchange involving physicians and NPs/PAs. During the exchange program planning, the visiting faculty itinerary was tailored to a well-planned agenda for 1 week, with separate tracks for physicians and NPs/PAs, giving increased access to their individual peer practice styles. Additionally, the visiting faculty had meetings and discussions with the HMG and hospital leadership, to specifically address the visiting faculty’s institutional challenges.

The overall goal of the exchange program was to promote cross-institutional collaboration, increase engagement, improve medical education through faculty development, and improve the quality of care. The focus of the exchange program was to share ideas and innovation, and learn the approaches to unique challenges at each institution. Out of this also grew collaboration and mentoring opportunities.

SHM’s New Mexico chapter is based in Albuquerque, a city in the desert Southwest with an ethnically diverse population of 545,000. The chapter leadership works at the University of New Mexico (UNM), a 553-bed medical center. UNM has a well-established internal medicine residency program, an academic hospitalist program, and an NP/PA fellowship program embedded within the hospital medicine depart-

ment. At the time of the exchange, the HMG at UNM has 26 physicians and 9 NP/PAs.

The SHM Wiregrass chapter is located in Dothan, Ala., a town of 80,000 near the Gulf of Mexico. Chapter leadership works at Southeast Health, a tertiary care facility with 420 beds, an affiliated medical school, and an internal medicine residency program. At the time of the exchange, the HMG at SEH has 28 physicians and 5 NP/PAs.

These are two similarly sized hospital medicine programs, located in different geographic regions, and serving different populations. SHM board member Howard Epstein, MD, SFHM, vice president and chief medical officer of Presbyterian Healthcare Services in Albuquerque, participated on behalf of the Society when SEH faculty visited UNM. Kris Rhem, MD, SFHM, a pediatric hospitalist and the vice chair of outreach medicine at Vanderbilt University Medical Center, Nashville, Tenn., came to Dothan during the faculty visit by UNM.

Two SEH faculty members, a physician and an NP, visited the University of New Mexico Hospital for 1 week. They participated as observers, rounding with the teams and meeting the UNM HMG leadership. The focus of the discussions included faculty education, a curriculum for quality improvement, and ways to address practice challenges. The SEH faculty also presented a QI project from their institution, and established collaborative relationships.

During the second part of the exchange, three UNM faculty members, including one physician and two NPs, visited SEH for 1 week. During the visit, they observed NP/PA hospitalist team models, discussed innovations, established mentoring relationships with leadership, and discussed QI projects at SEH. Additionally, the visiting UNM faculty participated in Women in Medicine events and participated as judges for a poster competition. They also had an opportunity to explore the rural landscape and visit the beach.

The evaluation process after the exchanges involved interviews, a survey, and the establishment of shared QI projects in mutual areas of challenge. The survey provided feedback, lessons learned from the exchange,



Dr. Apodaca

Dr. Skandhan

Dr. Apodaca is assistant professor and nurse practitioner hospitalist at the University of New Mexico. She serves as codirector of the UNM APP Hospital Medicine Fellowship and director of the APP Hospital Medicine Team. Dr. Skandhan is a hospitalist and member of the Core Faculty for the Internal Medicine Residency Program at Southeast Health, Dothan Ala., and an assistant professor at the Alabama College of Osteopathic Medicine. He serves as the medical director/physician liaison for the Clinical Documentation Program at SEH and also as the director for physician integration for Southeast Health Statera Network, an Accountable Care Organization.

and areas to be improved. Collaborative QI projects currently underway as a result of the exchange include paging etiquette, quality of sleep for hospitalized patients, and onboarding of NPs/PAs in HMGs.

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

This event created opportunities for faculty collaboration and expanded the professional network of participating institutions. The costs of the exchange were minimal given support from SHM. We believe that, once the COVID pandemic has ended, this initiative has the potential to expand facilitated exchanges nationally and internationally, enhance faculty development, and improve medical education.



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What hospitalists need to know about health care reimbursement and denial prevention

By Marina S. Farah, MD, MHA

Under a fee-for-service payment model, health care providers get paid by private and public payers for patient services such as physician visits, hospital stays, procedures, and tests. In an ideal world, providers would receive accurate, complete, and timely reimbursements. Unfortunately, the reality is far from ideal, where payment denials and delays are a common occurrence.

According to one study, out of \$3 trillion in total claims submitted by health care organizations, an estimated 9% of charges (\$262 billion), were initially denied.¹ The good news is that 90% of all denials are preventable, and two-thirds of those preventable denials can be successfully appealed.²

Hospitalists are essential in preventing denials for hospital services and should be familiar with the basics of health care reimbursement and common reasons for denials. In this article we will provide an overview of the U.S. health care payment system, revenue cycle management and types of denials, and focus on the role of physician advisors and hospitalists in preventing and combating denials.

Overview of the U.S. health care payment system

In 2018 alone, the United States spent \$3.6 trillion on health care. Of those dollars, 33% went to payments for hospital care and 20% went to physician and clinical services.³ So where do the nation's health care dollars come from?

The United States has a complex multiple-payer system that includes private insurance com-

Clinical denials are based on medical necessity, including level of care determination ... and length of stay. They can be concurrent and retrospective and typically start as soft denials.

panies and public payers funded by the federal and state governments, such as Medicare and Medicaid. Per the National Association of Insurance Commissioners' 2018 Market Share Reports, there are 125 private accident and health insurance companies in the United States, with the top five – UnitedHealth, Kaiser, Anthem, Humana, and CVS – holding a cumulative market share of almost 40%.⁴

Medicare accounts for 15% of federal budget spending and provides insurance coverage to almost 60 million people who are 65 and older, have end-stage renal disease, or have been approved for Social Security disability insurance benefits.⁵ Medicare Part A covers hospital, skilled nursing, home health, and hospice care. For example, for

inpatient stays, Medicare Part A pays hospitals a predetermined rate per discharge according to the Medicare Severity Diagnosis Related Groups (MS-DRGs), which are based on the principal and secondary diagnoses, and performed procedures.⁶

Medicare Part B covers physician services and outpatient services and supplies, including labs and durable medical equipment, which are paid based on submitted Healthcare Common Procedure Coding System (HCPCS) codes.⁷ It is important to know that hospital observation stays are considered outpatient services, and are paid by Medicare Part B. Outpatient stays often are reimbursed at a lower rate than inpatient admissions, even in cases with similar utilization of hospital resources.

Medicaid is jointly funded by the states and the federal government and offers insurance coverage to more than 75 million eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Over 10 million people are dually eligible for both Medicare and Medicaid.⁵ Increasingly, government payers, both state and federal, are contracting with private insurance companies to deliver Medicare and Medicaid services, also known as Medicare Advantage and Managed Medicaid Plans.

According to the U.S. Department of Treasury, in the 2019 fiscal year (October 2018 to September 2019), 33% of the nation's health care dollars came from private insurance, 21% from Medicare, 16% from Medicaid, 15% from other government programs (for example, Veteran Affairs), 10% from out-of-pocket, and 4% from other private sources.⁵

Explanation of revenue cycle management and denials

Providers, such as physicians or hospitals, submit claims to insurance companies that include, among other information, patient demographics and insurance, diagnoses, MS-DRGs and/or HCPCS codes, and charges. Revenue cycle management's goal is to receive accurate, complete, and timely reimbursement for provided patient services, which is a complex and resource-intensive process.

According to the Healthcare Financial Management Association (HFMA), revenue cycle management includes "all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue." These functions could be broken down into four main categories:

- Claims preparation (for example, patient registration, insurance eligibility, benefit verifications, and preauthorization).
- Claims submission (for example, charge capture, medical coding based on medical record documentation, and claims transmission).
- Claims management (for example, payment posting, denial management, and patient collections).
- Reporting and analysis.



Dr. Farah is a hospitalist, physician adviser, and Lean Six Sigma Black Belt. She is a performance improvement consultant based in Corvallis, Ore., and a member of The Hospitalist's editorial advisory board.

Claim denial is "the refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional."⁸ Payers can deny an entire claim or provide only a partial payment. Initial denial rate is tracked at the claim level (number of claims denied/number of claims submitted) and at the dollar level (total dollar amount of claims denied/total dollar amount of claims submitted).

Denials are classified as hard versus soft, and clinical versus technical or administrative:

- Hard denials result in lost revenue unless successfully appealed (for example, lack of medical necessity).
- Soft denials do not require appeal and may be paid if a provider corrects the claim or submits additional information (for example, missing or inaccurate patient information, and missing medical records).
- Clinical denials are based on medical necessity, including level of care determination (for example, inpatient versus outpatient) and length of stay. They can be concurrent and retrospective and typically start as soft denials.
- Technical or administrative denials are based on reasons other than clinical (for example, failure to preauthorize care or lack of benefits).

According to the Advisory Board's 2017 survey of hospitals and health care systems, 50% of initial denials were technical/demographic errors, 20% medical necessity, 16% eligibility, and 14% authorization. Forty seven percent of those denials came from commercial payers, 33% from Medicare/Medicare Advantage, 17% from Medicaid, and 3% from other payers.⁹

Determination of medical necessity may vary by payer. As an example, let's look at inpatient admissions. According to the Medicare Two-Midnight Rule, inpatient admission is appropriate "if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning two or more midnights, and such reasonable expectation is supported by the medical record documentation."¹⁰

Medicare guidelines acknowledge that a physician's decision to admit a patient is based on complex medical factors including, but not limited to:

- The beneficiary history and comorbidities, and the severity of signs and symptoms (also known as Severity of Illness or SI).
- Current medical needs (also known as Intensity of Service or IS).
- The risk of an adverse event.

Generally, private payers do not follow the Two-Midnight Rule, and instead utilize evidence-based MCG guidelines,¹¹ InterQual[®] criteria¹² or internal criteria to determine if an inpatient admission is "medically necessary." Hospital utilization review nurses often use MCG and/or InterQual[®] to aid admission status decisions and may request secondary review by a physician if medical necessity for an inpatient admission is not clear-cut.

The role of physician advisors

Considering the rising financial pressure and growing complexity of private and public payers' rules and regulations, many hospitals turned to physician advisors to help prevent and reduce denials. Typically, physician advisors perform concurrent secondary reviews to help determine the most appropriate level of care, participate in peer-to-peer discussions with payers, and write

"Hospitalists are the natural physician advisors as they have a working knowledge of which patients need to be inpatients and which are less sick and likely to be discharged quickly."

formal appeals to overturn clinical denials.

"Physician advisors are generally not in the business of critiquing clinical practice, instead they review whether the chart documentation supports initial and continued hospitalization," said Charles Locke, MD, senior physician advisor at the Johns Hopkins Hospital and president of the American College of Physician Advisors (ACPA). "However, physician advisors should seek additional information and provide feedback in those cases where the documentation does not support medical necessity for hospitalization."

Many physician advisors are current or former hospitalists. Chris Shearer, MD, chief medical officer for remote advisory at Sound Physicians Advisory Services, says that "hospitalists are the natural physician advisors as they have a working knowledge of which patients need to be inpatients and which are less sick and likely to be discharged quickly."

The role of physician advisors extends beyond

reviews to include physician engagement and education. Physician advisors are a critical link between physicians, utilization review nurses, case managers, and clinical documentation integrity (CDI) and revenue cycle teams, and are increasingly involved in hospital-wide denial prevention efforts.

Physician advisors are invaluable in identifying and validating root causes for clinical denials and generating potential solutions, as they bring to the table:

- Clinical expertise.
- Understanding of clinical workflows.
- Knowledge of the most current public and private payers' regulations.
- Insight into hospital-specific clinical documentation opportunities (for example, by diagnosis, procedure, service line, and provider).
- Understanding of payers' reasons for clinical denials through peer-to-peer discussions

Prevention of clinical denials with use of hospitalists

I asked three experienced physician advisors – Dr. Locke, Dr. Shearer, and Deepak Pahuja, MD, chief medical officer at Aerolib Healthcare Solutions – what hospitalists can do to prevent clinical denials. The experts had the following five recommendations:

1. "THINK IN INK."

The best tool in combating denials is well-documented clinical judgment that outlines:

- WHY the patient requires hospitalization, based on severity of presenting signs and symptoms, comorbidities, and risk of complications.
- WHAT the plan of care is, including diagnostic tests and/or interventions.
- HOW LONG you anticipate the patient will be in the hospital, including potential implications of social determinants (for example homelessness, active drug use) on discharge planning.

2. MASTER THE TWO-MIDNIGHT RULE.

If you expect that a Medicare Part A patient will require two or more midnights in the hospital, document it in the history and physical along with supporting clinical reasoning and sign an inpatient order. If the patient is discharged prior to the second midnight, document the reason in the progress notes and the discharge summary (for example, death, transfer to another hospital, departure against medical advice, faster than expected clinical improvement, or election of hospice in lieu of continued treatment in the hospital). Remember that Medicare Advantage plans may not follow the Two-Midnight rule and instead may use MCG guidelines, InterQual[®], or internal criteria.

3. KNOW "SLAM DUNK" MCG CRITERIA FOR TOP DIAGNOSES.

Most large private payers utilize MCG guidelines to determine medical necessity for hospital admissions. Those guidelines are complex and change every year, and it is not required for hospitalists to know them all. However, it might help to remember a few key inpatient admission criteria for the top 5-10 diagnoses, such as:

- First episode of heart failure without prior history.

- Upper gastrointestinal bleeding with liver cirrhosis, syncope, or orthostatic hypotension.
- Pneumonia with documented hypoxia, outpatient treatment failure, pneumonia severity index class 4 or 5, or CURB-65 score of 3 or greater.
- Cellulitis with outpatient treatment failure or high-risk comorbid conditions (cirrhosis, symptomatic heart failure, immunosuppression, or hemoglobin A1c greater than 10%).

4. EACH DAY, DEFEND WHY THE PATIENT NEEDS TO BE IN THE HOSPITAL.

Don't let your progress notes be swallowed by a "copy-forward" monster and instead provide daily updates, such as:

- Up-to-date clinical status and response to interventions (for example, oxygenation or pain level).
- Updated plan of care: current interventions, additional diagnostic work-up, or changes to the intensity of care (for example, increased intravenous pain medication dose or frequency).
- Documentation of why the patient cannot be safely discharged to a lower level of care (for example, a skilled nursing facility or home).

5. WORK YOUR UTILIZATION REVIEW NURSES AND PHYSICIAN ADVISORS.

In the end, the two most powerful tools in combating clinical denials for hospital services are good medicine and clear documentation. Armed with an understanding of health care reimbursement and denial prevention, hospitalists can help their hospitals prevent unnecessary clinical denials and receive the reimbursements they deserve.

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Movers and Shakers

By **Matt Pesyna**

MDedge News

Erin Shaughnessy, MD, assumed the role of director of pediatric hospital medicine at the University of Alabama at Birmingham and Children's of Alabama, also in Birmingham, on Sept. 1. Dr. Shaughnessy has done research in improving outcomes in hospitalized children, as well as improving communication between physicians and pediatric patients' families during care transitions.

Prior to joining UAB and Children's of Alabama, Dr. Shaughnessy was division chief of hospital medicine at Phoenix Children's Hospital while also serving as an associate professor at the University of Arizona, Phoenix.

Chandra Lingisetty, MD, MBA, MHCM, was recently named chief administrative officer for Baptist

Health Physician Partners, Arkansas. BHPP is Baptist Health's clinically integrated network with more than 1,600 providers across the state.

Baptist Health Arkansas is the state's largest not-for-profit health system with 12 hospitals, hundreds of provider clinics, a nursing school, and a graduate medical education residency program. Prior to his promotion, he worked in Baptist Health System as a hospitalist for 10 years, served on the board of managers at BHPP, and strategized COVID-19 care management protocols and medical staff preparedness as part of surge planning and capacity expansion. In his new role, he is focused on leading the clinically integrated network toward value-based care. He is also the cofounder and inaugural president of the Arkansas state chapter of the Society of Hospital Medicine.

Grace Farris, MD, recently accepted a position with the division of hospital medicine at the Dell Medical School in Austin, Tex., where she will be an assistant professor of in-

ternal medicine, as well as a working hospitalist.

Dr. Farris worked as chief of hospital medicine at Mount Sinai West Hospital in Manhattan from January 2017 until accepting her new position with Dell. In addition, she publishes a monthly comics column in *Annals of Internal Medicine*.

Her visual storytelling through comics has appeared in several media outlets, and she has penned literary columns as well, including one recently in the *New York Times* about living apart from her children while treating COVID-19 patients in the emergency room.



Dr. Pierce

Dell Medical School has also named a new division chief of hospital medicine. **Read Pierce, MD**, made the move to Texas from the University of Colorado at Denver, Aurora. Dr. Pierce will also serve as associate chair of faculty development of internal medicine at Dell. He is eager to build on his experience and passion for developing people, creating outstanding culture, and changing complex systems in innovative, sustainable ways.

Dr. Pierce worked at University of Colorado for the past 8 years, serving as the associate director of the school's Institute for Healthcare Quality, Safety and Efficiency, a program he cofounded. Prior to that, Dr. Pierce was chief resident at the University of San Francisco medical school and later founded the hospital medicine center at the San Francisco VA Medical Center.

Gurinder Kaur, MD, was recently named medical director of the Health Hospitalist Program at St. Joseph's Health Rome (N.Y.) Memorial Hospital. Dr.



Dr. Kaur

Kaur's focus will be on improving infrastructure to allow for the highest quality of care possible. She will oversee the facility's crew of eight hospitalists, who rotate to be available 24 hours per day.

Dr. Kaur comes to Rome from St. Joseph's Health in Syracuse, N.Y.,

where she was chief resident and a member of the hospitalist team.

Colin McMahon, MD, was recently appointed chief of hospital medicine at Eastern Niagara Hospital in Lockport, N.Y., where he will oversee the hospitalist program. He comes to ENH after serving as medical director of hospital operations at Buffalo (N.Y.) General Medical Center.

Dr. McMahon has worked in medicine for a quarter of a century. He also is the president and founder of Dimensions of Internal Medicine and Pediatric Care, PC (DMP). Associates from DMP Medicine make up the hospitalist team at ENH.

Sam Antonios, MD, has been promoted to chief clinical officer of Ascension Kansas, the parent group of Ascension Via Christi Hospital in Wichita, where Dr. Antonios has served as chief medical officer for the past 4 years. Dr. Antonios has emerged as a leader within Ascension Kansas during the COVID-19 pandemic.

Prior to his appointment at Via Christi, he worked at that facility as a hospitalist and as medical director of information systems. Dr. Antonios is a board-certified internist.

Bret J. Rudy, MD, was named a Top 25 Healthcare Innovator by *Modern Healthcare* magazine. Dr. Rudy is chief of hospital operations and senior vice president at NYU Langone



Dr. Rudy

Hospital-Brooklyn in New York, and the magazine cited his efforts in elevating the quality, safety, and accountability of the facility, which merged with NYU Langone Health in 2016.

Dr. Rudy has established a 24-hour hospitalist service, added full-time emergency faculty, and reduced hospital wait times, among other patient-experience benchmarks, since his appointment at Langone-Brooklyn.

Dr. Rudy is a board-certified pediatrician who has served on the National Institutes of Health's HIV research networks, including a spot on the White House Advisory Committee on Adolescents for the Office of National AIDS Policy.



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The path to leadership

Hospitalists should embrace opportunities to lead

By Swati Mehta, MD, FACP

It was 6 a.m. on a rainy, cold Pacific Northwest morning as I walked from my apartment to the hospital, dodging puddles and dreaming of the mediocre-yet-hot physician-lounge coffee. Another long day full of clinical and administrative tasks awaited me.

I was 6 months' pregnant with our first child and working my sixth 12-hour shift in a row. We had recently lost our medical director, and the C-suite had offered me the role. The day ahead seemed like an enormous mountain to climb.

I felt tired and more than a little overwhelmed. But I whispered to myself: "Today is going to be a fantastic day. I will not fail my team. I will not fail my patients!"

Physician leadership starts with a decision

The timing of this call to leadership had not been ideal. There's probably never a perfect time to step into a medical director role. And my situation was no exception.

In addition to the baby on the way, my husband was traveling a lot for work. Also, the job of a medical director seemed a little daunting – especially to a young physician leading a team for the first time.

But I knew that leadership was my calling. While I didn't yet have decades of experience, I had been selected as the chief resident in internal medicine, completed a nephrology fellowship, and mentored several medical students and residents along my career path.

I also knew that I was passionate about supporting my patients and hospitalist team. I'd previously served as associate medical director in charge of quality, readmission reduction, and patient experience. Having achieved the highest patient satisfaction scores on the team for 2 consecutive years, I was specially tasked to improve

our team's HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores.

These experiences taught me that coaching with positive reinforcement was in my blood. This gave me the courage to face my tallest mountain yet.

No one climbs a mountain alone

I also stepped into my new physician leadership role with amazing support. Our outgoing medical director had recommended me, and my entire team was rooting for me. My spouse was 100% behind the idea.

What's more, I had received amazing feedback from patients throughout my 3 years at the hospital. I had papered an entire office wall with their thank-you notes. I even had a quilt that an 85-year-old patient's wife made to thank me for my compassionate care.

As I weighed my decision, I realized that I had a higher calling to be a true advocate for my patients. I loved what I did. Each day, I resolved to bring my best and most authentic self for them – no matter how drained I felt.

My team and patients needed me now, not at some more convenient time down the road. A

medical director job was the natural next step for me. And so, I resolved to climb the mountain.

The mountain can be stormy

Stepping into a medical director job forced me to grow into a completely new person. So maybe starting that role during pregnancy was a great metaphor!

Each day, there was immense pressure to perform, to deliver quality outcomes, and to simultaneously meet expectations of the C-suite as well as my hospitalist team. There was no room for failure, because too much was at stake.

Looking back today, I wouldn't trade the experience for anything. The medical director role was one of the most gratifying experiences in my life, and I am truly thankful for it.

A leader's role truly boils down to working tirelessly to collaborate with different care teams. It's important to care not only about our patients but also about our fellow hospitalists. We can do this by truly leading by example – be it picking up extra shifts, covering holidays so team members can be with family, or coming in at 10 p.m. to round with your night team.

I was also able to bring a unique perspective to the hospital C-suite meetings as a woman, an immigrant, and a true "mama bear" – not only of my infant son but also of my team.

My first year as a medical director required more commitment and heart than I could have



Dr. Swati Mehta received the Vituity Distinguished Service Award.

COURTESY DR. SWATI MEHTA



COURTESY DR. SWATI MEHTA

A quilt was crafted by an 85-year-old patient's wife to thank Dr. Mehta for compassionate care.



Dr. Mehta is a hospitalist and director of quality & performance and patient experience at Vituity in Emeryville, Calif. She is vice chair of the SHM patient experience committee and executive board member of the SHM San Francisco Bay Area chapter.

imagined. But all this hard work paid off when our hospitalist group received the coveted Best Team Award for most improved quality outcomes, financial performance, and patient experience.

The summit is the beginning

My first medical director job fueled my passion for patient satisfaction even further. I now serve as the director of patient experience for the more than 4,200 clinicians at Vituity. Together we care for more than 6.5 million lives a year across the country.

In 2019, I coached 300 physicians and hospital leaders on communication, collaboration, and service recovery skills, leading to significant improvement in their HCAHPS scores. I was delighted to receive the Vituity Distinguished Service Award for my contributions. It's such an honor to be instrumental in impacting patient care at a larger scale.

This year, I was invited to serve as vice chair of the Society for Hospital Medicine's patient experience committee and to join the executive board of the SHM San Francisco chapter. Together, we have created a COVID-19 patient communication resource and reached out to our hospitalists to provide them with a space to share their stories during this pandemic. I am so excited to share my knowledge and passion with clinicians across the country given the wide reach of Vituity & SHM!

Many hospitalists shy away from leadership roles. The mountain is tough to scale, but the view from the top is worth it. The key is to start, even if you don't feel ready. I am here to tell you it can be done!

Hospital leadership lessons in the era of COVID-19

By Jim Kling

MDedge News

The year 2020 has brought the COVID-19 pandemic and civil unrest and protests, which have resulted in unprecedented health care challenges to hospitals and clinics. The daunting prospect of a fall influenza season has hospital staff and administrators looking ahead to still greater challenges.

This year of crisis has put even greater emphasis on leadership in hospitals, as patients, clinicians, and staff look for direction in the face of uncertainty and stress. But hospital leaders often arrive at their positions unprepared for their roles, according to Leonard Marcus, PhD, director of the Program for Health Care Negotiation and Conflict Resolution at Harvard T.H. Chan School of Public Health, Boston.

“Many times what happens in medicine is that someone with the greatest technical skills or greatest clinical skills emerges to be leader of a department, or a group, or a hospital, without having really paid attention to how they can build their leadership skills,” Dr. Marcus said during the 2020 Society of Hospital Medicine Leadership Virtual Seminar, held online Sept. 16-17.

Over 2 days, Dr. Marcus discussed the complex environments faced by hospital leaders, and some of the tools and strategies that can be used to maintain calm, problem-solve, and chart a course ahead.

He emphasized that hospitals and medical systems are complex, non-linear organizations, which could be swept up by change in the form of mergers, financial policies, patient surges due to local emergencies, or pandemics.

“Complexity has to be central to how you think about leadership. If you think you can control everything, that doesn’t work that well,” said Dr. Marcus.

Most think of leadership as hierarchical, with a boss on top and underlings below, though this is starting to change. Dr. Marcus suggested a different view. Instead of just “leading down” to those who report to them, leaders should consider “leading up” to their own bosses or oversight committees, and across to other departments or even beyond



Dr. Leonard Marcus

Leadership in hospitals is often dominated by egos, with individual leaders battling one another in a win-lose effort, and this gets in the way of incorporating different perspectives into problem-solving.

to interlinked organizations such as nursing homes.

“Being able to build that connectivity not only within your hospital, but beyond your hospital, lets you see the chain that goes through the experience of any patient. You are looking at the problem from a much wider lens. We call this meta-leadership,” Dr. Marcus said.

A key focus of meta-leadership is to create a culture where individuals are working together to help one another succeed. Leadership in hospitals is often dominated by egos, with individual leaders battling one another in a win-lose effort, and this gets in the way of incorporating different perspectives into problem-solving.

Dr. Marcus used an example from previous seminars in which he instructed participants to arm wrestle the person sitting next to them. The goal was to attain as many pins as possible in 30 seconds. About half

would fight as hard as they could, and achieve a few victories. The other half worked cooperatively, letting one person win, then the other, so that they could have 30 or 40 wins each. Dr. Marcus told the story of a young nurse who was paired up with a much stronger surgeon. She let him win twice, and when he asked her why she wasn’t resisting, she took his arm and placed it in a winning position, then a losing position, and then a winning position again, and he instantly understood that the cooperative approach could be more effective. Why didn’t she just tell him? She told Dr. Marcus that she knew he wouldn’t take instruction, so she let him win and then demonstrated an alternative. “We nurses learned how to do that a long time ago,” she told Dr. Marcus.

The idea is collaborative problem-solving. “How do you orient people looking to you for leadership so that we’re in this together and we can accomplish a whole lot more in 30 seconds if we’re working together instead of always battling one another? If we’re always battling one another, we’re putting all of our effort into the contest,” said Dr. Marcus. This sort of approach is all the more important when facing the complexity experienced by hospital systems, especially during crises such as COVID-19.

A critical element of meta-leadership is emotional intelligence, which includes elements such as self-awareness, self-regulation, empathy, determining motivation of yourself and others, and the social skills to portray yourself as caring, open, and interested.

Emotional intelligence also can help recognize when you’ve entered survival mode in reaction to a crisis or incident, or something as simple as losing your car keys – what Dr. Marcus terms “going to the basement.” Responses revolve around freeze, fight, or flight. It’s helpful in the wake of a car accident, but not when trying to make managerial decisions or respond to a complex situation. It’s vital for leaders to quickly get themselves out of the basement, said Dr. Marcus, and that they help other members of the team get out as well.

He recommended protocols designed in advance, both to recognize when you’re in the basement, and to

lift yourself out. Dr. Marcus uses a trigger script, telling himself “I can do this,” and then when he’s working with other people, “we can do this.” He also speaks slowly, measuring every word. Whatever you do, “it has to be a pivot you do to get yourself out of the basement,” he said. It can be helpful to predict the kinds of situations that send you “to the basement” to help recognize it when it has happened.

It’s very important not to lead, negotiate, or make important decisions while in the basement, according to Dr. Marcus. If one thinks about some of the things they’ve said to others while under duress, they are often some of the statements they regret most.

Practical leadership skills

On the second day of the Leadership Seminar, Dr. Marcus moved his focus to using leadership skills and techniques. One important technique is to incorporate multiple perspectives. He gave the example of an opaque cube with a cone inside it, with a window on the side and one on top. Viewers from the side see the cone in profile, and see it as a triangle. Viewers from the top see an aerial perspective that looks like the circular base of the cone. The two groups could argue about what’s inside the cube, but they can identify the object only if they work together.

“When dealing with complex reality, you oftentimes find there are different people with different perspectives on a problem. They may have different experiences of what the problem is, and what often happens is that people get into an adversarial fight. Looking at the problem from different perspectives actually allows a much richer and more comprehensive view,” said Dr. Marcus.

The metaphor comes from a study of the tragic events at the Twin Towers in Manhattan on Sept. 11, 2001. The New York Fire Department had a command center at the base of the building, while the police had a helicopter flying around the buildings. The helicopter could see the steel girders beginning to melt and predicted a collapse, and therefore ordered their personnel out of the buildings. But they were unable to convey that information to the

firefighters, who continued to send personnel into the buildings. In all, 343 firefighters lost their lives. The police force lost 32.

For the best understanding of a problem, a key element is the “unknown knowns.” That is, information that is available, that someone has, but is unknown to you. It takes some imagination to conceive of what “unknown knowns” might be out there, but it’s worth the effort to identify possible knowledge sources. It’s vital to seek out this information, because a common leadership mistake is to assume you know something when you really don’t.

A critical element of meta-leadership is emotional intelligence, which includes elements such as self-awareness, self-regulation, empathy, and the social skills to portray yourself as caring, open, and interested.

“In many ways what you’re doing is looking for obstacles. It could be you don’t have access to the information, that it’s beyond some sort of curtain you need to overcome, or it could be people in your own department who have the information and they’re not sharing it with you,” Dr. Marcus said.

He outlined a tool called the POP-DOC loop, which is a 6-step exercise designed to analyze problems and implement solutions. Step 1 is *Perceiving* the situation, determining knowns and unknowns, and incorporating multiple perspectives, emotions, and politics. Step 2 is to *Orient* oneself: Examine patterns and how they may replicate themselves as long as conditions don’t change. For example, during COVID-19, physicians have begun to learn how the virus transmits and how it affects the immune system. Step 3, based on those patterns is to make *Predictions*. With COVID-19, it’s predictable that people who assemble without wearing masks are vulnerable to transmission. Step 4 is to use the predictions to begin to make *Decisions*. Step 5 is to begin *Operationalizing* those decisions, and step 6 is to *Communicate* those decisions effectively.

Dr. Marcus emphasized that POP-DOC is not a one-time exercise. Once decisions have been made and

implemented, if they aren’t having the planned effect, it’s important to incorporate the results of those actions and start right back at the beginning of the POP-DOC loop.

“The POP side of the loop is perceiving, analysis. You get out of the basement and understand the situation that surrounds you. On the DOC side, you lead down, lead up, lead across, and lead beyond. You’re bringing people into the action to get things done,” Dr. Marcus said.

Another tool Dr. Marcus described, aimed at problem-solving and negotiation, is the “Walk in the Woods.” The idea is to bring two parties together to help each other succeed. The first step is *Self-Interest*, where both parties articulate their objectives, perspectives, and fears. The second step, *Enlarged Interests*, requires each party to list their points of agreement, and only then should they focus on and list their points of disagreement. During conflict, people tend to focus on their disagreements. The parties often find that they agree on more than they realize, and this can frame the disagreements as more manageable. The third step, *Enlightened Interest*, is a free-thinking period where both parties come up with potential solutions that had not been previously considered. In step 4, *Aligned Interests*, the parties discuss some of those ideas that can be explored further.

The Walk in the Woods is applicable to a wide range of situations, and negotiation is central to being a leader. “Being a clinician is all about negotiating – with patients, family members, with other clinicians, with the institution,” Dr. Marcus said. “We all want the patient to have the best possible care, and in the course of those conversations if we can better understand people, have empathy, and if there are new ideas or ways we can individualize our care, let’s do it, and then at the end of the day combine our motivations so that we’re providing the best possible care.”

In the end, meta-leadership is about creating a culture where individuals strive to help each other succeed, said Dr. Marcus. “That’s the essence: involving people, making them part of the solution, and if it’s a solution they’ve created together, everyone wants to make that solution a success.”

For more information, see the book “You’re It,” coauthored by Dr. Marcus, and available on Amazon for \$16.99 in hardback, or \$3.99 in Kindle format.

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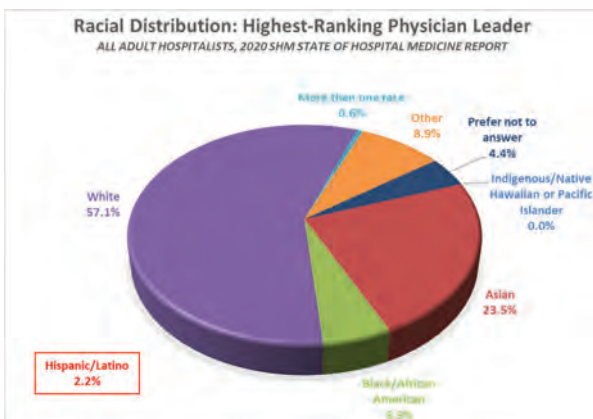
Increasing racial diversity in hospital medicine's leadership ranks

By Leslie Flores, MHA, SFHM

Have you ever done something where you're not quite sure why you did it at the time, but later on you realize it was part of some larger cosmic purpose, and you go, "Ahhh, now I understand ... that's why!"? Call it a fortuitous coincidence. Or a subconscious act of anticipation. Maybe a little push from God.

Last summer, as SHM's Practice Analysis Committee was planning the *State of Hospital Medicine* survey for 2020, we received a request from SHM's Diversity, Equity, & Inclusion (DEI) Special Interest Group (SIG) to include a series of questions related to hospitalist gender, race, and ethnic distribution in the new survey. We've generally resisted doing things like this because the *SoHM* is designed to capture data at the group level, not the individual level – and honestly, it's as much as a lot of groups can do to tell us reliably how many FTEs they have, much less provide details about individual providers. In addition, the survey is already really long, and we are always looking for ways to make it shorter and easier for participants while still collecting the information report users care most about.

But we wanted to take the asks from the DEI SIG seriously, and as we considered their request, we realized that though it wasn't practical to collect this information for individual hospital medicine group (HMG) members, we could collect



it for group leaders. Little did we know last summer that issues of gender and racial diversity and equity would be so front-and-center right now, as we prepare to release the 2020 *SoHM* Report in early September. Ahhh, now I understand ... that's why – with the prompting of the DEI SIG – we so fortuitously chose to include those questions this year!

Here's a sneak preview of what we learned. Among *SoHM* respondents, 57.1% reported that the highest-ranking leader in their HMG is White, and 23.5% of highest-ranking leaders are Asian. Only 5.5% of HMG leaders were Black/African American. Ethnicity was a separate question, and only 2.2% of HMG leaders were reported as Hispanic/Latino.

I have been profoundly moved by the wretched deaths of George Floyd and other people of color

at the hands of police in recent months, and by the subsequent protests and our growing national reckoning over issues of racial equity and justice. In my efforts to understand more about race in America, I have been challenged by my friend Ryan Brown, MD, specialty medical director for hospital medicine with Atrium Health in Charlotte, N.C., and others to go beyond just learning about these issues. I want to use my voice to advocate for change, and my actions to participate in effecting change, within the context of my sphere of influence.

So, what does that have to do with the *SoHM* data on HMG leader demographics? Well, it's clear that Black and brown people are woefully underrepresented in the ranks of hospital medicine leadership.

Unfortunately, we don't have good information on racial diversity for hospitalists as a specialty, though I understand that SHM is working on plans to update membership profiles to begin collecting this information. In searching the Internet, I found a 2018 paper from the *Journal of Health Care for the Poor and Underserved* that studied racial and ethnic distribution of U.S. primary care physicians (doi: 10.1353/hpu.2018.0036). It reported that, in 2012, 7.8% of general internists were Black, along with 5.8% of family medicine/general practice physicians and 6.8% of pediatricians. A separate data set issued by the Association of American Medical Colleges reported that, in 2019, 6.4% of all actively practicing general internal medicine doctors were Black (5.5% of male IM physicians and 7.9% of female IM physicians). While this doesn't mean hospitalists have the same racial and ethnic distribution, this is probably the best proxy we can come up with.

At first glance, having 5.5% of HMG leaders who are Black doesn't seem terribly out of line with the reported range of 6.4%-7.8% in the general population of internal medicine physicians (apologies to the family medicine and pediatric hospitalists reading this, but I'll confine my discussion to internists for ease and brevity, since they represent the vast majority of the nation's hospitalists). But do the math. It means Black hospitalists are likely underrepresented in HMG leadership ranks by something like 14%-29% compared to their likely presence among hospitalists in general.

The real problem, of course, is that according to the U.S. Census Bureau, 13.4% of the U.S. population is Black. So even if the racial distribution of HMG leaders catches up to the general hospitalist population, hospital medicine is still woefully underrepresenting the racial and ethnic distribution of our patient population.

The disconnect between the ethnic distribution of HMG leaders vs. hospitalists (based on general internal medicine distribution) is even more pronounced for Latinos. The JHCPU paper reported that, in 2012, 5.6% of general internists were Hispanic. The AAMC data set reported 5.8% of IM doctors were Hispanic/Latino. But only 2.2% of



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SoHM respondent HMGs reported a Hispanic/Latino leader, which means Latinos are underrepresented by somewhere around 61% or so relative to the likely hospitalist population, and by a whole lot more considering the fact that Latinos make up about 18.5% of the U.S. population.

I'm not saying that a White or Asian doctor can't provide skilled, compassionate care to a Black or Latino patient, or vice-versa. It happens every day. I guess what I am saying is that we as a country and in the medical profession need to do a better job of creating pathways and promoting careers in medicine for people of color. A *JAMA* paper from 2019 reported that, while the numbers and proportions of minority medical school matriculants has slowly been increasing from 2002 to 2017, the rate of increase was "slower than their age-matched counterparts in the U.S. population, resulting in increased underrepresentation" (doi: 10.1001/jamanetworkopen.2019.10490). This means we're falling behind, not catching up.

We need to make sure that people like Dr. Brown aren't discouraged from pursuing medicine by teachers or school counselors because of their skin color or accent, or their gender or sexual orientation. And among those who become doctors, we need to promote hospital medicine as a desirable specialty for people of color and actively invite them in.

In my view, much of this starts with creating more and better paths to leadership within hospital medicine for people of color. Hospital medicine group leaders wield enormous – and increasing – influence, not only within their HMGs

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Medicine and the meritocracy

Addressing systemic bias, gender inequity, and discrimination

By **Sowmya Kanikkannan, MD, SFHM**

There are many challenges facing modern medicine today. Recent events have highlighted important issues affecting our society as a whole – systemic racism, sexism, and implicit bias. In medicine, we have seen a renewed focus on health equity, health disparities, and the implicit systemic bias that affect those who work in the field. It is truly troubling that it has taken the continued loss of Black lives to police brutality and a pandemic for this conversation to happen at every level in society.

Systemic bias is present throughout corporate America, and it is no different within the physician workforce. Overall, there has been gradual interest in promoting and teaching diversity. Institutions have been slowly creating policies and administrative positions focused on inclusion and diversity over the last decade. So has diversity training objectively increased representation and advancement of women and minority groups? Do traditionally marginalized groups have better access to health? And are women and people of color (POC) represented

equally in leadership positions in medicine?

Clearly, the answers are not straightforward.

Diving into the data

A guilty pleasure of mine is to assess how diverse and inclusive an institution is by looking at the wall of pictures recognizing top leadership in hospitals. Despite women accounting for 47.9% of graduates from medical school in 2018-2019, I still see very few women or POC elevated to this level. Of the total women graduates, 22.6% were Asian, 8% were Black, and 5.4% were Hispanic.

Being of Indian descent, I am a woman of color (albeit one who may not be as profoundly affected by racism in medicine as my less represented colleagues). It is especially rare for me to see someone I can identify with in the ranks of top leadership. I find encouragement in seeing any woman on any leadership board because to me, it means that there is hope. The literature seems to support this degree of disparity as well. For example, a recent analysis shows that presidential leadership in medical societies are predominantly held by men (82.6% male vs. 17.4% female). Other data-

sets demonstrate that only 15% of deans and interim deans are women and AAMC's report shows that women account for only 18% of all department chairs.

As I grew up, my parents fueled my interest to pursue medicine. They described it as a noble profession that rewarded true merit and dedication to the cause. However, those that have been traditionally elevated in medicine are men. If merit knows no gender, why does a gender gap exist? If merit is blind to race, why are minorities so poorly represented in the workforce (much less in leadership)? My view of the wall leaves me wondering about the role of both sexism and racism in medicine.

These visual representations of the medical culture reinforce the acceptable norms and values – White and masculine – in medicine. The feminist movement over the last several decades has increased awareness about the need for equality of the sexes. However, it was not until the concept of intersectionality was introduced by Black feminist Professor Kimberle Crenshaw, that feminism become a more inclusive term. Professor Crenshaw's paper details how every individual has intersecting factors – race, gender,



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sexual identity, socioeconomic status – that create the sum of their experience be it privilege, oppression, or discrimination.

For example, a White woman has privileges that a woman of color does not. Among non-White women, race and sexual identity are confounding factors – a Black woman, a Black LGBTQ woman, and an Asian woman, for example, will not experience discrimination in the same way. The farther you deviate from the accepted norms and values, the harder it is for you to obtain support and achieve recognition.

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and within SHM, but within their institutions and health care systems. We need their voices and their influence to promote diversity within their groups, their institutions, within hospital medicine, and within medicine and the U.S. health care system more broadly.

The Society of Hospital Medicine is already taking steps to promote diversity, equity, and inclusion. These include issuing a formal Diversity and Inclusion Statement, creating the DEI SIG, and recently forming a Board-designated DEI task force charged with making recommendations to promote DEI within SHM and in hospital medicine more broadly. But I want to challenge SHM to do more, particularly with regard to promoting diversity in leadership. Here are a few ideas to consider:

- Create and sponsor a mentoring program in which hospitalists volunteer to mentor minority junior high and high school students and help them prepare to pursue a career in medicine.
- Develop a formal, structured advocacy or collaboration effort with organizations like AAMC and the Accreditation Council for Graduate Medical Education designed to promote mean-

ingful increases in the proportion of medical school students and residents who are people of color, and in the proportion who choose primary care – and ultimately, hospital medicine.

- Work hard to collect reliable racial, ethnic, and gender information about SHM members and consider collaborating with MGMA to incorporate demographic questions into its survey tool for individual hospitalist compensation and productivity data. Challenge us on the Practice Analysis Committee who are responsible for the *SoHM* survey to continue surveying leadership demographics, and to consider how we can expand our collection of DEI information in 2022.
- Undertake a public relations campaign to highlight to health systems and other employers the under-representation of Black and Latino hospitalists in leadership positions, and to promote conscious efforts to increase those ranks.
- Create scholarships for hospitalists from under-represented racial and ethnic groups to attend SHM-sponsored leadership development programs such as Leadership Academy, Academic Hospitalist Academy, and Quality and Safety Educators Academy, with the goal of increasing their ranks in positions of influence throughout health care. A scholarship program might

even include raising funds to help minority hospitalists pursue Master's-level programs such as an MBA, MHA, or MMM.

- Develop an educational track, mentoring program, or other support initiative for early-career hospitalist leaders and those interested in developing leadership skills, and ensure it gives specific attention to strategies for increasing the proportion of hospitalists of color in leadership positions.
- Review and revise existing SHM documents such as The Key Principles and Characteristics of an Effective Hospital Medicine Group, the Core Competencies in Hospital Medicine, and various white papers and position statements to ensure they address diversity, equity, and inclusion – both with regard to the hospital medicine workforce and leadership, and with regard to patient care and eliminating health disparities.

I'm sure there are plenty of other similar actions we can take that I haven't thought of. But we need to start the conversation about concrete steps our Society, and the medical specialty we represent, can take to foster real change. And then, we need to follow our words up with actions.

Empagliflozin cut PA pressures in heart failure

By Mitchel L. Zoler, PhD

MDedge News

Elevated pulmonary artery diastolic pressure is “perhaps the best predictor of bad outcomes in patients with heart failure, including hospitalization and death,” and new evidence clearly showed that the sodium-glucose cotransporter 2 (SGLT2) inhibitor

empagliflozin cuts this metric in patients by a clinically significant amount, Mikhail Kosi-borod, MD, said at the virtual annual scientific meeting of the Heart Failure Society of America.

The evidence he collected from a total of 65 heart failure patients with either reduced or preserved ejection fraction is the first documentation from a randomized, controlled study to show a direct effect by a SGLT2 inhibitor on

pulmonary artery (PA) pressures.

Other key findings were that the drop in PA diastolic pressure with empagliflozin treatment compared with placebo became discernible early (within the first 4 weeks on treatment), that the pressure-lowering effect steadily grew over time, and that it showed no link to the intensity of loop diuretic treatment, which held steady during 12

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Addressing the patriarchal structure and systemic bias in medicine

Why do patriarchal structures still exist in medicine? How do we resolve systemic bias? Addressing them in isolation – race or gender or sexual identity – is unlikely to create long-lasting change. For change to occur, organizations and individuals need to be intrinsically motivated. Creating awareness and challenging the status quo is the first step.

Over the last decade, implicit bias training and diversity training have become mandatory in various industries and states. Diversity training has grown to be a multi-billion-dollar industry that corporate America has embraced over the last several years. And yet, research shows that mandating such training may not be the most effective. To get results, organizations need to implement programs that “spark engagement, increase contact between different groups, and draw on people’s desire to look good to others.”

Historically, the medical curriculum has not included a discourse on feminist theories and the advancement of women in medicine. Cultural-competency training is typically offered on an annual basis once we are in the workforce, but in my experience, it focuses more on our interactions with patients and other health care colleagues, and less with regards to our physician peers and leadership. Is this enough to change deep-rooted beliefs and traditions?

We can take our cue from non-medical organizations and consider changing this culture of no culture in medicine – introducing diversity task forces that hold departments accountable for recruiting and promoting women and minorities; employing diversity managers; voluntary training; cross-training to increase contact among different groups and mentoring programs that match senior leadership to women and POC. While some medical institutions have im-

plemented some of these principles, changing century-old traditions will require embracing concepts of organizational change and every available effective tool.

Committing to change

Change is especially hard when the target outcome is not accurately quantifiable – even if you can measure attitudes, values, and beliefs, these are subject to reporting bias and tokenism. At the organizational level, change management involves employing a systematic approach to change organizational values, goals, policies, and processes.

Individual change, self-reflection, and personal growth are key components in changing culture. Reflexivi-

The combination of both individual and organizational commitment to change systemic bias in medicine can be quite powerful.

ty is being aware of your own values, norms, position, and power – an important concept to understand and apply in our everyday interactions. Believing that one’s class, gender, race, and sexual orientation are irrelevant to their practice of medicine would not foster the change that we direly need in medicine. Rather, identifying how your own values and professional identity are shaped by your medical training, your organization and the broader cultural context are critically important to developing a greater empathic sense to motivate systemic change.

There has been valuable discussion on bottom-up changes to ensure women and POC have support, encouragement and a pathway to advance in an organization. Some of these include policy and process changes including providing flexible working conditions for women

and sponsorship of women and minorities to help them navigate the barriers and microaggressions they encounter at work. While technical (policy) changes form the foundation for any organizational change, it is important to remember that the people side of change – the resistance that you encounter for any change effort in an organization – is equally important to address at the organizational level. A top-down approach is also vital to ensure that change is permanent in an organization and does not end when the individuals responsible for the change leave the organization.

Lewin’s three-stage change management model provides a framework for structural and organizational change in hospital systems. The three-stages of this model are: unfreezing, changing, and refreezing. Unfreezing is the process of determining what needs to change and obtaining leadership support. The actual change process involves getting people on board, empowering them to change, and communicating with them frequently. Refreezing cements this change into the organization’s culture by providing support and training to sustain changes. Research has shown that Lewin’s change management model has applicability in the hospital setting.

Industry research in change management methodologies in the business sector has identified sponsorship by CEOs/senior management of an organization and having a structured implementation model for change management as two important factors for ensuring that change efforts are successful and sustainable.

This can be extrapolated to health care organizations – top leadership committed to changing the status quo should solidify organizational commitment by incorporating new attainable and measurable goals into their vision for the organization. Designing a phased implementation of

change management methodologies should follow an open discussion to identify an organization’s weaknesses, strengths, capacity, and readiness for change. Lastly, helping busy professionals adapt to change requires innovative and continuous improvement strategies using formal, systematic tools for organization-wide strategic deployment.

Without a concrete commitment at the organizational level, programs such as diversity training may end up being band-aids on wounds that run deep.

I believe that the combination of both individual and organizational commitment to change systemic bias in medicine can be quite powerful. One without the other will fail to permanently change the system. The work to true equality – regardless of the intersecting factors of discrimination – starts with a commitment to change. We may all have different opportunities because of the inequality that is apparent in our systems today, but if we unite around the goal of a bias-free, merit-based equality, it gives us the strength we need to overcome challenges that we once thought insurmountable.

Each one of us is a leader in our own right. Speaking up for those with less power or opportunity than us and supporting talent and hard work solidifies medicine as a meritocracy. Even if the magnitude of change that we fight for may not be realized during our time in medical practice, our commitment to eradicate sexism, racism, and discrimination will shape the future of medicine.

Just as our children are a legacy that we leave behind, our work in correcting bias in medicine will pave the path for a better future for the doctors of tomorrow. After all, when I think that my young daughter will be affected by what I do or do not do to address the discrimination, there is no better motivation for me to break down every barrier for her success.

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weeks on treatment and 13 weeks of overall monitoring.

The study's primary endpoint was the change from baseline in PA diastolic pressure after 12 weeks on treatment. The 31 patients who completed the full 12-week course had an average drop in their PA diastolic pressure of about 1.5 mm Hg, compared with 28 patients who completed 12 weeks on placebo. Average PA diastolic pressure at baseline was about 21 mm Hg in both treatment arms, and on treatment this fell by more than 0.5 mm Hg among those who received empagliflozin and rose by close to 1 mm Hg among control patients.

"There appears to be a direct effect of empagliflozin on pulmonary artery pressure that's not been previously demonstrated" by an SGLT2 inhibitor, Dr. Kosiborod said. "I think this is one mechanism of action" for this drug class. "If you control pulmonary artery filling pressures you can prevent hospitalizations and deaths."

Small reductions matter

"Small pressure differences are particularly important for pulmonary hypertension," commented Lynne W. Stevenson, MD, professor of medicine at Vanderbilt University Medical Center in Nashville, Tenn., and the report's designated discussant.

"In the Vanderbilt heart failure database, pa-

tients with a pulmonary artery mean pressure of 20-24 mm Hg had 30% higher mortality than patients with lower pressures," Dr. Stevenson noted. "This has led to a new definition of pulmonary hypertension, a mean pulmonary artery pressure above at or above 20 mm Hg."

In Dr. Kosiborod's study, patients began with an average PA mean pressure of about 30 mm Hg, and empagliflozin treatment led to a reduction

in this metric with about the same magnitude as its effect on PA diastolic pressure. Empagliflozin also produced a similar reduction in average PA systolic pressure.

"We can expect a reduction in pulmonary hypertension to help protect against right heart congestion, which then protects against right heart

failure" and prevents right failure from triggering or worsening left ventricular failure, Dr. Stevenson explained.

The results "also provide more proof for the concept of ambulatory hemodynamic monitoring" in patients with heart failure to monitor their status, she added. The study enrolled only patients who had already received a CardioMEMS implant as part of their routine care. This device allows for frequent, noninvasive monitoring of PA pressures. Researchers collected PA pressure data from patients twice daily for the entire 13-week study.

The EMBRACE HF (Empagliflozin Impact on Hemodynamics in Patients With Heart Failure)

study enrolled patients with established heart failure, a CardioMEMS implant, and New York Heart Association class II-IV symptoms at any of eight U.S. centers. Patients averaged about 65 years old, and slightly more than half had class III disease, which denotes marked limitation of physical activity.

Despite the brief treatment period, patients who received empagliflozin showed other evidence of benefit including a trend toward im-

"There appears to be a direct effect of empagliflozin on pulmonary artery pressure that's not been previously demonstrated. ... If you control pulmonary artery filling pressures you can prevent hospitalizations and deaths."

proved quality of life scores, reduced levels of two different forms of brain natriuretic peptide, and significant weight loss, compared with controls, that averaged 2.4 kg.

The mechanism by which empagliflozin and other drugs in its class might lower PA filling pressures is unclear, but Dr. Kosiborod stressed that the consistent level of loop diuretic use during the study seems to rule out a diuretic effect from the SGLT2 inhibitor as having a role. A pulmonary vasculature effect is "much more likely," perhaps mediated through modified endothelial function and vasodilation, he suggested.



Dr. Kosiborod



Dr. Stevenson

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Burnout

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– or less? Steroids or not? In my experience as a hospitalist I never had patients die every day on my shift, but that was happening with COVID.” The crisis imposed serious stresses on frontline providers, and hospitalists were concerned about personal safety and exposure risk – not just for themselves but for their families.

“The first time I worked on the COVID unit, I moved into the guest room in our home, apart from my husband and our young children,” Dr. Barnes said. “Ultimately I caught the virus, although I have since recovered.” Her experience has highlighted how existing issues of job stress and burnout in hospital medicine have been exacerbated by COVID-19. Even physicians who

had waves of COVID patients.”

The Bayview hospitalist group has a diversified set of leaders, including a wellness director. “They’re always checking up on our people, keeping an eye on those who are most vulnerable. One of the stressors we hadn’t thought about before was for our people who live alone. With the isolation and lockdown, they haven’t been able to socialize, so we’ve made direct outreach, asking people how they were doing,” Ms. Panek said. “People know we’ve got their back – professionally and personally. They know, if there’s something we can do to help, we will do it.”

Bayview Medical Center has COVID-specific units and non-COVID units, and has tried to rotate

COVID-19 patients in New York. “Northwell likely cared for more COVID patients than any other health care system in the United States if not the world.

“It’s vastly different now. We went from a peak of thousands of cases per day down to about 70-90 new cases a day across our system. We’re lucky our system recognized that COVID could be an issue early on, with all of the multifaceted stressors on patient care,” Dr. Case said. “We’ve done whatever we could to give people time off, especially as the census started to come down. We freed up as many supportive mental health services as we could, working with the health system’s employee assistance program.”

Northwell gave out numbers for the psychiatry department, with clinicians available 24/7 for a confidential call, along with outside volunteers and a network of trauma psychologists. “Our system also provided emergency child care for staff, including hospitalists, wherever we could, drawing upon community resources,” Dr. Case added.

“We recognize that we’re all in the same foxhole. That’s been a helpful attitude – recognizing that it’s okay to be upset in a crisis and to have trouble dealing with what’s going on,” he said. “We need to acknowledge that some of us are suffering and try to encourage people to face it head on. For a lot of physicians, espe-

cially those who were redeployed here from other departments, it was important just to have us ask if they were doing okay.”

Brian Schroeder, MHA, FACHE, FHM, assistant vice president for hospital and emergency medicine for Atrium Health, based in Charlotte, N.C., said one of the biggest sources of stress on his staff has been the constant pace of change

– whether local hospital protocols, state policies, or guidelines from the Centers for Disease Control and Prevention. “The updating is difficult to keep up with. A lot of our physicians get worried and anxious that they’re not following the latest guidelines or correctly doing what they should be doing to care for COVID patients. One thing we’ve done to alleviate some of

that fear and anxiety is through weekly huddles with our hospital teams, focusing on changes relevant to their work. We also have weekly ‘all-hands’ meetings for our 250 providers across 13 acute and four postacute facilities.”

Before COVID, it was difficult to get everyone together as one big group from hospitals up to 5 hours apart, but with the Microsoft Teams platform, they can all meet together.

“At the height of the pandemic, we’d convene weekly and share national statistics, organiza-



Dr. Clarissa Barnes



Tiffani Panek



Dr. Joshua Case

consider themselves healthy may have little emotional reserve to draw upon in a crisis of this magnitude.

“We are social distancing at work, wearing masks, not eating together with our colleagues – with less camaraderie and social support than we used to have,” she said. “I feel exhausted and there’s no question that my colleagues and I have sacrificed a lot to deal with the pandemic.” Add to that the second front of the COVID-19 crisis, Dr. Barnes said, which is “fighting the medical information wars, trying to correct misinformation put out there by people. Physicians who have been on the front lines of the pandemic know how demoralizing it can be to have people negate your first-hand experience.”

The situation has gotten better in Sioux Falls, Dr. Barnes said, although cases have started rising in the state again. The stress, while not gone, is reduced. For some doctors, “COVID reminded us of why we do what we do. Some of the usual bureaucratic requirements were set aside and we could focus on what our patients needed and how to take care of them.”

Gravity of job stress

Tiffani Panek, MA, SFHM, CLHM, administrator of the division of hospital medicine at Johns Hopkins Bayview Medical Center in Baltimore, said job stress is a major issue for hospitalist groups.

“We take it seriously here, and use a survey tool to measure morale in our group annually,” she said. “So far, knock on wood, Baltimore has not been one of the big hot spots, but we’ve definitely

hospitalist assignments because more than a couple days in a row spent wearing full personal protective equipment (PPE) is exhausting, Ms. Panek said. The group also allocated a respite room just outside the biocontainment unit, with a computer and opportunities for providers to just sit and take a breather – with appropriate social distancing. “It’s not fancy, but you just have to wear a mask, not full PPE.”

The Hopkins hospitalist group’s wellness director, Catherine Washburn, MD, also a working hospitalist, said providers are exhausted, and trying to transition to the new normal is a moving target.

“It’s hard for anyone to say what our lives will look like in 6 months,” she said. “People in our group have lost family members to COVID, or postponed major life events, like weddings. We acknowledge losses together as a group, and celebrate things worth celebrating, like babies or birthdays.”

Greatest COVID caseload

Joshua Case, MD, hospitalist medical director for 16 acute care hospitals of Northwell Health serving metropolitan New York City and Long Island, said his group’s hospitalists and other staff worked incredibly hard during the surge of

“One of the stressors we hadn’t thought about before was for our people who live alone. With the isolation and lockdown, they haven’t been able to socialize, so we’ve made direct outreach, asking people how they were doing.”

tional statistics, testing updates, changes to protocols,” Mr. Schroeder said. As the pace of change has slowed, these meetings were cut back to monthly. “Our physicians feel we are passing on information as soon as we get it. They know we’ll always tell them what we know.”

Sarah Richards, MD, assistant professor of internal medicine at the University of Nebraska, Omaha, who heads the Society of Hospital Medicine’s Well-Being Task Force, formed to address staff stress in the COVID environment, said there are things that health care systems can do to help mitigate job stress and burnout. But broader issues may need to be addressed at a national level. “SHM is trying to understand work-related stress – and to identify resources that could support doctors, so they can spend more of their time doing what they enjoy most, which is taking care of patients,” she said.

“We also recognize that people have had very different experiences, depending on geography, and at the individual level stressors are experienced very differently,” Dr. Richards noted. “One of the most common stressors we’ve heard from doctors is the challenge of caring for patients who are lonely and isolated in their hospital rooms, suffering and dying in new ways. In low-incidence areas, doctors are expressing guilt because they aren’t under as much stress as their colleagues. In high-incidence areas, doctors are already experiencing posttraumatic stress disorder.”

SHM’s Well-Being Task Force is working on a tool to help normalize these stressors and encourage open conversations about mental health issues. A guide called “HM COVID Check-In Guide for Self & Peers” is designed to help hospitalists break the culture of silence around well-being and burnout during COVID-19 and how people are handling and

processing the pandemic experience. It is expected to be completed later this year, Dr. Richards said. Other SHM projects and resources for staff support are also in the works.

The impact on women doctors

In a recent *Journal of Hospital Medicine* article entitled “Collateral Damage: How COVID-19 Is Adversely Impacting Women Physicians,” hospitalist Yemisi Jones, MD, medical director of continuing medical education at Cincinnati Children’s Hospital Medical Center, and colleagues argue that preexisting gender inequities in compensation, academic rank, and leadership positions for physicians have made the COVID-19 crisis even more burdensome on female hospitalists.¹

“Increased childcare and schooling obligations, coupled with disproportionate household responsibilities and an inability to work from home, will likely result in female hospitalists struggling to meet family needs while pandemic-related work responsibilities are ramping up,” they write. COVID may intensify workplace inequalities, with a lack of recognition of the undue strain that group policies place on women.

“Often women suffer in silence,” said coauthor Jennifer O’Toole, MD, MEd, director of education

“Increased childcare and schooling obligations, coupled with disproportionate household responsibilities and an inability to work from home, will likely result in female hospitalists struggling to meet family needs.”

in the division of hospital medicine at Cincinnati Children’s Hospital Medical Center and program director of the internal medicine–pediatrics residency. “We are not always the best self-advocates, although many of us are working on that.”

When women in hospital medicine take leadership roles, these often tend to involve mutual support activities, taking care of colleagues, and promoting collaborative work environments, Dr. Jones added. The stereotypical example is the committee that organizes celebrations when group members get married or have babies.



Brian Schroeder



Dr. Yemisi Jones

These activities can take a lot of time, she said. “We need to pay attention to that kind of role in our groups, because it’s important to the cohesiveness of the group. But it often goes unrecognized and doesn’t translate into the currency of promotion and leadership in medicine. When women go for promotions in the future, how will what happened during the COVID crisis impact their opportunities?”

What is the answer to overcoming these systemic inequities? Start with making sure women are part of the leadership team, with responsibilities for group policies, schedules, and other important decisions. “Look at your group’s leadership – particularly the higher positions. If it’s not diverse, ask why. ‘What is it about the structure of our group?’ Make a more concerted effort in your recruitment and retention,” Dr. Jones said.

The JHM article also recommends closely monitoring the direct and indirect effects of COVID-19 on female hospitalists, inquiring specifically about the needs of women in the organization, and ensuring that diversity, inclusion, and equity efforts are not suspended during the pandemic. Gender-based disparities in pay also need a closer look, and not just one time but reviewed periodically and adjusted accordingly.

Mentoring for early career women is important, but more so is sponsorship – someone in a high-level leadership role in the group sponsoring women who are rising up the career ladder, Dr. O’Toole said. “Professional women tend to be overmentored and undersponsored.”

Solutions to burnout

Ultimately, listening is key to try to help people get through the pandemic, Dr. Washburn said. “People become burned out when they feel leadership doesn’t understand their needs or doesn’t hear their concerns. Our group leaders all do clinical work, so they are seen as one of us. They try very hard; they have listening ears. But listening is just the first step. Next step is to work creatively to get the identified needs met.”

A few years ago, Johns Hopkins developed training in enhanced communication in health care for all hospital providers, including nurses and doctors, encouraging them to get trained in how to actively listen and address their patients’ emotional and social experiences as well as disease, Dr. Washburn explained. Learning how to

listen better to patients can enhance skills at listening to colleagues, and vice versa. “We recognize the importance of better communication – for reducing sentinel events in the hospital and also for preventing staff burnout.”

Dr. Barnes also does physician coaching, and says a lot of that work is helping people achieve clarity on their core values. “Healing patients is a core identity for physicians; we want to take care of people. But other things can get in the way of that, and hospitalist groups can work at minimizing those barriers. We also need to learn, as hospitalists, that we work in a group. You need to be creative in how you do your team building, especially now, when you

can no longer get together for dinner. Whatever it is, how do we bring our team back together? The biggest source of support for many hospitalists, beyond their family, is the group.”

Dr. Case said there is a longer-term need to study the root causes of burnout in hospitalists and to identify the issues that cause job stress. “What is modifiable? How can we tackle it? I see that as big part of my job every day. Being a physician is hard enough as it is. Let’s work to resolve those issues that add needlessly to the stress.”

“I think the pandemic brought a magnifying glass to how important a concern staff stress is,” Ms. Panek said. Resilience is important.

“We were working in our group on creating a culture that values trust and transparency, and then the COVID crisis hit,” she said. “But you can still keep working on those things. We would not have been as good or as positive as we were in managing this crisis without that preexisting culture to draw upon. We always said it was important. Now we know that’s true.”

Reference

1. Jones Y et al. Collateral Damage: How COVID-19 Is Adversely Impacting Women Physicians. *J Hosp Med.* 2020 August;15(8):507-9.

More data on impact of corticosteroids on COVID-19 mortality in patients with COPD

By Will Pass

MDedge News

Inhaled corticosteroids (ICS) do not protect patients with chronic respiratory conditions against COVID-19–related death, a study of almost 1 million individuals in the United Kingdom has shown.

Patients with chronic obstructive pulmonary disease or asthma who used ICS on a regular basis were more likely to die from COVID-19 than COPD or asthma patients who were prescribed non-ICS therapies, reported co-lead author Anna Schultze, PhD, of London School of Hygiene & Tropical Medicine and colleagues.

Of note, the increased risk of death among ICS users likely stemmed from greater severity of preexisting chronic respiratory conditions, instead of directly from ICS usage, which has little apparent impact on COVID-19 mortality, the investigators wrote in *The Lancet Respiratory Medicine*.

These findings conflict with a hypothesis proposed early in the pandemic: that ICS may protect individuals from SARS-CoV-2 infection and poor outcomes with COVID-19.

According to Megan Conroy, MD, of the department of internal medicine at the Ohio State University Wexner Medical Center, Columbus, this hypothesis was based on some unexpected epidemiological findings.

“In general, we tend to think people with underlying lung disease – like COPD or asthma – to be at higher risk for severe forms of lower respiratory tract infections,” Dr. Conroy said. “Somewhat surprisingly, early data in the pandemic showed patients with COPD and asthma [were] underrepresented [among patients with COVID] when compared to the prevalence of these diseases in the population.”

This raised the possibility of an incidental protective effect from regular ICS therapy, which “had some strong theoretic pathophysiologic basis,” Dr. Conroy said, refer-

ring to research that demonstrated ICS-mediated downregulation of SARS-CoV-2 entry receptors ACE2 and TMPRSS2.



Dr. Conroy

Dr. Schultze and colleagues noted that investigators for two ongoing randomized controlled trials (NCT04331054, NCT04330586) are studying ICS as an intervention for COVID-19; but neither trial includes individuals already taking ICS for chronic respiratory disease.

The present observational study therefore aimed to assess mortality risk within this population. Data were drawn from electronic health records and a U.K. national mortality database, with follow-up ranging from March 1 to May 6, 2020. Eligibility required a relevant prescription within 4 months of first follow-up. In the COPD group, patients were prescribed a long-acting beta-agonist plus a long-acting muscarinic antagonist (LABA-LAMA), LABA alone, LABA plus ICS, LABA-LAMA plus ICS, or ICS alone (if prescribed LABA within 4 months).

In the asthma group, patients received low/medium-dose ICS, high-dose ICS, or a short-acting beta-agonist (SABA) alone. Patients with COPD were at least 35 years of age, while those with asthma were 18 years or older. Hazard ratios were adjusted for a variety of covariates, including respiratory disease–exacerbation history, age, sex, body mass index, hypertension, diabetes, and others.

These eligibility criteria returned 148,557 patients with COPD and 818,490 with asthma.

Patients with COPD who were prescribed ICS plus LABA-LAMA or ICS plus LABA had an increased risk of COVID-19–related death, compared with those who did not receive ICS (adjusted hazard ratio, 1.39; 95% confidence interval, 1.10-1.76). Separate analyses of patients who received a triple combination (LABA-LAMA plus ICS) versus those who took a dual combination (LABA plus ICS) showed that triple-combination therapy was significantly associated with increased COVID-19–related mortality (aHR, 1.43; 95% CI, 1.12-1.83),

while dual-combination therapy was less so (aHR, 1.29; 95% CI, 0.96-1.74). Non-COVID-19–related mortality was significantly increased for all COPD patients who were prescribed ICS, with or without adjustment for covariates.

Asthma patients prescribed high-dose ICS instead of SABA alone had a slightly greater risk of COVID-19–related death, based on an adjusted hazard ratio of 1.55 (95% CI, 1.10-2.18). Those with asthma who received low/medium-dose ICS demonstrated a slight trend toward increased mortality risk, but this was not significant (aHR, 1.14; 95% CI, 0.85-1.54). ICS usage in the asthma group was not linked with a significant increase in non-COVID-19–related death.

“In summary, we found no evidence of a beneficial effect of regular ICS use among people with COPD and asthma on COVID-19–related mortality,” the investigators concluded.

In agreement with the investigators, Dr. Conroy said that the increased mortality rate among ICS users should not be misconstrued as a medication-related risk.

“While the study found that those with COPD or asthma taking ICS and high-dose ICS were at an increased risk of death, this could easily be explained by the likelihood that those are the patients who are more likely to have more severe underlying lung disease,” Dr. Conroy said. “While this observational study did attempt to control for exacerbation history, the ability to do so by electronic health records data is certainly imperfect.”

With this in mind, patients with chronic respiratory disease should be encouraged to adhere to their usual treatment regimen, Dr. Conroy added.

“There isn’t evidence to increase or decrease medications just because of the pandemic,” she said. “A patient with asthma or COPD should continue to take the medications that are needed to achieve good control of their lung disease.”

The study was funded by the U.K. Medical Research Council. The investigators reported additional relationships with the Wellcome Trust, the Good Thinking Foundation, the Laura and John Arnold Foundation, and others. Dr. Conroy reported no conflicts of interest.



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Stroke may be the first symptom of COVID-19 in younger patients

By **Batya Swift Yasgur, MA, LSW**

Stroke may be the first presenting symptom of COVID-19 in younger patients, new research suggests. Investigators carried out a meta-analysis of data, including 160 patients with COVID-19 and stroke, and found that nearly half of patients under the age of 50 were asymptomatic at the time of stroke onset.

Although younger patients had the highest risk of stroke, the highest risk of death was in patients who were older, had other chronic conditions, and had more severe COVID-19–associated respiratory symptoms.

“One of the most eye-opening findings of this study is that, for patients under 50 years old, many were totally asymptomatic when they had a stroke related to COVID-19, [which] means that, for these patients, the stroke was their first symptom of the disease,” lead author Luciano Sposato,



Dr. Sposato

MD, MBA, associate professor and chair in stroke research at Western University, London, Ont.

The study was published online Sept. 15 in *Neurology* (doi: 10.1212/WNL.0000000000010851).

Anecdotal reports

“In early April of 2020, we realized that COVID-19 was a highly thrombogenic disease,” said Dr. Sposato. “Almost in parallel, I started to see anecdotal reports in social media of strokes occurring in patients with COVID-19, and there were also very few case reports.”

The investigators “thought it would be a good idea to put all the data together in one paper,” he said, and began by conducting a systematic review of 10 published studies of COVID-19 and stroke (n = 125 patients), which were then pooled with 35 unpublished cases from Canada, the United States, and Iran for a total of 160 cases.

The analysis examined in-hospital mortality rates of patients with stroke and COVID-19.

In addition, the researchers conducted a second review of 150 papers, encompassing a final cohort of 3,306 COVID-19 patients with stroke of any type and 5,322 with ischemic stroke.

“Some studies reported data for only ischemic stroke, and some reported data for all strokes considered together, which resulted in a different number of patients on each meta-analysis, with a lower number of ‘any stroke’ cases,” Dr. Sposato explained. “This review looked at the number of patients who developed a stroke during admission and included thousands of patients.”

Dr. Sposato noted that the first review was conducted on single case reports and small case series “to understand the clinical characteristics of strokes in patients with COVID-19 on an individual patient level,” since “large studies, includ-

ing hundreds of thousands of patients, usually do not provide the level of detail for a descriptive analysis of the clinical characteristics of a disease.”

Cluster analyses were used to “identify specific clinical phenotypes and their relationship with death.” Patients were stratified into three age groups: <50, 50-70, and >70 years (“young,” “middle aged,” and “older,” respectively). The median age was 65 years and 43% were female.

‘Remarkably high’ mortality

The review showed that 1.8% (95% confidence interval, 0.9%-3.7%) of patients experienced a new

“One of the most eye-opening findings of this study is that, for patients under 50 years old, many were totally asymptomatic when they had a stroke related to COVID-19.”

stroke, while 1.5% (95% CI, 0.8%-2.8%) of these experienced an ischemic stroke. “These numbers are higher than historical data for other infectious diseases – for example, 0.75% in SARS-CoV-1, 0.78% in sepsis, and 0.2% in influenza,” Dr. Sposato commented.

Moreover, “this number may be an underestimate, given that many patients die without a confirmed diagnosis and that some patients did not come to the emergency department when experiencing mild symptoms during the first months of the pandemic,” he added.

Focusing on the review of 160 patients, the researchers described in-hospital mortality for strokes of all types and for ischemic strokes alone as “remarkably high” (34.4% [95% CI, 27.2%-42.4%] and 35.7% [95% CI, 27.5%-44.8%], respectively), with most deaths occurring among ischemic stroke patients.

“This high mortality rate is higher than the [roughly] 15%-30% reported for stroke patients without COVID-19 admitted to intensive care units,” Dr. Sposato said.

High-risk phenotype

Many “young” COVID-19 patients (under age 50) who had a stroke (42.9%) had no previous risk factors or comorbidities. Moreover, in almost half of these patients (48.3%), stroke was more likely to occur before the onset of any COVID-19 respiratory symptoms.

Additionally, younger patients showed the highest frequency of elevated cardiac troponin compared with middle-aged and older patients (71.4% vs. 48.4% and 27.8%, respectively). On the other hand, mortality was 67% lower in younger versus older patients (odds ratio, 0.33; 95% CI, 0.12-0.94; P = .039).

Dr. Sposato noted that the proportion of isch-

emic stroke patients with large-vessel occlusion was “higher than previously reported” for patients with stroke without COVID-19 (47% compared with 29%, respectively).

“We should consider COVID-19 as a new cause or risk factor for stroke. At least, patients with stroke should probably be tested for SARS-CoV-2 infection if they are young and present with a large-vessel occlusion, even in the absence of typical COVID-19 respiratory symptoms,” he suggested.

The researchers identified a “high-risk phenotype” for death for all types of stroke considered together: older age, a higher burden of comorbidities, and severe COVID-19 respiratory symptoms. Patients with all three characteristics had the highest in-hospital mortality rate (58.6%) and a threefold risk of death, compared with the rest of the cohort (OR, 3.52; 95% CI, 1.53-8.09; P = .003).

“Several potential mechanisms can explain the increased risk of stroke among COVID-19 patients, but perhaps the most important one is increased thrombogenesis secondary to an exaggerated inflammatory response,” Dr. Sposato said.

Not just elders

Commenting on the study, Jodi Edwards, PhD, director of the Brain and Heart Nexus Research Program at the University of Ottawa Heart Institute, said the findings are “consistent with and underscore public health messaging emphasizing that COVID-19 does not only affect the elderly and those with underlying health conditions, but can have serious and even fatal consequences at any age.”

Dr. Edwards, who was not involved with the study, emphasized that “adherence to public health recommendations is critical to begin to reduce the rising incidence in younger adults.”

Dr. Sposato acknowledged that the study was small and that there “can be problems associated with a systematic review of case reports, such as publication bias, lack of completeness of data, etc., so more research is needed.”

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Clinician reviews of HM-centric research

By Kristen E. Fletcher, MD; Sean M. Lockwood, MD; Francis Ouyang, MD, MPH, FACP; Joseph R. Sweigart, MD, SFHM, FACP; Taylor Walker, MD; Peter M. Wallenhorst, MD

Lexington (Ky.) VA Health Care System

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By Kristen E. Fletcher, MD

1 Autopsy findings reveal venous thromboembolism in patients with COVID-19

CLINICAL QUESTION: What pathologic features contribute to the cause of death in COVID-19?

BACKGROUND: Despite the increased mortality rate of the novel coronavirus compared with influenza, little is understood about its pathogenicity. Prior studies have identified D-dimer levels, high Sequential Organ Failure Assessment score, and older age as markers for more severe disease and mortality. The specific cause of death of COVID-19 remains largely unknown.

STUDY DESIGN: Prospective cohort study.

SETTING: Single academic center in Germany.

SYNOPSIS: A complete autopsy was performed on 12 consecutive COVID-19 patient deaths at a single center. Seven had evidence of venous thromboembolism (VTE): three with bilateral lower extremity deep venous thrombosis (DVT) and four with massive pulmonary embolism/associated lower-extremity DVT. Prior to death, VTE was suspected clinically in only a single patient.

This small case series piques interest in the potential underrecognized thromboembolic pathology of COVID-19. While not practice changing, this study highlights the importance of hospitalists staying

attuned to further studies regarding VTE prophylaxis in COVID-19.

BOTTOM LINE: Autopsies of COVID-19 patients revealed a high incidence of thromboembolic events; COVID-19-induced coagulopathy may play an underrecognized role in pathogenesis.



Dr. Fletcher

CITATION: Wichmann D et al. Autopsy findings

and venous thromboembolism in patients with COVID-19. *Ann Intern Med.* 2020;173(4):268-77.

2 Resident physician work-hour regulations associated with improved physician safety and health

CLINICAL QUESTION: Do consecutive work-hour restrictions for first-year resident physicians improve physician safety?

BACKGROUND: In 2011, the Accreditation Council for Graduate Medical Education (ACGME) enacted a consecutive work-hour restriction of 16 hours for first-year residents. Reports of these changes have focused on patient safety, resident education, and resident well-being. The impact on resident safety had not been addressed.

STUDY DESIGN: Prospective cohort study.

SETTING: U.S. Academic institutions training resident physicians.

SYNOPSIS: This study compared first-year resident physicians from 2002 to 2007 (pre-implementation) and 2014 to 2017 (post-implementation). In all, 5,680 pre-implementation residents and 9,596 post-implementation residents consented to the study. With the 2011 ACGME restriction, the risk of motor vehicle crash decreased 24% (relative risk [RR] .76; .67-.85), and percutaneous injury risk decreased more than 40% (RR .54; .48-.61). Although weekly work hours were significantly higher pre-implementation, self-reported hours involved in patient care were similar for both groups.

While this large, well-powered study suggests extended work-hour restrictions for resident physicians improve their safety, the study is limited by self-reporting of resident physicians. As the ACGME has re-introduced extended duration shifts for first-year resident physicians, hospitalists should advocate for objective physician safety studies in relation to extended-hour shifts.

BOTTOM LINE: The 2011 ACGME work-hour reform for first-year physicians improved their safety and health.

CITATION: Weaver MD et al. The association between resident physician work-hour regulations and physician safety and health. *Am J Med.* 2020 July;133(7):e343-54.

Dr. Fletcher is a hospitalist at the Lexington (Ky.) VA Health Care System.

By Sean M. Lockwood, MD

3 Medical comanagement did not improve hip fracture outcomes

CLINICAL QUESTION: Does medical comanagement improve perioperative outcomes in patients admitted with hip fracture?

BACKGROUND: Medical comanagement of hip fracture patients is common. Prior evidence comes from mostly single-center studies, with most improvements being in process indicators such as length of stay and staff satisfaction.

STUDY DESIGN: Retrospective cohort study.

SETTING: American College of Surgeons National Surgical Quality Improvement Program database.

SYNOPSIS: With the NSQIP database targeted user file for hip fracture of 19,896 patients from 2016 to 2017, unadjusted analysis showed patients in the medical comanage-



Dr. Lockwood

ment cohort were older with higher burden of comorbidities, higher morbidity (19.5% vs. 9.6%, odds ratio, 2.28; 95% CI, 1.98-2.63; $P < .0001$), and higher mortality rate (6.9% vs. 4.0%;

OR, 1.79; 95% CI, 1.44-2.22; $P < .0001$). Both cohorts had similar proportion of patients participating in a standardized hip fracture program. After propensity score matching, patients in the comanagement cohort continued to show inferior morbidity (OR, 1.82; 95% CI, 1.52-2.20; $P < .0001$) and mortality (OR, 1.36; 95% CI, 1.02-1.81; $P = .033$).

This study failed to show superior outcomes in comanagement patients. The retrospective nature and propensity matching will lead to the question of unmeasured confounding in this large multinational database.

BOTTOM LINE: Medical comanagement of hip fractures was not associated with improved outcomes in the NSQIP database.

CITATION: Maxwell BG, Mirza A. Medical comanagement of hip fracture patients is not associated with superior perioperative outcomes: A propensity score-matched retrospective cohort analysis of the National Surgical Quality Improvement Project. *J Hosp Med.* 2020;15:468-74.

4 QI reduces daily labs and promotes sleep-friendly lab timing

CLINICAL QUESTION: Will a quality improvement project involving physician education and an EHR

shortcut reduce the quantity and optimize the timing of daily routine labs on medical inpatients?

BACKGROUND: Daily labs are often unnecessary on clinically stable inpatients. Additionally, daily labs are frequently drawn very early in the morning, resulting in sleep disruptions. No prior studies have attempted an EHR-based intervention to simultaneously improve both frequency and timing of labs.

STUDY DESIGN: Quality improvement project.

SETTING: Resident and hospitalist services at a single academic medical center.

SYNOPSIS: After surveying providers about lab-ordering preferences, an EHR shortcut and visual reminder were built to facilitate labs being ordered every 48 hours at 6 a.m. (rather than daily at 4 a.m.). Results included 26.3% fewer routine lab draws per patient-day per week, and a significant increase in sleep-friendly lab order utilization per encounter per week on both resident services (intercept, 1.03; standard error, 0.29; $P < .001$) and hospitalist services (intercept, 1.17; SE, .50; $P = .02$).

BOTTOM LINE: An intervention consisting of physician education and an EHR tool reduced daily lab frequency and optimized morning lab timing to improve sleep.

CITATION: Tapaskar N et al. Evaluation of the order SMARTT: An initiative to reduce phlebotomy and improve sleep-friendly labs on general medicine services. *J Hosp Med.* 2020;15:479-82.

Dr. Lockwood is a hospitalist and chief of quality, performance, and patient safety at the Lexington (Ky.) VA Health Care System.

By Francis Ouyang, MD, MPH, FACP

5 Universal masking of health care workers decreases SARS-CoV-2 positivity

CLINICAL QUESTION: Does a universal masking policy for health care workers have any impact on SARS-CoV-2 positivity among health care workers?

BACKGROUND: Many health care facilities have instituted universal masking policies for health care workers while also systematically testing any symptomatic health care workers. There is a paucity of data examining the effectiveness of universal masking policies in reducing COVID positivity among health care workers.

STUDY DESIGN: Retrospective co-

hort study.

SETTING: A database of 9,850 COVID-tested health care workers in Mass General Brigham health care system from March 1 to April 30, 2020.

SYNOPSIS: The study compared weighted mean changes in daily COVID-positive test rates between



Dr. Ouyang

the pre-masking and post-masking time frame, allowing for a transition period between the two time frames. During the pre-masking period, the weighted mean increased by 1.16% per day. During the post-masking period, the weighted mean decreased 0.49% per day. The net slope change was 1.65% (95% CI, 1.13%-2.15%; $P < .001$), indicating universal masking resulted in a statistically significant decrease in the daily positive test rate among health care workers.

This study is limited by the retrospective cohort, nonrandomized design. Potential confounders include other infection-control measures such as limiting elective procedures, social distancing, and increasing masking in the general population. It is also unclear that a symptomatic testing database is generalizable to the asymptomatic spread of SARS-CoV-2 among health care workers.

BOTTOM LINE: Universal masking policy for health care workers appears to decrease the COVID-positive test rates among symptomatic health care workers.

CITATION: Wang X et al. Association between universal masking in a health care system and SARS-CoV-2 positivity among health care workers. *JAMA.* 2020;324(7):703-4.

Dr. Ouyang is a hospitalist and chief of the hospitalist section at the Lexington (Ky.) VA Health Care System.

By Joseph R. Sweigart, MD, SFHM, FACP

6 Open ICUs giveth and taketh away

CLINICAL QUESTION: Do open ICUs improve or detract from patient care and education?

BACKGROUND: Some academic medical centers and many community centers use "open" ICU models in which primary services longitudinally follow patients into the ICU with intensivists comanagement.

DESIGN: Semistructured interviews

with 12 hospitalists and 8 intensivists.

SETTING: Open 16-bed ICUs at the University of California, San Francisco. Teams round separately at the bedside and are informally encouraged to check in daily.

SYNOPSIS: The authors iteratively developed the interview questions.



Dr. Sweigart

Participants were selected using purposive sampling. The main themes were communication, education, and structure. Communication was challenging among teams as well as with patients and families. The open ICU was felt to affect handoffs and care continuity positively. Hospitalists focused more on longitudinal relationships, smoother transitions, and opportunities to observe disease evolution. Intensivists focused more on fragmentation during the ICU stay and noted cognitive disengagement among some team members with certain aspects of patient care. Intensivists did not identify any educational or structural benefits of the open ICU model.

This is the first qualitative study of hospitalist and intensivist perceptions of the open ICU model. The most significant limitation is the risk of bias from the single-center design and purposive sampling. These findings have implications for other models of medical comanagement.

BOTTOM LINE: Open ICU models offer a mix of communication, educational, and structural barriers as well as opportunities. Role clarity may help optimize the open ICU model.

CITATION: Santhosh L and Sewell J. Hospital and intensivist experiences of the "open" intensive care unit environment: A qualitative exploration. *J Gen Intern Med.* 2020;35(8):2338-46.

7 Geographic cohorting increased direct care time and interruptions

CLINICAL QUESTION: Does geographic cohorting improve hospitalist efficiency?

BACKGROUND: Geographic cohorting localizes hospitalist teams to a single unit. It has previously been shown to improve outcomes.

Continued on following page

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DESIGN: Prospective time and motion study.

SETTING: 11 geographically cohorted services and 4 noncohorted teams at Indiana University Health, a large academic medical center.

SYNOPSIS: Geotracking was used to monitor time spent inside and outside of patient rooms for 17 hospitalists over at least 6 weeks. Eight hospitalists were also directly observed. Both groups spent roughly three times more time outside patient rooms than inside. Geographic cohorting was associated with longer patient visits (ranging from 69.6 to 101.7 minutes per day depending on team structure) and a higher percentage of time in patient rooms. Interruptions were more common with geographic cohorting. These hospitalists were interrupted every 14 minutes in the morning and every 8 minutes in the afternoon. Of these interruptions, 62% were face-to-face, 25% were electronic, and 13% were both simultaneously.

An important limitation of this study is that the investigators did not evaluate clinical outcomes or provider satisfaction. This may give some pause to the widespread push toward geographic cohorting.

BOTTOM LINE: More frequent interruptions may partially offset potential increases in patient-hospitalist interactions achieved through geographic cohorting.

CITATION: Kara A et al. A time motion study evaluating the impact of geographic cohorting of hospitalists. *J Hosp Med.* 2020;15:338-44.

Dr. Sweigart is a hospitalist at the Lexington (Ky.) VA Health Care System.

By Taylor Walker, MD

8 Symptoms persist in patients after acute COVID-19

CLINICAL QUESTION: What is the duration of symptoms after recovery from acute COVID-19 infection?

BACKGROUND: A large proportion of Italian patients with COVID-19 presented with symptoms, most commonly cough, fever, dyspnea, myalgias, anosmia, and gastrointestinal symptoms. Information is lacking on persistent symptoms after recovery.

STUDY DESIGN: Retrospective observational study.

SETTING: Hospital system in Rome.

SYNOPSIS: A postacute outpatient service for individuals discharged after recovery from COVID-19 was established. All patients who met World Health Organization criteria

for discontinuation of quarantine (no fever for 3 consecutive days, improved symptoms, and two negative SARS-CoV-2 tests 24 hours apart) were offered a comprehensive medical assessment. Patients were asked to retrospectively recount the presence or absence of symptoms during



Dr. Walker

the acute phase of COVID-19 and whether each symptom persisted at the time of the visit.

From April 21 to May 29, 2020, 179 patients were potentially eligible; 143 ultimately were included. During hospitalization, 72.7% of participants had evidence of interstitial pneumonia. Patients were assessed a mean of 60.3 days after onset of the first COVID-19 symptom. Only 18 (12.6%) were completely free of any COVID-19–related symptoms, 32% had one or two symptoms, and 55% had three or more. Worsened quality of life was observed among 44.1% of patients.

BOTTOM LINE: 87.4% of patients who had recovered from COVID-19 reported persistence of at least one symptom, particularly fatigue and dyspnea.

CITATION: Carfi A et al. Persistent symptoms in patients after acute COVID-19. *JAMA.* 2020;324(6):603-5.

Dr. Walker is a hospitalist at the Lexington (Ky.) VA Health Care System.

By Peter M. Wallenhorst, MD

9 New prescription for loop diuretic improves 30-day heart failure outcomes

CLINICAL QUESTION: Does a new prescription for a loop diuretic improve short-term outcomes in patients hospitalized for heart failure?

BACKGROUND: In patients with heart failure, loop diuretics are used to manage symptoms. However, the effect of loop diuretics on morbidity and mortality is not well studied.

STUDY DESIGN: Retrospective matched cohort study.

SETTING: OPTIMIZE-HF registry.

SYNOPSIS: Using the data from the OPTIMIZE-HF registry to develop a matched cohort of 2,191 pairs of patients, researchers showed that patients hospitalized for heart failure who were not previously taking any diuretic had significantly better 30-day clinical outcomes if they were discharged on a loop diuretic. Specifically, a loop diuretic on discharge

SHORT TAKES

Recreational marijuana laws do not consistently result in traffic mortalities

This study showed discordance of traffic fatality impacts of recreational marijuana laws in Colorado and Washington state. Results may be influenced by multiple confounders, including heterogeneity of marijuana laws.

CITATION: Santaella-Tenorio J et al. Association of recreational cannabis laws in Colorado and Washington state with changes in traffic fatalities, 2005-2017. *JAMA Intern Med.* 2020;180(8):1061-8.



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Olanzapine effective for advanced cancer-related chronic nausea

Olanzapine 5 mg daily effectively controlled nausea and improved quality of life parameters in patients with advanced cancer. The olanzapine group had an 8-point reduction (scale 0-10) in nausea at 1 week.

CITATION: Navari RM et al. Olanzapine for the treatment of advanced cancer-related chronic nausea and/or vomiting. *JAMA Oncol.* 2020;6(6):895-9.



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resulted in a lower 30-day all-cause mortality (hazard ratio, 0.73; 95% CI, 0.57-0.94; $P = .016$) and a lower risk of 30-day heart failure readmission



Dr. Wallenhorst

(HR, 0.79; 95% CI, 0.63-0.99; $P = .037$), compared with patients not discharged on a loop diuretic.

Neither of these associations was statistically significant during a 60-day follow-up,

and the authors acknowledge that significant 30-day associations may be sensitive to an unmeasured confounder.

BOTTOM LINE: Starting an outpatient loop diuretic on discharge for patients hospitalized for heart failure improves 30-day all-cause mortality and lowers the risk of 30-day heart failure readmission.

CITATION: Faselis C et al. Loop diuretic prescription and 30-day outcomes in older patients with heart failure. *J Am Coll Cardiol.* 2020;76:669-79.

10 Benefit of combined ascorbic acid, corticosteroids, and thiamine in septic shock remains unproven

CLINICAL QUESTION: Does the combination of ascorbic acid, corticosteroids, and thiamine attenuate organ injury in septic shock?

BACKGROUND: Sepsis is a common

reason for hospitalization, and studies of the combination of ascorbic acid, corticosteroids, and thiamine have had conflicting results.

STUDY DESIGN: Double-blind randomized controlled trial.

SETTING: 14 hospitals in the United States.

SYNOPSIS: A total of 205 patients were randomly assigned to receive parenteral ascorbic acid, hydrocortisone, and thiamine every 6 hours for 4 days or placebo in matching volumes and time points. The primary outcome was change in the Sequential Organ Failure Assessment (SOFA) score between enrollment and 72 hours. There was no statistically significant difference in SOFA scores (adjusted mean difference, -0.8 ; 95% CI, -1.7 to 0.2 ; $P = .12$), kidney failure (adjusted risk difference, 0.03 ; 95% CI, -0.1 to 0.2 ; $P = .58$), or 30-day mortality (HR, 1.3; 95% CI 0.8-2.2; $P = .26$) between the two groups. Adverse effects included hyperglycemia, hypernatremia, and new hospital-acquired infection.

BOTTOM LINE: The combination of ascorbic acid, corticosteroids, and thiamine in patients with septic shock does not improve SOFA score.

CITATION: Moskowitz A et al. Effect of ascorbic acid, corticosteroids, and thiamine on organ injury in septic shock: The ACTS randomized clinical trial. *JAMA.* 2020;324(7):642-50.

Dr. Wallenhorst is a hospitalist and palliative medicine physician at the Lexington (Ky.) VA Health Care System.

Optimal sedation strategies for COVID-19 ICU patients: A work in progress

By **Doug Brunk**

MDedge News

According to the best available evidence, analgesia remains the focus for managing COVID-19 ICU patients, according to Steven B. Greenberg, MD, FCCP, FCCM.

"The choice of sedation and analgesia is important," Dr. Greenberg, vice chair of education in the department of anesthesiology at Evanston Hospital, part of NorthShore University Health System, Chicago, said at a Society for Critical Care virtual meeting: COVID-19: What's Next. "We know that the right choice of these two components may increase liberation from ventilators, earlier ICU discharge, and return to normal brain function and independent functional status."

Analgesia first

Prior to the current pandemic, the approach to sedation of patients in the ICU was based on the PADIS Guidelines of 2018, which call for an assessment-driven, protocol-based stepwise approach to pain and sedation management in critically ill adults (Crit Care Med. 2018;46:e825-73). "[A strategy for COVID-19 in the ICU] should focus on analgesia-first sedation rather than jumping to sedation first," Dr. Greenberg said. "We know that pain management should be a priority of sedation, because pain may increase the risk of delirium, anxiety, and endocrine suppression, and may increase the risk of release of endogenous catecholamines, ischemia, and hypermetabolic states."

Fentanyl appears to be the most common opioid analgesic used for patients in the ICU, "but fentanyl is a very lipophilic drug and has a long context-sensitive half-life," he said. "There are components to fentanyl that allow it to become a very long-acting drug upon days and days of infusion. Another opioid used is remifentanyl, which is typically short-acting because it is broken down in the blood by esterases, but may cause rigidity at higher doses. Dilaudid seems to be the least affected by organ dysfunction. In our very critically ill, prolonged mechanically ventilated COVID-19 patients, we've been using methadone for its NMDA [N-methyl-D-as-

partate] antagonistic effect and its opioid-sparing effects."

As for nonopioid analgesics, Dr. Greenberg said that clinicians have shied away from using NSAIDs because of their side effects. "Trama-



Dr. Greenberg

"The ideal sedative agent has a rapid, predictable onset; is short-acting; has anxiolytic, amnestic, and analgesic properties; is soluble; has a high therapeutic index and no toxicity."

dol indirectly inhibits reuptake of norepinephrine and serotonin, and ketamine is being used a lot more because of its NMDA antagonist effect," he said. "Lidocaine and gabapentin have also been used."

In a recent systematic review and meta-analysis, researchers assessed 34 trials that examined adjuvant analgesic use with an opioid in critically ill patients versus an opioid alone (Crit Care Expl. 2020;2:e0157). They found that, when using an adjuvant such as acetaminophen, clonidine, dexmedetomidine, gabapentin, ketamine, magnesium, nefopam, NSAIDs, pregabalin, and tramadol, there was a reduction in pain scores as well as a reduction in opioid consumption. "So, clinicians should consider using adjuvant agents to limit opioid exposure and improve pain scores in the critically ill," Dr. Greenberg said.

ICU delirium: Risk factors, prevention

Delirium in COVID-19 patients treated in the ICU is of particular concern. According to a systematic review of 33 studies, 11 risk factors for delirium in the ICU were supported by strong or moderate levels of evidence (Crit Care Med. 2015;43:40-7). These include age, dementia, hypertension, emergency surgery, trauma, APACHE score of II, need for mechanical ventilation, metabolic acidosis, delirium on prior day, coma, and dexmedetomidine use. Risk factors for ICU delirium among COVID-19 patients, however, "are far different," Dr. Greenberg said. "Why? First and foremost, we are restricting visitation of family," he said. "That family connection largely can be lost. Second, there are limitations of non-

pharmacologic interventions. There is less mobility and physical therapy employed because of the risk of health care workers' exposure to the virus. There's also uncertainty about the global pandemic. Anxiety and

patients who have them, use ear plugs to cancel noise, mobilize patients, maintain sleep/awake cycles, and encourage sedation holidays (Crit Care Med. 2018;46[9]:e825-73).

A recent study from France found that, among 58 patients with COVID-19, 65% had positive Confusion Assessment Method (CAM)-ICU findings and 69% had agitation (N Engl J Med. 2020;382:2268-70). Most of the patients (86%) received midazolam, 47% received propofol, and all received sufentanil. "In the pre-COVID days, we would use midazolam as a second-line agent for many of these patients," Dr. Greenberg said. "So, times really have changed."

The fate of COVID-19 patients following discharge from the ICU remains a concern, continued Dr. Greenberg, clinical professor of anesthesiology at the University of Chicago. A recent journal article by Michelle Biehl, MD, and Denise Sese, MD, noted that post-intensive care

Continued on following page



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Continued from previous page syndrome (PICS) or new or worsening impairment in any physical, cognitive, or mental domain is of significant concern among COVID-19 patients following their ICU stay (Cleveland Clin J Med. 2020 Aug doi: 10.3949/ccjm.87a.ccc055). The authors stated that COVID-19 patients may face a higher risk of PICS because of restricted family visitation, prolonged mechanical ventilation, exposure to higher amounts of sedatives, and limited physical therapy during hospital stay.

Lack of ideal sedative agent

The 2018 PADIS Guidelines on the use of ICU sedation suggested strong evidence for modifiable risk factors producing delirium in the context of benzodiazepines and blood transfusion. They recommend a light level of sedation and the use of propofol or dexmedetomidine over benzodiazepines. They also recommend routine delirium testing such as using the CAM-ICU or Intensive Care Delirium Screening Checklist (ICDSC) and nonpharmacologic therapies such as reorientation, cognitive stimulation, sleep improvement, and mobilization.

Several sedation-related factors may be related to an increased risk of delirium. “The type, dose, duration, and mode of delivery are very important,” Dr. Greenberg said. “The ideal sedative agent has a rapid, predictable onset; is short-acting; has anxiolytic, amnestic, and analgesic properties; is soluble; has a high therapeutic index and no toxicity. The ideal sedative is also easy to administer, contains no active metabolites, has minimal actions with other drugs, is reversible, and is cost effective. The problem is, there really is no ideal sedative agent. There is inadequate knowledge about the drugs [used to treat COVID-19 in the ICU] available to us, the dosage, and importantly, the pharmacokinetics and dynamics of these medications.”

The classic types of sedation being used in the ICU, he said, include the benzodiazepines midazolam, lorazepam, and diazepam, as well as propofol. Alternatives include dexmedetomidine, clonidine, ketamine, and the neuroleptics – haloperidol, quetiapine, olanzapine, ziprasidone, and risperidone. “The advantages of benzos are that they are anxiolytics, amnestics, and they are good sedatives with minimal hemodynamic effects,” Dr. Greenberg said.

Advantages of propofol include its sedative, hypnotic, and anxiolytic properties, he said. It reduces the ce-

rebral metabolic rate and can relieve bronchospasm. “However, small studies have found that its use may be associated with an increased risk of delirium,” he said. “It is a respiratory depressant, and it can cause hypotension and decreased contractility. It has no analgesic properties, and two of the big concerns of its use in COVID-19 are the potential for hypertriglyceridemia and propofol infusion syndrome, particularly at doses of greater than 5 mg/kg per hour for greater than 48 hours. It is

being given in high doses because patients are requiring higher doses to maintain ventilator synchrony.”

Choice of the right drug

The keys to success for sedation of ICU patients are choosing the right drug at the right dose for the right duration and the right mode of delivery, and applying them to the right population. However, as noted in a recent study, the pandemic poses unique challenges to clinicians in how they care for critically ill COVID-19 patients who require sedation (Anesth Analg. 2020 Apr 22. doi: 10.1213/ANE.000000000004887). The use of provisional work areas “has escalated because of the amount of patients we’ve had to care for over the past 9 months,” Dr. Greenberg said. “We’ve used alternate providers who are not necessarily familiar with the sedation and analgesic protocols and how to use these specific medications. Drug shortages have been on the rise, so there’s a need to understand alternative agents that can be used.”

COVID-19 patients face the potential risk for an increase in drug-drug interactions and side effects due to the polypharmacy that is often required to provide adequate sedation during mechanical ventilation. He noted that these patients may have “unusually high” analgesia and sedation requirements, particularly when they’re mechanically ventilated. A hypothesis as to why patients with COVID-19 require so much sedation and analgesia is that they often have a high respiratory drive and ventilator dyssynchrony, which requires increased neuromuscular blockade. “They also have an intense inflammatory response, which may be linked to tolerance of specific opioids and other medications,” Dr. Greenberg said. “Many ventilated



Dr. Narasimhan

COVID-19 patients are of younger age and previously in good health, and therefore, have an excellent metabolism. Health care providers are concerned about self-extubation. This prompts bedside providers to administer more sedatives to prevent this unwanted complication. There may also be a reduction of

“The recommendations echo the experience we have had with large numbers of intubated COVID-19 patients.”

drip modifications by health care workers because of the potential risk of contracting COVID-19 when going into the room multiple times and for long periods of time” (Anesth Analg. 2020;131[1]:e34-5).

According to a sedation resource on the SCCM website, about 5% of COVID-19 patients require mechanical ventilation. “There has been a massive shortage of the usual drugs that we use,” Dr. Greenberg said. “The demand for sedatives has increased by approximately 91%, while the demand for analgesics has increased by 79%, and neuromuscular blocker demand has increased by 105%.”

A retrospective study of 24 COVID-19 patients who required ventilation in the ICU found that the median daily dose of benzodiazepines was significantly higher, compared with the median daily dose used in the OSCILLATE trial (a median of 270 mg vs. 199 mg, respectively; Anesth Analg. 2020;131[4]:e198-200. doi: 10.1213/ane.0000000000005131). In addition, their median daily dose of opioid was approximately three times higher, compared with patients in the OSCILLATE trial (a median of 775 mg vs. 289 mg). Other agents used included propofol (84%), dexmedetomidine (53%), and ketamine (11%).

“A potential strategy for COVID-19 ICU patient sedation should be analgesia first, as indicated in the 2018 PADIS guidelines,” Dr. Greenberg advised. “We should also apply nonpharmacologic measures to reduce delirium. In nonintubated patients, we should use light to moderate sedation, targeting a RASS of –2 to +1, using hydromorphone or fentanyl boluses for analgesia and midazolam boluses or dexmedetomidine for sedation.”

For intubated patients, he continued, target a RASS of –3 to –4, or –4 to –5 in those who require neuromuscular blockade. “Use propofol first then intermittent boluses of benzodiazepines,” said Dr. Greenberg, editor-in-chief of the Anesthesia Patient Safety Foundation newsletter. “For heavy sedation, use midazolam and supplement with ketamine and other analgesics and sedatives such as barbiturates, methadone, and even inhalation anesthetics in some cases.”

For analgesia in intubated patients, use fentanyl boluses then infusion. “Patients can easily become tachyphylactic to fentanyl, and it has a long context-sensitive half time,” he said. “Hydromorphone may be least affected by organ dysfunction.”

Dr. Greenberg concluded his presentation by stating that more studies are required “to delineate the best analgesia/sedation strategies and monitoring modalities for COVID-19 ICU patients.”

In commenting on the presentation, Mangala Narasimhan, DO, FCCP, senior vice president and director of critical care services at Northwell Health, said that the recommendations regarding sedation highlight a struggle that ICU providers have been dealing with during the COVID-19 epidemic.

“There have been unique challenges with COVID-19 and intubated patients. We have seen severe ventilator dyssynchrony and prolonged duration of mechanical ventilation. I think we can all agree that these patients have extremely high metabolic rates, have required high levels of sedation, have an increased need for neuromuscular blockade, and have high levels of delirium for extended periods of time. The recommendations provided here are reasonable. Strategies to prevent delirium should be employed, pain management should be prioritized, analgesics can help reduce the need for opioids. Alternatives to sedation are useful in this patient population and are well tolerated. Drug shortages have provided additional challenges to these strategies and have required us to think about the use of alternative agents. The recommendations echo the experience we have had with large numbers of intubated COVID-19 patients.”

Dr. Greenberg disclosed that he receives a stipend from the Anesthesia Patient Safety Foundation for serving as editor-in-chief of the foundation’s newsletter.

The socioeconomic revolving door of 30-day heart failure readmissions

By Steve Stiles

Patients receiving even top-notch hospital care for heart failure (HF) are, once discharged to home, at higher short-term risk of another HF hospitalization if home is in a socioeconomically deprived neighborhood. That helps explain why Blacks in the United States have a much higher 30-day HF readmission risk than Whites, a disparity that only worsens with the level of neighborhood deprivation, a new analysis suggests.

Some systemic and entrenched socioeconomic inequities that health care providers have little sway over, and which disproportionately affect Black individuals, are independent and robust predictors of worsened HF outcomes, Alanna A. Morris, MD, MSc, Emory University, Atlanta, said during her presentation at the virtual annual scientific meeting of the Heart Failure Society of America.

In a retrospective cohort study, Blacks had a 45% higher risk of 30-day readmission than Whites ($P < .001$) independent of cardiovascular risk factors, clinical history, comorbidities, type and location of hospital, and type of third-party payer coverage. The analysis included more than 30,000 patients with at least one HF hospitalization at centers in a major metropolitan health system.

The racial disparity widened with worsening socioeconomic deprivation of patients' residential neighborhoods, that is, with rising quartiles of neighborhood scores on the Social Deprivation Index (SDI).

The SDI, based on U.S. census data, incorporates seven socioeconomic criteria, including household income, education level, employment, and prevalence of rented housing and households that are without a car, single parent, or overcrowded.

There was a 4-percentage point gap in adjusted 30-day readmission rate between Blacks and Whites in the lowest quartile that widened to more than 8 points by the third quartile; the disparity in both the second and fourth quartiles was the same, at about 5.5 percentage points.

A remaining question, Dr. Morris said in an interview, is why the outcomes disparity between Blacks and Whites peaks in the third SDI quartile but drops a bit in the fourth quartile representing the most se-

vere neighborhood deprivation.

"Our hypothesis is that, when you look at patients who are the poorest, who live in the most deprived neighborhoods, race may be less of a factor," she said. Socioeconomic deprivation may have similar consequences for everyone "regardless of race, ethnicity, gender, or other demo-



Dr. Keith C. Ferdinand

graphic characteristics if you live in a neighborhood that's highly deprived."

Based on the current study, "it does appear that increased heart failure incident rates are related to living in deprived neighborhoods, and it raises important clinical and public health concerns that must be addressed," Keith C. Ferdinand, MD, Tulane University, New Orleans, said as invited discussant after the presentation from Dr. Morris.

"These findings could serve as an aid to policy makers, going forward, in terms of allocating resources for primary health care," he said. "And it's important looking at these data and other [data] that we target heart failure patients who reside in deprived neighborhoods before, during, and [after] hospitalization."

Dr. Morris agreed that policy makers are in a better position to attack the racial disparity in HF readmission rates identified in the study.

If the reported interpretation is correct, it could add a twist to the public health care debate in the United States, observed session moderator Mandeep R. Mehra, MD, Brigham and Women's Hospital in Boston.

That debate, he noted, has often focused on insurability, access to coverage, and the merits or shortcomings of a single-payer system. Yet the study suggests outcomes disparities stemming from neighborhood deprivation will not be corrected by

improved access to health insurance, a conclusion he finds "startling," Dr. Mehra said in an interview.

Some proposed explanations for the disparities by race blame unequal access to health care and or variable health insurance coverage, Dr. Morris observed in an interview. But "that may not fully explain the increased risk that we see."

Black patients followed at Emory University's advanced HF clinic still have a higher risk of rehospitalization than Whites. "These are patients who have insurance, who are followed by advanced heart failure providers, who are on equal amounts of guideline-recommended medical therapy – and you still see about a 50% higher risk of rehospitalization," Dr. Morris said, citing data that aren't part of the current analysis.

"We can say that these patients are certainly able to access care, because they are able to access our emergency room and be taken care of within the hospital setting," he said. The study controlled for whether health coverage was by private insurance, Medicare, or Medicaid.

Instead, the current analysis points to socioeconomic and environmental factors as a major source of the disparity in 30-day readmissions, Dr. Morris said.

"When patients are discharged from our health care systems, they still go back into environments where they don't have the same resources as patients who live in higher-SDI neighborhoods," she explained.

For example, "we tell them to eat low-sodium [foods], exercise, eat fresh fruits and vegetables, take their medicines, but the reality is that certain neighborhoods within the United States – and this is much more true for Blacks – make it very difficult to follow those self-care recommendations."

The analysis included 16,147 Black patients and 14,483 White patients hospitalized with HF within the Emory Healthcare system at least once from 2010-2018, Dr. Morris reported. Compared with Whites, Blacks were younger (63.5 vs 69.1 years) and less likely to be 65 or older (48.9% vs. 66.5%); more likely to be women (53.5% vs. 42.2%); more likely to reside in deprived census tracts and to have diabetes, hypertension, or chronic kidney disease; and had

higher comorbidity scores.

In all, 20.6% of Black and 13.5% of White patients were readmitted for HF within 30 days of discharge, for an unadjusted risk ratio of 1.52 (95% confidence interval, 1.44-1.61).

The RR hardly budged, 1.45 (95% CI, 1.37-1.54; $P < .001$), after adjustment for age, sex, type of insurance, type of HF, vital signs and laboratory values, medical history (diabetes, hypertension, atrial fibrillation, coronary disease, chronic kidney disease, and chronic pulmonary disease), Charlson Comorbidity Index, discharging medical specialty, and hospital location.

The excess in 30-day HF readmissions for Black, compared with White patients climbed from the first to the third neighborhood SDI quartile, the disparity peaking at 8.2 absolute percentage points.

A major criticism of the Hospital Readmissions Reduction Program component of the Affordable Care Act, Dr. Morris said, is that it can hold hospitals "responsible for structural inequalities that exist beyond the health care system," including neighborhood deprivation.

"There are certain patients we take care of who don't have the resources to carry out the therapeutic lifestyle changes that will allow them to live healthy."

The HRRP's 30-day HF readmission metric that steers reimbursement "is penalizing health care systems across the United States" with its premise that hospital performance can be measured by 30-day HF readmission rates, Dr. Morris said in an interview.

"The reality is that some of these patients are going to a postdischarge environment that is inherently high risk, and that many of them are going to come back to us within 30 days," she said. "We would like to make sure that we don't put excess penalties on health care systems that take care of disproportionate numbers of African Americans in neighborhoods that have fewer resources."

Dr. Mehra discloses consulting or serving on an advisory board for Abbott, Medtronic, Janssen, Leviticus, NupulseCV, FineHeart, Portola, Bayer, the Baim Institute for Clinical Research, and Mesoblast.

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

Rounding to make the hospital go 'round

Hospitalists and performance incentive measures

By Tresa Muir McNeal, MD, FACP, SFHM

No matter how you spin it, hospitalists are key to making the world of the hospital go 'round, making their daily work of paramount interest to both hospitals and health systems.

In an effort to drive quality, safety, and efficiency, hospitals most commonly measure hospitalist work and reward it through ties to compensation. There are several trends in performance incentive metrics highlighted by the SHM 2020 *State of Hospital Medicine* (SoHM) Report. As hospitals support the subsidy required for hospitalist salaries, there is an increasing ask for hospitalist groups to partner with hospital operations to achieve certain goals. The lever of compensation, when appropriately applied to meaningful metrics, is one way of promoting desired behaviors.

Hospitalists are the primary attending physicians for patients in the hospital while also bridging the patient and their needs to the

services of other subspecialists, allied health professionals, and when needed, postacute services. In this way, patients are efficiently moved along the acute care experience with multiple process and outcome measures being recorded along the way.

Some of these common perfor-



mance incentive measures are determined by the Centers for Medicare & Medicaid Services while others may be of interest to third-party payers. Often surrogate markers of process metrics (i.e., order set usage for certain diagnoses) are measured and incentivized as a way of directionally measuring small steps that each hospitalist can reliably control toward a presumably associated improvement in mortality or readmissions, for instance. Still other measures such as length of stay or timely completion of documentation have more to do with hospital

operations, regulatory governance, and finance.

There are a variety of performance incentive metrics reported in the 2020 SoHM Report. Survey respondents could choose all measures that applied as compensation measures for their group in the past year. The most common metrics reported include patient satisfaction (48.7%), citizenship (45.8%), accuracy or timeliness of documentation (32.8%), and clinical process measures (30.7%).

It is important to acknowledge that most of these metrics are objective measurements and can be measured down to the individual physician. However, some of the objective measures, such as patient satisfaction data, must rely on agreed-upon methods of attribution – which can include anything from attributing based on admitting physician, discharging attending, or the attending with the greatest number of days (i.e., daily charges) seeing the patient. Because of challenges with attribution, groups may opt for group measurement of metrics for some of the compensation metrics where attribution is most muddy.

For performance incentive metrics that may be more subjective, such as citizenship, it is important for hospitalist leaders to consider having a method of determining a person's contribution with a rubric as well as some shared decision-making among a committee of leaders or team members to promote fairness in compensation.

Hospital leaders must also recognize that what is measured will lead to "performance" in that area. The perfect example here is the "early morning discharge time/orders" which is a compensation metric in 27.6% of hospitalist groups. Most agree that having some early discharges, up to maybe 25%-30% of the total number of discharges before noon, can be helpful with hospital throughput. The trick here is that, if a patient can be discharged that early, it is likely that some of those patients could have gone home the evening prior. It is important for hospitalist physician leaders and administrators to think about the behaviors that are incentivized in compensation metrics to ensure that the result is indeed helpful.



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Other hospitalist compensation metrics such as readmissions are most effectively addressed if there are multiple physician teams working toward the same metric. Hospitalist work does affect readmissions within the first 7 days of discharge based on available evidence.¹ Preventing readmissions from days 8 to 30 following discharge are more amenable to outpatient and home-based interventions. Also, effective readmission work involves collaboration among the emergency physician team, surgeons, primary care, and subspecialty physicians. So while having this as a compensation metric will gain the attention of hospitalist physicians, the work will be most effective when it is shared with other teams.

Overall, performance incentive metrics for hospitalists can be effective in allowing hospitals and hospitalist groups to partner toward achieving important outcomes for patients. Easy and frequent sharing of data on meaningful metrics with hospitalists is important to effect change. Also, hospital leadership can facilitate collaboration among nursing and multiple physician groups to promote a team culture with hospitalists in achieving goals related to performance incentive metrics.

Reference

1. Graham KL et al. Preventability of early versus late hospital readmissions in a national cohort of general medicine patients. *Ann Intern Med.* 2018 Jun 5;168(11):766-74.





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Being a pediatric hospitalist during the COVID-19 pandemic

By Saba Fatima, MD

“Times of great calamity and confusion have been productive for the greatest minds. The purest ore is produced from the hottest furnace. The brightest thunderbolt is elicited from the darkest storm.”

– Charles Caleb Colton

I walk inside the pediatric unit of our hospital, only to be welcomed by an eerie silence. There are a handful of nurses at the nursing station, faces covered with masks sitting 6 feet apart and quietly working on their computers. The resident work lounge also depicts a similar picture of emptiness. Just over a month ago, these halls were bustling with children, parents, consultants, and a host of ancillary staff. I recall times in which I was running around from one patient room to another talking to families and attending to patient needs. For the past 2 months I have often spent hours alone in my office waiting to see a patient. This is the new norm for many of us.

Across the board in hospitals, pediatric census has dropped since the start of the COVID-19 pandemic. Reasons for these are nonspecific but may include fear among parents of “exposure” to the virus by bringing their sick children to the hospital to get evaluated for other concerns. A few patients that we have seen in our hospital are sicker when they have arrived because their parents avoided seeking medical care earlier, plagued by the same fear. Social distancing and school closure have also limited the amount of infectious diseases going around, which are responsible for a bulk of pediatric admissions.

While many of us are still coming in to see the limited number of patients we have, we are not in the true sense frontline providers during this pandemic. There have been limited cases of COVID-19 in children, most of which – fortunately – present with mild symptoms. Although multisystem inflammatory syndrome in children (MIS-C) is a new disease that COVID-19 has brought us closer to, many of us have yet to see our first case because of its rarity.

I have read through the news daily

in the past few months to find many adult provider physicians succumbing to COVID-19 and felt a pang of guilt. My social media is full of heart-breaking stories as adult hospitalists are having difficult conversations with families and supporting them through this unknown territory, often sacrificing their own safety. I feel so proud of them and my profession. My heart tells me, though, I personally may not be living up to the true calling I was expected to have as a physician.

The closure of pediatric units has put an additional strain on the overall framework of the community.

As pediatric hospitalists, while we sit and wait for this pandemic to pass, we have been ruminating on and anxious about our future. As census drops, there is a financial strain that many of us are feeling. Job cuts and furloughing of health care workers in our surroundings leave us with a sense of insecurity and low morale. Many small inpatient pediatric units have had to be shut down temporarily either so they could be used for adult patients or because of lack of pediatric patients. Limiting staffing to avoid exposure and cohorting providers has also been a challenge.

A big question that has risen in these times is how to ensure productivity and stay useful while preparing for the unknown that lies ahead. The economics of medicine is staring hard at our years of hard work, questioning the need for our specialty in the first place.

In smaller community settings, the closure of pediatric units has put an additional strain on the overall framework of the community, parents, and referring primary care providers. With the absence of local resources, children who have needed care have had to be transferred to bigger referral centers that are still taking care of pediatric patients. On one end of the spectrum there is concern for pediatric inpatient units not being produc-

tive enough for the hospital, but that coexists with a worry that, as we pass through this pandemic, we could see more hospitalizations for vaccine-preventable illnesses, child abuse/medical neglect, and respiratory syncytial virus plus COVID.

The question remains about how best to cope and use this time of uncertainty to be productive and prepare for the worst. A few suggestions are highlighted below.

- **Helping adult providers:** Many pediatric hospitalist colleagues in highly affected states have filled the increasing need for clinicians and taken care of adult patients. As pediatric units have closed, providers have continued to offer care where it is needed. Pediatric hospitalists have used this time to take urgent refresher courses in advanced cardiac life support and adult critical care. In states that are not as severely hit, many pediatric hospitalists have utilized this time to plan and prepare protocols for the future as information continues coming in regarding MIS-C and COVID-19 in pediatric patients.
- **Using telemedicine:** With the ease in restrictions for use of telemedicine in many states, pediatric hospitalists can consider using it to restructure their staffing model whenever feasible. This can help in cohorting and allowing high-risk and quarantined providers to work from home. This model simultaneously provides opportunities for pediatric hospitalists to continue providing their services, while at the same time decreasing financial burden on their institution.
- **Reaching out to the community:** Engaging with the community during these times can help ensure services and options remain available to our referral providers and patients for pediatric services. Information about COVID-19 can be widely disseminated. We can also play our part by continuing to encourage parents in our maximum capacity to obtain care for their children when needed and to not avoid the hospital because of fears of exposure.
- **Supporting each other:** There is no doubt that these times are unsettling for the pediatric hospitalist community, and the uncertainty



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that surrounds us can feel crippling. Strong team building is imperative in these times. While we may not be frequently meeting in work lounges and sharing meals, a good sense of support and camaraderie will go a long way in building morale for the future. Seeking mental health resources if needed is essential for us and should not be looked at with shame or guilt. This is something that many of us have never seen before, and it is okay to ask for help. Seeking help is and always will be a sign of strength.

Today, as I envision myself walking in the hospital on the other side of this pandemic I see a cheerful pediatric unit, smiling faces without masks, my 3-year-old patient cruising around the hallways in a toy car, our therapy dog walking around bringing joy to many, and many healthy patients feeling better and ready to go home. A time when we are not scared to hug each other, shake hands, or share emotion. When our teams are stronger and more well bonded. A time when parents are not scared to bring their sick children to the hospital. Will it be many months before this happens? I don’t know. But I do know that the children I take care of are known for their resilience. I will live up to them today by practicing the same.

Hospitalist Insight

Social media and health information: Empowering or misleading?

By Taru Saigal, MD

The search engine giants, Dr. Google or Dr. Bing, are visited by most of our patients before seeking medical help. In 1976, medical student Tom Ferguson, MD, first coined the term e-Patient. It means a health consumer who uses the Internet to gather information about a medical condition for themselves or on behalf of family and friends and uses electronic communication tools to cope with medical conditions. Dr. Ferguson described e-Patients as “empowered medical consumers.”

During the COVID-19 pandemic, social media and networking platforms – such as Facebook, Twitter, Instagram, Snapchat, YouTube, WhatsApp, online health support groups – are used increasingly by e-Patients to gather critical health information. Health care providers often take a conflicted stand on the use of social media. Though we want our patients to read about their illnesses and make informed choices, we often get frustrated by misdiagnoses, misinformation, and disinformation that comes with it.

According to a study investigating the differential diffusion of news stories distributed on Twitter from 2006 to 2017, fake news was considered more novel than true news, and people were more likely to share novel information. Bots accelerated the spread of true and fake news at the same rate, implying that fake news spreads more than the truth because humans, not robots, are more likely to spread it. Social media has promoted some of the best health campaigns, like public cancer awareness, the ALS Ice Bucket Challenge, World Heart Day, and others. At the same time, it has also provided a platform for antivaccination activists, dangerous and unproven alternative cancer therapies, weight-loss pills, and nutrition plans.

According to a Pew Research Center survey, 72% of adult Internet users had searched online for information about a range of health issues of their own or for others in the past 12 months. A survey from 2019 to 2020 showed that those who relied on social media for news were

among the least knowledgeable about key facts during the COVID-19 outbreak. About 74% of public posts about COVID-19 were linked to news organizations, while just 1% linked to health and science sites. While social media has emerged as one of the most significant health information sources, it famously has only a few safeguards in place against medical misinformation. Requiring responsibility and regulations for accurate or evidence-based information walks a thin line on infringing freedom of speech. Medical misinformation related to COVID-19 has become as contagious as the virus itself.

In February 2020, the World Health Organization warned that a massive “Infodemic” had accompanied the COVID-19 outbreak, with an overabundance of information, some accurate and some not, making it difficult for people to find reliable sources and trustworthy information. The Black immunity myth, groups opposing vaccines, campaigns against 5G mobile phone networks, suggestions that SARS-CoV-2 was an engineered bioweapon, and online rumors leading to mob attacks in India and mass poisonings in Iran are some of the misleading health information that has circulated related to COVID-19.

In the Web 2.0 era, in which credible health information comes packaged with divisive and misleading information, social media’s full impact on health care, health outcomes, and mental health has yet to be explored. Social networks and media sharing networks have recently announced initiatives to stop misinformation and disinformation by fact-checking, flagging, issuing warnings, and deleting misinformation or misleading content. Providing links to more and correct information and partnering with health and science organizations can also encourage the spread of verifiable information.

While we have yet to see if social media safeguards are adequate, the medical community needs to proactively educate patients on the appropriate use of social media for health information, e-Health literacy, and media health literacy. Like health care providers evaluating sci-

entific papers, we need to cultivate e-Patients’ ability to seek, evaluate, understand, and convey health information from electronic sources. Although the measurement and training tools for e-Health and media health literacy are still scarce, a good place to start could be to have simple conversations with patients. Encouraging patients to critically analyze online information, use credible social media sources, and recognize the warnings, red flags, and links on unreliable information are some of the discussions worth considering. Equally important is to discourage patients from changing health behaviors or practices based on unverified social media resources and discussing the possible impact of medical misinformation.

A practical approach for e-Patients could be to ask the Five Ws, considered fundamental in information gathering: Who, What, Why, When, and Where.

- **Who** runs the website? Examine the authors, sponsors, and sources. Federal agencies’ website addresses end in “.gov,” educational institutions maintain “.edu,” large professional or nonprofit organizations often use “.org,” and commercial websites use “.com.”
- **What** is offered, and What is the evidence? Does it provide unbelievable solutions or quick, miracle cures?
- **Why** was the site created? Is the mission or goal to inform, explain, or sell health or medical products? Check details on “About This Site” or “About Us.”
- **When** was the information written or the webpage last updated?
- **Where** are the privacy policies? Is your privacy protected?

The anonymity of sources, sponsors, financial interests, or the lack of medical credentials and reputable medical research, the use of testimonials as evidence, outdated or incomplete information, and emotional or exaggerated language should raise suspicion about the reliability of the information. Tools like the online tutorial and a checklist from the National Institute of Health’s National Library of Medicine can also be offered to e-Patients to learn how to evaluate



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health information online.

Online health support groups widely used by patients can be an additional layer of support but can also be a source of misinformation. Since they have fewer gatekeepers than traditional face-to-face communication, keeping a check on the credibility of the information can be difficult. Support groups affiliated with local hospitals or national organizations, or those endorsed by well-known scientific societies, can be encouraged instead of less credible sources. Some online support groups, run by non-health care professionals but with experienced and reliable scientific panels, can be useful resources. However, patients must check for the credibility and reliability of the information.

Lastly, just as hospitalists take a social history of our patients, we could also ask for a “social media history” to understand patients’ sources of health information. We can then guide them toward more credible sources to make them truly empowered medical consumers.

For a complete list of references, see the online version of this article: www.the-hospitalist.org/hospitalist/article/229003/mixed-topics/social-media-and-health-information-empowering-or-misleading?channel=41022.

A detailed illustration of a microbiome. The background is a teal color. In the foreground, there are several large, blue, rod-shaped bacteria with internal structures. A large, semi-circular white arc is on the right side. Inside this arc, there are red, branching, root-like structures and several pink, rod-shaped bacteria. The overall theme is the complexity and diversity of the human microbiome.

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